State of West Virginia Department of Human Services

Adult Residential Services Policy

Bureau for Social Services

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SECTION 1 - INTRODUCTION AND OVERVIEW

1.1 Mission, Vision, and Values

The Bureau for Social Services promotes the safety, permanency, and well-being of children and vulnerable adults, supporting individuals to succeed and strengthening families. Our vision is for all West Virginia families to experience safe, stable, healthy lives and thrive in the care of a loving family and community. Our values include professionalism, integrity, excellence, relationships, and staff contributions.

1.2 Introduction

Adult residential services (ARS) includes adult family care (AFC) homes and assisted living facilities. These placement options may be appropriate for individuals who are no longer able to safely remain in their own homes due to physical, cognitive, and/or emotional deficits. Although an individual may be experiencing deficits in one or more of these domains, the deficits are not significant enough to warrant the level of care provided in a nursing home.

Adult family care homes are placement settings for adults that provide support, protection and security in a family setting. The AFC home may provide care for up to three adults and is certified to provide care by the department homefinder. Assisted living facilities are residential settings for adults that provide supervision, support, protection, and security in a group living setting to four or more residents. The residents may need limited and intermittent nursing care. Assisted living facilities must be licensed by the Office of Health Facilities Licensure and Certification.

1.3 General Definitions

Term	*Definition*
Abuse	The infliction or threat of physical or psychological harm, including the use of undue influence or the imprisonment of any vulnerable adult or facility resident. See, W. Va. Code §9-6-1
Activities of daily living (ADL)	Routine activities that people do every day without needing assistance. There are six basic ADL's: eating, bathing, dressing, toileting, transferring and continence.
Adult family care home	A placement setting within a family unit that provides support, protection and security for up to three individuals over the age of 18 who meet the criteria for Adult Residential Services.
Adult family care provider	An individual or family unit certified by the department. The provider will provide support, supervision, and assistance to adults placed in their home and receive a supplemental payment from the department for the adults' care.
Advanced nurse practitioner	A nurse with substantial theoretical knowledge in a specialized area of nursing practice and a proficient clinical utilization of the knowledge in implementing

	the nursing process and has met the applicable licensing requirements. See, W. Va. Code §16-30-3
Adult residential services	Adult Residential Services is made to encompass all Adult Placement types including Adult Family Care and Assisted Living.
Assisted living residence	Any living facility, residence or place of accommodation available for four or more residents, which is advertised, offered, maintained or operated by the ownership or management, for the express or implied purpose of having personal assistance or supervision, or both, provided to any residents therein who are dependent upon the services of others by reason of physical or mental impairment and who may also require nursing care at a level that is not greater than limited and intermittent nursing care. The facility is licensed by the Office of Health Facilities and Licensure and Certification (OHFLAC) and provides twenty-four hour awake supervision of activities of daily living. See, W. Va. Code §16-5D-2
Attending physician	the physician selected by or assigned to the person who has primary responsibility for treatment and care of the person and who is a licensed physician. If more than one physician shares that responsibility, any of those physicians may act as the attending physician. See, W. Va. Code §16-30-3
Change of venue	This is a legal process whereby the court with jurisdiction over a guardianship proceeding may transfer jurisdiction of the proceeding to a court in another county or state pursuant to W. Va. Code §44A-1-7. A guardian and/or conservator shall continue to file their respective reports and/or accountings to the court that has jurisdiction over the proceeding.
Comprehensive Child Welfare Information System (CCWIS) (WVPATH)	The automated client information system used by the West Virginia Department of Human Services Bureau for Social Services. WV PATH provides a comprehensive child welfare information system, allowing employees to more efficiently track and view data.
Cognitive deficit	Impairment of an individual's thought processes.
Conservator	A person appointed by the circuit court and is responsible for managing the estate and financial affairs of a protected person. The 'estate' can include personal property, stocks, bonds, or other interest in property. The conservator appointment could be full, temporary, or limited. See, W. Va. Code §44A-1-4
Limited conservator	A person appointed by the Circuit Court who has only those responsibilities for managing the estate and financial affairs of a protected person, as specified in the order of appointment. See, W. Va. Code §44A-1-4
Temporary conservator	A person appointed by the Circuit Court who has only those responsibilities for managing the estate and financial affairs of a protected person, as specified in the order of appointment. The appointment of a temporary conservator shall expire within six months unless it is terminated or extended

	for up to six months by the court or mental hygiene commissioner for good cause shown following a hearing. See, W. Va. Code §44A-1-4
Durable power of attorney	A written, signed directive by a capacitated individual designating another person to act as their representative. The durable power of attorney specifies the areas in which this individual can exercise authority. A Durable Power of Attorney will become effective or remain effective in the event the individual becomes disabled or incapacitated.
EFT (Electronic Funds Transfer)	An electronic transfer of provider payment, commonly known as direct deposit, into the provider's designated bank account.
Elder	A person age sixty-five (65) or older
Electronic communication	Any communication sent or received electronically through one or more computers and/or electronic communication devices, which includes but is not limited to cell phones, iPads, fax machines, etc.
Emergency or emergency situation	A situation or set of circumstances which present a substantial and immediate risk of death or serious injury to an incapacitated adult. See W. Va. Code §9-6-1
Estate	Any real and personal property or any interest in the property and anything that may be the subject of ownership. See, W. Va. Code §44A-1-4
Fiduciary duty	Means that a special relation of trust, confidence, or responsibility exists. This duty legally obligates one entity/individual to act in the best interest of another. A guardian has a fiduciary relationship to a protected person.
Financial exploitation	The intentional misappropriation, misuse, or use of undue influence to cause the misuse of funds or assets of a vulnerable adult or facility resident but does not apply to a transaction or disposition of funds or assets where a person made a good faith effort to assist the vulnerable adult or facility resident with the management of his or her money or other things of value. See, W. Va. Code §9-6-1
Guardian	A person appointed by the circuit court responsible for the personal affairs of a protected person including living arrangements, daily care and health care decisions. The guardianship appointment can be a full guardian, limited guardian or temporary guardian. See, W. Va. Code §44A-1-4
Limited guardian	A guardian appointed by the court who has only those responsibilities for the personal affairs of a protected person, as specified in the order of appointment. See, W. Va. Code §44A-1-4
Temporary guardian	A person appointed by the circuit court who has only those responsibilities for the personal affairs of a protected person, as specified in the order of appointment. A temporary guardian may be appointed upon finding that an immediate need exists, that adherence to the procedures otherwise set forth in Chapter 44A for the appointment of a guardian may result in significant harm to the person that no other individual or entity appears to have the

	authority to act on behalf of the person, or that the individual or entity with authority to act is unwilling, unable or has ineffectively or improperly exercised the authority. A temporary guardian is time limited to six months unless terminated or extended by the circuit court upon good cause following a hearing. See, W. Va. Code §44A-2-14
Guardian ad litem	A guardian appointed by a court to protect the interest of an incapacitated adult in a particular matter. State employees are prohibited from serving as guardian ad litem.
Health care decision	A decision to give, withhold or withdraw informed consent to any type of health care, including, but not limited to, medical and surgical treatments, including life-prolonging interventions, psychiatric treatment, nursing care, hospitalization, treatment in a nursing home or other facility, home health care and organ or tissue donation. See, W. Va. Code §16-30-3
Health care facility	A facility including but not limited to hospitals, psychiatric hospitals, medical centers, ambulatory health care facilities, physician's offices and clinics, extended care facilities, nursing homes, rehabilitation centers, hospice, home health care and other facilities established to administer health care in its ordinary course of business practice.
Health care provider	Any licensed physician, dentist, nurse, physician's assistant, paramedic, psychologist or other person providing medical dental or nursing, psychological or other health care services of any kind. See, W. Va. Code §16-30-3
Health care surrogate	An individual 18 years of age or older or an authorized entity appointed or selected by an attending physician or advanced nurse practitioner to make medical decisions on behalf of an incapacitated individual.
Incompetence	A legal determination that an individual lacks the ability to understand the nature and effects of their acts and as a result is unable to manage his/her business affairs or is unable to care for his/her physical well-being thereby resulting in substantial risk of harm.
Interested person	Children, spouses, creditors, beneficiaries and any others having a property right in or claim against a trust estate or the estate of a decedent, ward or protected person. It also includes persons having priority for appointment as personal representative and other fiduciaries representing interested persons. See, W. Va. Code §42-1-1
Legal representative	A person lawfully invested with the power and charged with the duty of taking care of another person or with managing the property and rights of another person, including, but not limited to, a guardian, conservator, medical power of attorney, trustee, or other duly appointed person.
Life prolonging interventions	Any medical procedure or intervention that, when applied to a person, would serve to artificially prolong the dying process or to maintain the person in a persistent vegetative state. Includes, among others, nutrition and hydration

	administered intravenously or through a feeding tube. Does not include administration of medication or performance of other medical procedures deemed necessary to provide comfort or alleviate pain. See, W. Va. Code §16-30-3
Limited and intermittent nursing care	Direct hands on nursing care of an individual who needs no more than two hours of nursing care per day for a period of time no longer than ninety consecutive days per episode: These limitations do not apply to an established resident who subsequently qualifies for and receives services through a licensed hospice. Neither do the time limitations apply to Medicare certified home health agencies providing services to the residents. Limited and intermittent nursing care may only be provided by or under the supervision of a registered professional nurse.
Liquid assets	Cash, or property immediately convertible to cash, such as securities, notes, life insurance policies with cash surrender values, U.S. savings bonds, or an account receivable. Although the ownership of real property is considered an asset, it is not a liquid asset because it cannot be readily converted into cash.
Missing person	An adult individual, eighteen years of age or older, who is absent from their usual place of residence in the state and whose whereabouts are unknown for a period of six months or more. According to W. Va. Code §15-3D-3, it also is any person who is reported missing to a law-enforcement agency.
Most integrated setting	A setting which enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.
Neglect	The unreasonable failure by a caregiver to provide the care necessary to maintain the safety or health of a vulnerable adult or self-neglect by a vulnerable adult, including the use of undue influence by a caregiver to cause self-neglect. See, W. Va. Code §9-6-1
Personal expense allowance	The amount of monthly income the resident in an Adult Residential Services placement is permitted to retain for personal expenses. They must receive the full personal expense allowance monthly or have it readily available for their use; when the department is making a supplemental provider payment. The amount of this allowance is regulated by the Office of Social Services and may be adjusted periodically.
Physical deficit	Impairment of an individual's physical abilities.
POST form	The Portable Orders for Scope of Treatment (POST) is a standardized form containing orders by a qualified physician, an advanced practice registered nurse, or a physician assistant that details a person's life sustaining wishes as provided by W. Va. Code §16-30-25.
Qualified physician	A physician licensed to practice medicine who has personally examined the person. See, W. Va. Code §16-30-3

Qualified psychologist	A psychologist licensed to practice psychology who has personally examined the person. See, W. Va. Code §16-30-3
Representative payee	An individual appointed by the funding source to handle that individual's benefits.
Substitute decision maker	A person chosen by an individual to make healthcare decisions on their behalf in the event they become unable or incompetent to make their own health care decisions. This may include a surrogate decision maker or a court appointed guardian.
Surrogate decision maker	An individual 18 years of age or older or an authorized entity appointed or selected by an attending physician or advanced nurse practitioner to make medical decisions on behalf of an incapacitated individual.

SECTION 2 - INTAKE

2.1 Intake Definitions

The definitions used below are specific to this section and are a supplement to the general definition section.

Disposable income	The amount of money that households have available for spending and saving after income taxes and other mandatory payments have been deducted.

2.2 Eligibility Criteria

Assisted living residences and AFC and the associated services, including pre-admission evaluation, placement, supportive services, supervision and discharge planning, are available to adults who are no longer able to remain in their own home and require an alternate living arrangement due to physical, mental, or emotional limitations. Assisted Living Residences provides 24 hour awake care. Adult family care services provide 24 hour care at a least restrictive level. In addition to the income and assets requirement listed below, eligibility for placement and supplemental payment by the department in this type of setting requires that an individual must meet at least one of the following criteria:

- 65 or older and in need of supportive living.
- At least 18 years of age and have an established disability or a disability may be established by a thorough evaluation and documentation of the person's condition by a licensed physician and a determination by the worker that this medical evaluation does indicate the need for supervised care; or,
- Currently receiving adult protective service (APS) or preventative APS (PAPS) from the department. For more information, refer to *Adult Protective Services* policy

Supplemental payment by the department for placement in ARS is limited by the amount of income received by the client and the level of liquid assets available. Client's monthly disposable income cannot exceed the current rate of pay as established by the department. The clients' assets cannot exceed the established level, currently $2,000.

In the case of eligibility based on an active APS or PAPS case, ARS placement must be needed to eliminate the abuse, neglect, or financial exploitation that was verified during the APS investigation. The identified concerns and placement in ARS must be documented in the client's case plan in the APS case and ARS case.

Required Information

Basic identifying information and detailed information about the client's needs are to be gathered during the Intake process. This information must be sufficient to determine the type of services and assistance being requested, the specific needs of the individual, and other relevant information. At a minimum, the following must be included:

- Name of client.
- Date of birth or approximate age of the client.
- Social security number.
- Client's current living arrangements.
- Client's current location.
- Household composition.
- Physical and mailing address of client.
- Directions to client's home.
- Telephone number of client.
- Significant others - relatives, neighbors, friends.
- Legal representative(s), if known.
- Reporter/caller information, if different from the client.
- Physical, mental or emotional limitations of the client.
- Description of how needs are currently being met.
- Any known income or assets.
- Any known benefits from the department benefits; and,
- Other relevant information.

Referent Information

Information about the person(s) making the referral is to be documented.

- Referent name.
- Referent address.
- Referent telephone number.
- Relationship to the client.
- How they know of the client's needs.
- Referent's expectations of the department.
- Referent name.
- Referent address.
- Referent telephone number.
- Relationship to the client.
- How they know of the client's need; and,

- Referent's expectations of the department.

Services Requested

Document the specific service(s) being requested. This should include information such as the following:

- The specific type(s) of assistance being requested.
- Why assistance is being requested.
- How needs are currently being met; and,

2.3 Referral Disposition

The disposition provides for referrals to be assigned for assessment and assigned a response time or for the referral to be screened out. Considerations in determining whether to accept or screen out the referral:

- The presence of factors which do/could present a risk to the adult.
- Determine if allegations of abuse, neglect or exploitation are indicated, then an APS referral is required.
- The information related to the identified client and their current circumstances.
- Whether the information collected appears to meet the eligibility criteria for ARS placement.
- The sufficiency of information in order to locate the individual/family.
- Client's wishes; and,
- Client's capacity to make their own decisions.

After the referral is accepted or screened out:

- If the referral is accepted, a response time and a primary worker will be assigned for the adult services assessment.
- If the referral is screened out, any necessary referrals to other resources will be completed, and the intake will be closed.

Response Times

The following are the options for response times for face-to-face visit:

- **Within 5 Days:** This time frame will apply in cases where it is determined that, based on the referral information, a situation where a prompt response is critical. A situation or set of circumstances which present a substantial and immediate risk to the adult, such as the hospital discharge is imminent in less than five days. A face-to-face contact with the identified client must be made within five days. This contact is to occur in the adult's usual living environment whenever possible.
- **Within 14 Days:** This time frame will apply in cases where it is determined that, based on the referral information, a situation where a prompt response is critical does not currently exist and is not expected to develop without immediate intervention. A face-to-face contact with the client must be made within 14 days. This contact is to occur in the adult's usual living environment whenever possible.

Considerations in Determining Response Time

To assist with the determination of the appropriate response time for initiation of an adult services assessment, the following will be considered:

- The information reported indicates the presence of a situation requiring prompt attention.
- The location of the adult at the time the intake is received.
- The circumstances that exist could change rapidly.
- The living arrangements are life threatening or place the adult at risk.
- Determine if allegations of abuse, neglect or exploitation are indicated, then an APS referral is required.
- The adult requires medical attention.
- The adult is without needed assistance and supervision.
- The adult is capable of self-preservation/protection.
- The adult is currently connected to any formal support system.
- There are any family or friends available for support.
- There is a caregiver(s) and if so, are they physically, cognitively and emotionally able to provide needed care to the adult.
- There is a past history of referrals or current referrals requesting assistance; and,
- If there are injuries.

Reported Missing Person

Any time a missing person is reported to Adult Protective Services (APS), the worker must immediately contact the West Virginia State Police and supply them with all necessary information including a recent photograph.

SECTION 3 - ADULT SERVICES ASSESSMENT

3.1 Adult Services Assessment Definitions

The definitions used below are specific to this section and are a supplement to the general definition section.

Advance directives	A legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions because of a serious illness or injury. An advance directive may also give a person (such as a spouse, relative, or friend) the authority to make medical decisions for another person when that person can no longer make decisions. There are different types of advance directives, including a living will, durable power of attorney (DPOA) for healthcare, and do not resuscitate (DNR) orders. Note: The department's staff is prohibited to assist with the completion of advance directives.
De facto conservator	A person who is not the power of attorney representative or appointed surrogate and has assumed substantial responsibility for any portion of the

	estate and financial affairs of another person later found to be a protected person. See, W. Va. Code §44A-1-4
Do Not Resuscitate (DNR)	A written, signed directive by a capacitated individual directing the health care provider not to administer cardiopulmonary resuscitation or any mechanical means to prolong or continue life.
Emancipated minor	A child over the age of 16 who has been emancipated by: 1) Order of the court based on a determination that the child can provide for their physical well-being and has the ability to make decisions for themselves or 2) marriage of the child. An emancipated minor has all the privileges, rights and duties of an adult including the right to contract. See, W. Va. Code §49-4-115
De facto guardian	A person who is not the medical power of attorney representative or appointed surrogate and has assumed substantial responsibility for any of the personal affairs of another person later found to be a protected person. See, W. Va. Code §44A-1-4
Incapacity	The inability because of physical or mental impairment to appreciate the nature and implications of a health care decision, to make an informed choice regarding the alternatives presented and to communicate that choice in an unambiguous manner.
Living will	A written, witnessed advance directive governing the withholding or withdrawing of life-prolonging intervention, voluntarily executed by a person in accordance with the requirements of W. Va. Code §16-30-4.
Medical power of attorney representative	18 years of age or older, appointed by another person to make health care decisions pursuant to W. Va Code §16-30-6 of this code or similar act of another state and recognized as valid under the laws of this state.The Medical Power of Attorney Representative shall have the authority to release or authorize the release of an incapacitated person's medical records to third parties and make any and all health care decisions on behalf of an incapacitated person, except to the extent that a medical power of attorney representative's authority is clearly limited in the medical power of attorney.

3.2 Introduction

Completion of the adult services assessment involves gathering a variety of information about the client and their current status. Information is gathered by conducting interviews with the client, caregiver, if applicable, legal representative, if applicable, family members, or others having knowledge of the situation. The worker will focus on determining the level of risk the client’s circumstances present to their well-being and safety. The worker will collaborate with the client, legal decision-maker, medical professionals, and others, as appropriate, to determine if ARS is least-restrictive and will meet the wishes and needs of the individual.

3.3 Adult Services Assessment Information Gathering

The APS worker will gather Information for the adult services assessment by conducting interviews with the client and all other relevant parties during face-to-face interviews. In addition to interviews, the worker may gather information through documents, reports, records, written statements, etc. Workers should attempt to gain a release of information from the adult or legal representative.

Demographic Information

Demographic information about the client, their family and their unique circumstances is to be documented. This includes information such as (not an all-inclusive list):

- Name.
- Address (mailing and residence).
- Telephone number.
- Date of birth/age.
- Household members.
- Other significant individuals.
- Legal representatives/substitute decision-makers (if applicable).
- Identification numbers (SSN, Medicaid, Medicare, SSA Claim, etc.).
- Gender identity.
- Ethnicity.
- Marital status.
- Advance directives, if applicable; and,
- Directions to the home.

Living Arrangements

Documenting information about the client's current living arrangements should include information about where the client currently resides, such as the following:

- Client's current location (own home, relative's home, hospital, etc.).
- Is this setting considered permanent or temporary?
- Type of setting (private home/residential facility, etc.).
- Household/family composition.
- Physical description of residence: single family dwelling, duplex, townhouse, apartment, retirement community, foster home, group home, nursing facility, etc.
- Interior condition of the residence.
- Exterior condition of the residence.
- Type of geographic location (rural, urban, suburban, etc.); and,
- Access to resources such as family, friends, transportation, shopping, medical care/services, social activities, recreational activities, religious affiliations, etc.

Client Functioning

The worker shall document the client's personal characteristics and include information about how the client's personal needs are currently met. The assessment will include the client's strengths and needs.s.

If a client is fully dependent for assistance or only requires some assistance in an Activity of Daily Living (ADL), the APS worker shall document the level of assistance required in the client portion of the adult services assessment within CCWIS. If a client is independent in a specific ADL, it will not be included in the picklist portion of the assessment, but instead the worker will document this in the comments section. The assessment will also include:

- If client needs are currently being met and by whom.
- Ability to manage finances.
- Ability to manage personal affairs.
- Ability to make and understand medical decisions; and,
- Assessment of decision-making capacity.

Physical/Medical Health

Documenting information about the client's current physical and medical conditions should include information about the physical condition and description of the client as observed by the APS worker during face-to-face contact, as well as information about the client's diagnosed health status. Included are areas such as:

- Observed/reported physical conditions of the client.
- Primary care physician.
- Diagnosed health conditions.
- Current medications.
- Durable medical equipment and supplies used/needed; and,
- Nutritional status.

Mental/Emotional Health

Documenting information about the client's current and past mental health status should include information about how the client is currently functioning, their current needs, and supports, and their history of mental health treatment involvement, if applicable. Included are areas such as:

- Current treatment status.
- Current mental health provider.
- Mental health services currently receiving.
- Medication prescribed for treatment of a mental health condition.
- Prescribing/treating professional
- Observed/reported mental health/behavioral conditions; and,
- Mental health treatment history.

Financial Information

It is important to document information about the client's resources and their ability to manage these independently or with assistance. Included are areas such as:

- Financial resources - type and amount.
- Other resources available to the client - non-financial (i.e., bonds).
- Assets available to the client.

- Health insurance coverage.
- Life insurance coverage.
- Pre-need burial agreements/ arrangements in effect, if applicable.
- Information about client's ability to manage their own finances.
- Outstanding debts or expenses.
- Court ordered obligation for child support or alimony.
- Whoever manages the client's finances or who has access to client's accounts; and,
- Benefits.

Educational/Vocational Information

Document information about the educational and vocational training the client has received or is currently receiving. This should include information such as:

- Last grade completed.
- Field of study.
- History of college attendance and graduation.
- History of special licensure and training; and,
- Current educational and training needs.

Employment Information

Document information about the client's past and present employment, such as:

- Current employment status.
- Current employer.
- Prior employment history.
- Current employment needs; and,
- Current employer retirement information or 401K.

Military Information

Information about the client's military history including information such as:

- Branch of service.
- Type of discharge received.
- Veteran's eligibility for benefits (contact local veteran representative if necessary).
- Service-related disability, if applicable.

Legal Information

Documenting information about the client's current legal status should include information about all known legal representatives, and the specific nature/scope of that relationship. This should include information such as:

- Opinion of client's decision-making capacity by the APS worker.
- Information about legal determination of competence, if applicable.
- Information about efforts to have a client's decision-making capacity formally evaluated.
- Individuals who assist the client with decision-making; and,

- Court/hearing information.

Critical Questions that must be Considered

In addition to gathering information, several critical questions must also be considered. These include the following:

- Does the adult appear to meet eligibility criteria for ARS?
- Has there been a medical determination concerning decision making capacity?
- Does the adult have an acting substitute-decision maker? (guardian, conservator, de facto guardian, de facto conservator, health care surrogate, medical power of attorney, power of attorney, representative payee, etc.)
- Does the adult have any advance directive in effect? (Living will, DNR, power of attorney, medical power of attorney, etc.)
- If adult residential services are not to be provided, are referrals to other resources needed?

3.4 Determining Eligibility

In addition to the Eligibility Criteria, an individual must meet the following to be eligible to receive ARS subsidy provided by the department:

- Be a United States citizen.
- Be a resident of West Virginia.
- Liquid assets cannot exceed $2000.00.
- Willing to apply their income, with the exception of the personal needs allowance, to the department's established cost of placement in ARS.
- If a client has over $2,000 in assets, has no DPOA, and client is not able to manage their own finances, then the worker should consult their supervisor to determine if a conservator will need to be applied for through the Conservatorship process in that district. For more information, refer to *Legal Requirements and Processes* policy.

Assessment for Adult Residential Services Placement

The worker will complete a thorough assessment of the client in order to determine if ARS placement is an appropriate option. If so, a client who is being considered for this type of placement setting must meet the following criteria:

- In need of supportive living in order to remain in or return to a community living setting.
- Ambulatory and capable of self-preservation- able to vacate the premises independently in an emergency (devices to aid ambulation such as a wheelchair or walker may be permitted only if the client is capable of using the device unassisted and is able to remove themselves from the home by their own power).
- Able to care for their own personal needs such as bathing and dressing with minimal assistance or has the capacity to develop these skills with training from the ARS provider or other professional.

- Alert and stable enough to be able to express their wishes regarding their living arrangements and able to participate in planning for their needs or has been determined by a medical professional to be in need of ARS and able to benefit from placement.
- Able, or have a legally appointed representative who is able, to understand what ARS placement is and expresses a desire for this type of placement.
- Unable to live alone as a result of physical or mental incapacity.
- No other suitable living arrangements are available.
- Able to meet the established admission criteria for the facility being considered.
- Free from communicable disease that would endanger the health of others; and,
- Willing to contribute to their cost of care to the extent possible.

In addition, the client must not:
- Be incontinent at time of admission, or if incontinent, the provider must be willing to accept the client in their home or facility.
- Be in need of nursing home care or highly structured institutional care.
- Be in need of acute medical or psychiatric care.
- Be intoxicated by alcohol or drugs; and,
- Be a danger to themselves or others.

If a client requires an assistive medical support, such as oxygen, this will not necessarily disqualify the individual from participation in the ARS program. Considerations will be made on a case by case basis with consideration of the client and their abilities, and the provider and their abilities.

3.5 Conclusion of Adult Services Assessment

The adult services assessment is to be completed within 30 days of the date of intake. At the conclusion of the adult services assessment, the worker will determine if the client meets all criteria for ARS.

Adult Services Assessment Disposition Options

The disposition shall be based on all the information gathered during completion of the adult services assessment. In the event a client has left the state, worker cannot locate, client is deceased, etc., an incomplete assessment can be completed in consultation with the supervisor. The APS worker will need to complete a policy exception in CCWIS when requesting an incomplete assessment by selecting the appropriate item from the picklist. This exception request will be approved or denied by the supervisor. The possible dispositions available are:
- Close Adult Services.
- Close Adult Services, Refer to Community Services.
- Open Adult Residential Services.

SECTION 4 - CASE MANAGEMENT

4.1 Case Management Definitions

The definitions used below are specific to this section and are a supplement to the general definition

section.

Incapacity	The inability because of physical or mental impairment to appreciate the nature and implications of a health care decision, to make an informed choice regarding the alternatives presented, and to communicate that choice in an unambiguous manner. See, W. Va. Code §16-30-3. NOTE: Incompetence of an adult is determined by a legal proceeding and is not the same as a determination of incapacity. Similar definition of incapacitated adult is contained in W. Va. Code §61-2-29, for abuse or neglect of incapacitated adult or elder person regarding criminal penalties.
Protected person	A protected person is an adult individual, eighteen years of age or older, who has been found by a court, because of mental impairment, to be unable to receive and evaluate information effectively or to respond to people, events, and environments to such an extent that the individual lacks the capacity: A) To meet the essential requirements for his or her health, care, safety, habilitation, or therapeutic needs without the assistance or protection of a guardian; B) to manage property or financial affairs or to provide for his or her support or for the support of legal dependents without the assistance or protection of a conservator. A finding that the individual displays poor judgment, alone, is not sufficient evidence that the individual is a protected person within the meaning of this subsection. “Protected person” also means a person whom a court has determined is a missing person. See, W. Va. Code §44A-1-4

4.2 Introduction

Once an individual has been approved for ARS, various case management activities must occur. These activities may include: identification of available homes based on the characteristics of individuals needing placement, monitoring of the placement setting, issuing monthly payment based off of the current ARS contract, making other demand payments as needed, issuing clothing vouchers, and making regular visits with the client in the home.

4.3 Time Frames

The worker will complete the adult services assessment within the first 30 calendar days following the date the case is opened and every six months thereafter. If the adult service worker is knowingly going to court for a guardianship assessment, the worker should open the guardianship program, so that it meets the assigned 30 day timeframe while waiting on the court hearing.

4.4 Responsibilities of the Client

- The client or their legal representative is responsible to make payment to the provider in accordance with the terms of the payment agreement.
- The client shall inform the provider before inviting friends or relatives to the home.
- It is the responsibility of the client, or their legal representative, to immediately inform the worker and the provider of changes in his income and/or living arrangements.
- The client, or their legal representative, will be responsible to make restitution in the event there is an error in payment as a result of their failure to immediately inform the APS worker and the provider of any changes.
- The client is to respect the rights of others in the home, including the provider; and,
- The client is to become familiar with and abide by the provider's house rules and regulations.

4.5 Responsibilities of the Adult Protective Service Worker

Once a client has been opened as a recipient of ARS through the department, various case management activities must occur. These include tasks such as:

- Advise the client of their approval to receive ARS.
- Locate and select an appropriate provider.
- Arrange for trial visits when appropriate.
- Furnish the provider with information about the client including any special considerations and client needs.
- Facilitate the client to move into ARS placement.
- Explain the payment process to the provider, client, and decision maker, if applicable.
- Complete the payment agreement.
- Complete all necessary paperwork and documentation.
- Make a face-to-face visit with the client every 90 days unless the client is also receiving guardianship services, then make face-to-face visit with the client every 60 days. Refer to the Non-Guardianship Adult Residential Services Client and Guardianship Client Receiving Adult Residential Services sections.
- Review and monitor the case as required.
- Obtain a photograph of the client, which shall be updated annually and at the time of significant changes to physical appearance. The client's permission for the photograph shall be obtained. The photograph is to be uploaded into CCWIS and added to the paper file.

Non-Guardianship Adult Residential Services Client

For an individual who is not receiving guardianship services but is receiving ARS, the APS worker will make face-to-face contact at least once during the first month. The worker must have face-to-face contact with the individual at least **every 90 days**. These contacts are to be documented in CCWIS within three business days of completion of the contact. Documentation is to be pertinent and relevant to carrying out the activities set forth in the case plan. This is a minimum standard. Workers are strongly encouraged to have more frequent contact, and the need for more frequent contact with the client should be determined based on their unique needs and circumstances.

Guardianship Client Receiving Adult Residential Services

For an individual receiving guardianship services and ARS, the APS worker will make face-to-face contact at least once during the first month. The worker must have face-to-face contact with the protected person at least **every 60 days**. These contacts are to be documented in CCWIS within three business days of completion of the contact, and documentation is to be pertinent and relevant to carrying out the activities set forth in the case plan. This is a minimum standard. Workers are strongly encouraged to have more frequent contact. The need for more frequent contact with the client should be determined based on their unique needs and circumstances.

Refer to *Substitute Decision-Maker Policy*, which outlines face-to-face contact minimum standards for substitute decision-making clients.

4.6 Placement

When placing a client in ARS, a supplemental payment by the department will NOT be made if there is any source available that will pay for the client's cost of care. The department will supplement the cost of care as a last resort only.

W. Va. Code §16-5D-6 states that no public official or employee may place any person in, or recommend that any person be placed in, or directly or indirectly cause any person to be placed in any assisted living placement or legally unlicensed home as defined in section two of this article, which is being operated without a valid license from the secretary. Therefore, the department cannot place or cannot authorize, recommend, or facilitate placement in an unlicensed assisted living residence.

Selection of the Provider

The successful placement of a client in ARS will depend largely on ensuring an appropriate match is made between the client and the provider.

Note: It is important to remember that providers cannot be forced to admit clients to their residential placements.

Placement of Clients Being Discharged From a State Institution

Individuals who have resided in a state operated facility for an extended period of time will face some unique challenges as they adjust to the ARS setting. In order to ensure a smooth adjustment, it is important for the ARS provider to be aware, not only of the client's needs, but also of the prior routine and personal habits to which the client has become accustomed. A gradual transition from the familiar routine to a new setting and new routines will make for a smoother and more successful transition to ARS placement.

In no instance shall a client who has been institutionalized in a mental health facility on an involuntary commitment be fully discharged from the institutional setting to placement in ARS per W. Va. Code

§27-7-2. Clients who are coming from a mental health facility are required to be released from the facility on convalescent status and placed on a provisional basis in ARS. This provisional placement may last for a period of up to six months.

Trial Visit - General

If possible, a trial visit can last up to seven days between the client and the prospective ARS provider. The worker must provide all of their contact information so that the provider is able to keep in contact. A worker will call and check up on the client if the client is there longer than one day.

Trial Visit - Clients from another County or Institutional Setting

If the client is coming from another county the sending county will provide a detailed client summary to the receiving county. The sending county should also provide any contact information to speak to an APS worker in that district.

4.7 Transfer of Case Between Counties

It is recommended that case transfers be planned for the beginning or end of a month to minimize confusion related to payment, if applicable. If payment is an issue and it is not possible to transfer at the beginning or end of month; the sending APS worker must calculate the amount of payment due to the original provider from the client. If the client paid the provider the full monthly amount, the APS worker must request that the original provider reimburse a prorated amount for the remaining days of the month. This amount is then to be used by the client to pay the new provider upon placement. The client is responsible for paying the new provider in accordance with the new payment agreement.

Sending County Responsibilities

When it is necessary to transfer the case from one county to another, the sending county is responsible for completing the following tasks:

- Prior to arranging or actually completing a transfer to a provider in another county, the sending supervisor must contact the supervisor in the receiving county to notify them that a client is being transferred to their county
- Provide a summary about the client’s needs (i.e. reason for the transfer, problems in other settings, disturbing behaviors, family and financial resources, insurance coverage, and legal representative(s), if applicable).
- Arrange for a trial visit(s) by the client to the proposed setting. Whenever possible this visit should be arranged at the convenience of the receiving county and the new provider.
- Complete all applicable case documentation prior to case transfer.
- Immediately upon transfer of the client to the receiving county, send the updated client record (paper and CCWIS) to the receiving county; and,
- Notify the department’s family support staff, the Social Security Administration office, and all other appropriate agencies of the client’s change of address.

Receiving County Responsibilities

- The receiving county is responsible for completing the following tasks in preparation for the transfer.
- Notify the department family support staff of the client's arrival when the transfer is complete.
- Complete all applicable documentation; and,
- Assist with arranging or initiating any needed community resources.

When a case is transferred from one county to another, problems that arise during the first 30 day period, following the transfer, are to be addressed jointly between the counties. When this occurs, the receiving county may request assistance from the sending county. If such a request is received, the sending county is to work cooperatively with the receiving county to resolve the problem(s). The APS worker should maintain frequent contact during this initial adjustment period to ensure a smooth transition. This will permit timely resolution of problems that may occur during this time.

4.8 Client Medical Evaluations

Each client placed by the department in ARS must receive an initial medical examination. The APS worker will arrange for this. The evaluation will contain information including that the client is free of communicable diseases to the best of the physician's knowledge. The worker will upload this evaluation into CCWIS and the hard copy should be placed in the paper file.

A current medical evaluation will be completed annually thereafter to document the health status of the client. The provider will arrange for this examination to be completed. If reimbursement to the provider is required and not covered under Medicare, Medicaid or private insurance the APS worker must first approve the expense prior to incurring the expense. Once completed, the provider will send a copy of this evaluation to the worker. Once received, the worker will upload the evaluation into CCWIS and a hard copy will be placed in the paper file.

4.9 Ongoing Medical Care for Adult Residential Services clients

All clients placed in ARS are to receive ongoing medical care through their placement. Clients will receive an annual client medical evaluation. Providers will ensure appropriate transportation to and from medical appointments.

4.10 Initial Placement Period

During the first several weeks following placement, the client and provider will need regular guidance and support. Workers need to contact the provider and client to ensure they are aware of the district's contact numbers and the contact information for Centralized Intake.

4.11 Resident Agreement for Participation

At the time of placement in ARS, the client, or their legal representative, must be able to understand and agree with the terms set forth and to signify their agreement by signing. The APS worker will upload the signed document into CCWIS and maintain the original in the paper file.

4.12 If the Adult Residential Services Placement Fails

It is essential the characteristics and needs of the client and the characteristics and resources of the provider are considered to ensure a stable placement. It is recommended that the worker set up a trial visit to help prevent any failed placement. If the placement fails, the worker will need to ensure they work on finding alternative placements and keep in contact with the provider to let them know of the worker's progress on alternative placements until a new placement is secured and client is transported from provider to the alternative placement.

4.13 Complaint Against the Provider

When a complaint is received against an ARS provider, the worker will obtain the information and make appropriate referrals. Refer to *Adult Protective Services Policy, Referrals Involving Specific Situations* for more information, if maltreatment is alleged. If a complaint is made regarding an AFC provider, the homefinder and program manager must be notified.

4.14 Private Pay Placement

All placements will be handled as private pay arrangements if financial resources exceed the determined cost of care. In private pay arrangements, the department shall not be responsible for any portion of the payment. The provider and the client or the client’s representative will be responsible for determining payment arrangements. When a client is private pay, they are not eligible for any other payments made by the department.

4.15 Case Plan

Following completion of the adult service assessment and review process, the worker will develop a case plan to guide the provision of services, to provide the milestones for assessing progress, and measure success of the implementation of the plan. Evaluation and monitoring of the ARS case and the progress being made should be a dynamic process and ongoing throughout the life of the case. For ARS cases, regular monitoring by the worker is essential to evaluate progress, identify potential problems, and seek prompt resolution. A case plan review should occur, at a minimum, every six months or when there is a substantial change in the client’s functioning.

Inclusion of the Incapacitated Adult in Case Planning

Inclusion of incapacitated adults in the case planning process presents some unique challenges. Although legally determined to lack decision-making capacity, the client may have the capacity to participate in the development of the case plan and should be encouraged to participate in the development as well as signing of the completed document.

Determining the Least Intrusive Level of Intervention

In the provision of services to adults, the principle is well established both in law and policy that the least intrusive means of intervention should always be used. When applying this principle to individual situations there is some discretion in determining the appropriateness of the manner in which the department intervenes in the life of the client and the level of care/assistance required in order to meet the client's needs.

Required Elements

The case plan is part of the adult services assessment and review process and developed based on the information gathered during the adult services assessment. Other important considerations for the case planning process are:

- The client's needs.
- The client's real and potential strengths.
- Attitudes, influences, and interpersonal relationships and their real or potential impact on implementation of the case plan and,
- Levels of motivation of both the client and the ARS provider.

Developing a Plan to Reduce Risk and Assure Safety

When developing a plan to ensure the safety of the client the worker should:

- Involve the client in the discussion of any problematic behaviors.
- Include causes of the behaviors; and,
- Establish a protocol to address these behaviors and their causes.

Conducting the Review

The review process consists of evaluating progress toward the goals identified in the current case plan. Information that may be considered during review process includes:

- Summary of changes in the individual or family's circumstances.
- Summary of significant case activity since the last review.
- Evaluate need for clothing allowance,
- If applicable, collect receipts or bills for any co-pays which may be eligible for a reimbursement or payment via a demand payment.
- If applicable, assess the need for a continued Special Medical Card.
- Assessment of the extent of progress made toward goal achievement.
- If the identified goals continue to be appropriate and, if not, what changes or modifications are needed.
- Barriers to achieving the identified goals; and,
- Other relevant factors.

Review of Personal Expense Allowance Use

The APS worker will review the accounting records for the client's personal needs allowance maintained by the ARS provider to ensure that the client is receiving the benefit of their personal needs allowance. If it is believed the ARS provider is negligent, exploitative, or is mismanaging the client's personal expense allowance, a referral will be made to Centralized Intake and the homefinder. Law enforcement will be notified in writing by the assigned investigative APS worker

Record Keeping

Upon placement of the client in ARS or shortly thereafter, the worker will provide information about the client's service needs to the ARS provider. The provider is to establish a file for each individual placed in their home and maintain all information about the client for reference as needed including the following:

- Identifying information about the client.
- Significant others such as family members, friends, legal representatives, etc.
- Client's interests, hobbies and church affiliation.
- Medical status including current medications, precautions, limitations, attending physician, hospital preference, allergies, special diet, etc.
- Advance directives.
- Client's burial wishes, plans, and resources.
- Copy of the signed *Resident Agreement for Participation* form.
- Copy of the current and previous payment agreements.
- Copy of the current case plan.
- Copy of the current *Provider Agreement for Participation* form.

All other information received by the provider that is specifically related to the client is to be maintained in the provider's client file. This information must be maintained in a confidential manner. This applies to all client information.

SECTION 5 - CONFIDENTIALITY

5.1 Confidentiality Definitions

The definitions used below are specific to this section and are a supplement to the general definition section.

Financial exploitation	The intentional misappropriation, misuse, or use of undue influence to cause the misuse of funds or assets of a vulnerable adult or facility resident, but does not apply to a transaction or disposition of funds or assets where a person made a good-faith effort to assist the vulnerable adult or facility resident with the management of his or her money or other things of value. See, W. Va. Code §9-6-1

5.2 Confidential Nature of Adult Services Records

Legal provisions concerning confidentiality have been established on both the state and federal levels. In federal law, provisions are contained in the Social Security Act. On the state level, a provision related to confidentiality of client information is contained in West Virginia Code.

Unless the vulnerable adult concerned is receiving adult protective services, or unless there are pending proceedings regarding the vulnerable adult, the records maintained by the adult protective services agency shall be destroyed 30 years following their preparation. Additionally, requirements related to confidentiality specifically related to Adult Protective Services cases are contained in W. Va Code §9-6-8.

When Confidential Information May be Released

All records are to be kept confidential and may not be released except as follows:

- Employees or agents of the department who need access to the records for official business.
- Any law-enforcement agency investigating a report of known or suspected abuse, neglect, or financial exploitation of a vulnerable adult.
- The prosecuting attorney of the judicial circuit in which the vulnerable adult resides or in which the alleged abuse, neglect, or financial exploitation occurred.
- A circuit court or the Supreme Court of Appeals subpoenaing the records. The court shall, before permitting use of the records in connection with any court proceeding, review the records for relevance and materiality to the issues in the proceeding. The court may issue an order to limit the examination and use of the records or any part of the record.
- A grand jury, by subpoena, upon its determination that access to the records is necessary in the conduct of its official business.
- The recognized protection and advocacy agency for the disabled of the State of West Virginia.
- The victim and,
- The victim's legal representative, unless he or she is the subject of an investigation.

For reporting and statistical purposes, non-identifying information may be released for the preparation of non-client specific reports. The client may request to view their client record and should be permitted to do so; although, certain information contained in the record may not be accessible.

5.3 Records Maintained by the Provider

Records maintained by the provider are confidential and are to be maintained in a secure location. Information about the client shall only be released to other parties in order to provide needed services Examples include medical information to medical providers, income information if eligibility is based on financial information, allergies and dietary needs to day treatment provider, etc.

5.4 Subpoenas, Subpoena Duces Tecum, Administrative Subpoenas, & Court Orders

The department may be requested by the court or other parties to provide certain information regarding adult services cases with which we are currently involved or had previous involvement. The various mechanisms that may be used are:

- Subpoena.
- Subpoena duces tecum, or
- Court order.

Upon receipt of any of these, the department MUST respond. Failure to comply is contempt of court and could result in penalties. Refer to *Legal Requirements and Processes Policy* for more information about subpoenas.

SECTION 6 - PAYMENTS

6.1 Determination of Rate of Payment

Determination of the rate of payment due to an ARS provider is done automatically and based on a variety of client information entered in the system by the social worker. Key areas used in calculating the rate of payment include employment information including sheltered employment, income and asset information, and debts and expense information. Complete and accurate documentation in each of these areas is essential in determining the rate of payment. Adult residential placement providers are paid a flat rate for the care and supervision furnished to each adult placed in the facility by the department.

In addition to the client's income, if there is a payment made from any other source on behalf of the client, this amount must be applied toward the client's cost of care to reduce or eliminate the supplemental amount paid by the department. If the supplemental payment made by the department is eliminated, the case must be closed.

If the client receives services from any other agency that provides supervision or care for the client, the worker must evaluate to determine if the client remains eligible to receive a supplemental payment from the department.

When placing a client in ARS a supplemental payment by the department will NOT be made if there is any source available that will pay for the client's cost of care up to the current state rate. The department will supplement the cost of care as a last resort. If the client receives services from the Title XIX Waiver program, the client is not eligible for a supplemental payment and the client's ARS case may be closed.

In addition, the AFC home must be evaluated for closure. If the AFC provider is certified as a Title XIX waiver provider or employed as a personal care provider, the provider must decide if they want to continue being a provider with that program or if they want to be a provider through the AFC program.

If the decision is to continue as a provider with the Title XIX waiver program or as a personal care provider, the AFC provider record must be closed. For more information, refer to *Request to Provide Adult Family Care policy.*

If the client receives services from any other agency that provides supervision or care for the client, this must be evaluated to determine if the client remains eligible to receive a supplemental payment from the department or remains eligible for AFC placement.

Resource Deductions

In unique situations the client may be allowed to redirect a portion of their monthly resources rather than using these to pay for their care. The following are examples of possible resource deductions:

- Irrevocable pre-need burial plan IF this was in effect for a long period of time prior to placement in adult residential services and the total amount of the pre-need burial does not exceed $5,000.00. In addition, the client must have paid at least 50% of the total cost of the pre-need burial.);
- OTC/Non-Medicaid covered medications that are needed on a regular basis;
- Conservator charge- the usual fee is 5% of the total monthly income of the client.
- Representative payee fees.

Note: Life insurance policies must not be considered for a resource deduction.

If the only financial responsibility of the conservator is the disbursement of the monthly income of the client, with no assets involved, the worker must:

- Explore the possibility of the provider becoming the representative payee and document these efforts in CCWIS.
- If the provider is willing to become the representative payee, a petition must be filed for removal of the conservator.
- If the court approves removal of the conservator, a new contract must be done in CCWIS to remove the resource deduction of conservator fee.

Granting of a resource deduction may be considered only when the following criteria are met:

- The client has a special need- if a medical need, it must be documented by their physician.
- All potential resources must be thoroughly explored and documented to validate no resources are available to meet this need. The APS worker should explore community or civic organizations, family members, religious organizations, Medicare Part D, drug company assistance programs, samples from physicians, mental health agencies, health right clinics, and any other potential available resource.
- If the resource deduction is for a prescription medication, the worker will obtain a statement from the client's physician stating why this particular medication is needed; and,
- After a thorough search, if alternate resources are not available.

If an alternate source is located that will pay part of the cost, but not all the monthly amount, the worker will indicate the amount on the contract that is to be considered as a resource deduction. An example is if the total debt amount is $100, and $40 will be paid by a civic organization, then $60 is the amount to be requested for the resource deduction.

Durable Medical Equipment, Supplies, and Food Supplements

In certain situations, the cost of obtaining durable medical equipment or supplies may be reimbursed for adults who have been placed in ARS by the department and for whom the department is making a supplemental payment. In unique situations, food supplements may also be required by an adult placed by the department in ARS to maintain sound nutritional status. In either instance the following must be considered:

- Prescribed by the adult's physician- written statement must be filed in the client's paper record.
- Meet an identified need on the adult's case plan.
- Necessary to prevent the need for a higher level of care.
- One time only expense rather than a recurring cost.
- Not exceed the current Medicaid rate.
- Not in violation of OHFLAC requirements for an assisted living provider.

Note: Examples of durable medical equipment and supplies may include safety rails, grab bars, quad canes, colostomy supplies, etc. that are not covered by Medicare/Medicaid or any other resource.

6.2 Personal Expense Allowance

The personal expense allowance is the amount a client placed in ARS is permitted to retain from the total income they receive in order to meet their personal expenses.

The amount of the personal expense allowance is established by BSS and may be adjusted periodically. All clients placed by the department in ARS shall receive the full personal expense allowance amount each month or have this amount readily available for their use. If a client is not in ARS for an entire month, the personal expense allowance will be prorated. When the client moves from one provider to another provider in the middle of the month, any personal expense allowance remaining must be given either to the client or the new provider, if the new provider is going to handle the client's personal expense allowance through serving as representative payee or handling the client's personal expense allowance. The provider must maintain a record of funds received and expenditures made on the client's behalf.

Office of Health Facility Licensure & Certification (OHFLAC)regulations require an assisted living residence to set up an accounting system so as not to blend resident's funds with the facility funds or with the funds of any other person. If the resident's fund exceeds $200, these funds shall be deposited for the resident in an interest-bearing account at a local bank. The resident account record shall show in detail, with supporting documentation, all monies received on behalf of the resident and the disposition of all funds received. Persons shopping for the resident shall provide a list showing a description and price of items purchased if the purchase exceeds $10, along with payment receipts for these items. This record must be available for review by the resident, their legal representative, any authorized entity, and to the department at any time.

The client may use their personal expense allowance to purchase any items they choose so long as the purchases do not conflict with established house rules or regulations applicable to operation as an ARS placement. The allowance must be available to the client and used as they desire.

The personal expense allowance shall NOT be used to obtain basic necessities such as food, clothing, shelter costs, medication, transportation, or medical care unless it is the desire of the client to do so. These goods and services are supplied or arranged by ARS providers.

Examples of Items that may be Purchased

- Hair styling/permanents.
- Tobacco products.
- Hair spray, cologne, aftershave.
- Extra clothing.
- Jewelry
- Radio or television.
- Games, books and other recreational items of interest to the client.
- Postage stamps and stationery.
- Long distance telephone calls.
- Cosmetics.
- Pre-need burial trust fund; and,
- Hair care above and beyond the basic care that must be provided to maintain cleanliness and neatness of the client's hair.

Examples of Items that may not be Purchased

- Basic personal hygiene articles, such as toothbrush, toothpaste, soap, deodorant, towels, wash cloths, and other items.
- Regular haircut- applies to all clients, regardless of gender identity.
- Basic recreational needs.
- Medications, including over the counter drugs prescribed by the client's physician; and,
- Copay on client's medication.

If certain prescribed medications are determined, by a physician, to be the sole drug the client can take, and that drug is not eligible for reimbursement by Medicaid, the worker will explore alternative resources to pay for this medication. Examples of alternate resources include Medicare Part D waiver process, drug company program assistance programs, samples from physicians, mental health agencies, health right clinics, and other resources.

If the client has a court appointed conservator, the conservator has the ultimate decision-making authority regarding the use of the personal expense allowance; however, the funds must be used for the client's benefit and the client should be permitted and encouraged to be involved in decisions about how the funds are to be used.

Sheltered Employment Income

Adults, who have been placed in an ARS setting by the department, that receive income for sheltered employment are entitled to keep a portion of their income from this source. The adult is permitted to keep up to $65.00 of their net income earned from this source. Individuals who receive $65.00 or less per month from this source are entitled to keep the full amount earned while those who earn more than $65.00 from this source are permitted to keep $65.00 and the balance is to be applied to their monthly payment to their ARS provider. If the earnings exceed $65.00 a new contract will need to be completed.

6.3 Payment Agreement

Whenever the department is making a supplemental payment, the amount set forth in the payment agreement is PAYMENT IN FULL. The client shall not be assessed additional charges, payable by the client or others for the care furnished by the ARS provider. The payment agreement contains:

- The total daily rate due to the provider for a partial month's care.
- The portion of the daily rate that is to be paid by the client for a partial month's care.
- The portion of the daily rate, if any, that is to be paid by the department for a partial month's care; and,
- The amount, if any, the provider must furnish the client for their personal expense allowance.

The payment agreement also identifies the date on which the agreement becomes effective. Payment to the ARS provider will be an automatic payment and will be based on the amounts set forth in the payment agreement.

The payment agreement is created by CCWIS based on a variety of information entered in CCWIS by the APS worker. Specifically, information from the following areas of CCWIS is used in creating the payment agreement:

- Income.
- Assets.
- Debts/expenses; and,
- Employment.

Payment for Individuals without Income

If a client has no income, the worker must explore all potential financial resources, including preparation of referrals to other agencies such as the Social Security Administration or Veterans Administration.

If the client requires assistance with these applications, the provider may assist the client to secure the necessary resources to pay for their cost of care. If the client requires that an application be made on their behalf and there is no one to assist with this, the APS worker may need to file a petition for guardianship and/or conservatorship to get the necessary applications made to secure potential financial resources for the client.

If the client has no income, the department will reimburse the provider for the full cost of care. Client's personal expense allowance will also be included in the provider's reimbursement; the provider is responsible for making the personal expense allowance available for the client's use. If the client begins to receive income, the payment agreement will need to be revised after the information is entered into CCWIS.

Payment for Individuals with Unavailable Income

If a client has income that is not presently available to them, the worker must determine how the client might gain access to their resources and what other potential resources the client might be eligible for. This may involve working closely with individuals who are assisting the client in making their personal and financial decisions.

The payment agreement developed between the client, APS worker, and provider will reflect that the department will reimburse the provider for the full cost of care. Client's personal expense allowance will also be included in the provider's reimbursement; the provider is responsible for making the personal expense allowance available for the client's use. When income becomes accessible, the payment agreement will need to be revised after the information is entered into CCWIS.

Review of the Payment Agreement

The payment agreement must be reviewed by the worker, whenever there is a change in the client's financial situation and a new payment agreement will be created. The APS worker is responsible for reviewing the payment agreement with the client and the provider. The worker will obtain signatures, upload the document into CCWIS, provide copies for both the client and the provider, and maintain the original in the paper file.

Overpayment

After all reasonable attempts, if the AFC provider does not agree to repay or defaults on monthly payments, the provider will be considered for corrective action from the homefinder and/or closure of the home. If the assisted living provider does not agree to repay or defaults on monthly payments, the APS worker will notify the office of finance.

6.4 Automatic Payments

The primary method used to make payment to ARS providers will be the automatic payment process. The automatic payment process takes in consideration the following conditions:

- Type of placement.
- Client's personal expense allowance.
- Client benefits and income.
- Client employment income.
- Client assets.
- Client monthly expenses (in certain circumstances).
- Date of placement; and

- Date of discharge.

Based on all these various pieces of information, CCWIS will calculate the total rate of the monthly payment due to the provider. Workers will enter the required information in a timely manner. Payment information and supervisory approval must be completed by the last working day of the month. Payment information that is not entered by the end of the last working day of the month may require the APS worker to request a demand payment for the purpose of doing a payment adjustment/correction. All automatic payments are completed on the first Monday of each month.

For payments to be made correctly, workers will need to verify income, debts/expenses, placement dates, rates, and service authorizations. Workers are to verify this information each month. Supervisors are to confirm all information is correct and approved.

The payment agreement will reflect several amounts related to the payment the provider is to receive. These include:

- Total monthly rate of payment due to the provider for a full month of care.
- Total daily rate due to the provider for a partial month's care.
- The portion of the monthly payment which is to be paid by the client for a full month of care.
- The portion of the daily rate that is to be paid by the client for a partial month's care.
- The portion of the monthly payment, if any, which is to be paid by the department for a full month of care.
- The portion of the daily rate, if any, that is to be paid by the department for a partial month's care; and,
- The amount, if any, the provider must furnish the client for their personal expense allowance.

General Requirements & Information

The assisted living residence provider must submit a monthly invoice in order to receive payment from the department. Payment will not be made without an invoice. The invoice is to include all adults for whom the department is making a payment. Residents for whom the department is NOT making a supplemental payment are NOT to be included on the invoice.

Note: The department pays after services are rendered. Payments for cost of care will be made the following month. Cost of care payment received in April, would be for the services provided in March.

Invoicing Procedures

An original, signed invoice must be submitted by the provider to the Bureau for Social Services, Office of Financial Services, by the 5th working day of month following services provided. Invoices may be emailed if encrypted to dhhrbsspayments@wv.gov. The invoice must be on the agency's letterhead.

6.5 Demand Payments

Most costs associated with the care of an adult placed in ARS will be included in the monthly reimbursement paid to the provider by automatic payment. There are certain specific costs that may be incurred that are not included in the monthly reimbursement. The demand payment process may be used to request reimbursement for certain costs incurred for or on behalf of clients placed in ARS by the department or for specific expenses incurred by the ARS provider that are not client specific. Reimbursement by the department may only be considered after it has been determined there are no other personal or community resources that can meet this need. In order for the department to reimburse the provider for these costs, the provider must submit receipts for the costs incurred. The supplies or services must:

- Be prescribed/ordered by the adult's physician or deemed medically necessary by the adult's physician (written statement of need required).
- Meet an identified need on the adult's case planservice plan.; and
- Be necessary to remain at the current level of care or prevent the need for a higher level of care.
- Be a one (1) time only expense rather than a recurring cost.
- Not exceed the current Medicaid Rate; and
- No other resources are available.

The worker must have the provider connected in case services in CCWIS for payment to be made. The request must then be submitted to the supervisor for approval. Once the supervisor approves, they will submit the payment to the program manager for approval.

Co-Payment on Prescription Medications

The cost incurred for copayments for medications may be reimbursed at Medicaid and/or Medicare D rates for adults who have been placed in an ARS by the department and for whom the department is making a supplemental payment.

Over-the-Counter Drugs/ Drug Efficacy Study Implementation (DESI) Drugs or Rx Not Covered

In certain situations, medications may be required by an adult placed by the department in an ARS placement that is not covered by Medicaid or other insurance. These include items such as over-the-counter medications, DESI drugs, or other prescription medications that are medically necessary but not covered by Medicaid or other insurance. The cost of these medications may be reimbursed by the department. Reimbursement by the department may only be considered after it has been determined there are no other personal or community resources that can meet this need.
In addition, the medications for which payment is requested must:

- Be prescribed/ordered by the adult's physician or deemed medically necessary by the adult's physician written statement of need required).
- Meet an identified need on the adult's service plan.
- Be necessary to prevent the need for a higher level of care; and,
- Not in violation of OHFLAC requirements.

Prior to any expense being incurred, the provider must submit the receipt for the medication after it has been purchased. DESI Drugs (Drug Efficiency Study Implementation) - These are older drugs that have since been replaced by newer versions and are now considered to be less than effective. In some situations, however, an individual cannot tolerate the newer versions of the drugs or experience higher degree of side effects and the physician chooses to continue prescribing the older version of the drug.

Payment Adjustment

This demand payment type is to be used for the purpose of correcting an under payment to an ARS provider. A payment adjustment may be requested to reimburse the provider for any unpaid portion due. For the assisted living provider, the demand payment would be used to correct an underpayment and can only be completed by the division of finance.

Specialized AFC Payment

This demand payment type applies only to payments made to existing Specialized AFC providers in Lewis County. This type of provider is different from the rate of payment for regular AFC providers.Therefore, this demand payment type is to be used to reimburse Specialized AFC providers for the balance of payment due each month.

Educational Expenses for Special Education Students

Adults who are enrolled in special education programming may incur costs associated with their educational program. In order for the department to reimburse the provider for these costs, the adult must be enrolled on a full-time basis in an educational program. In addition, the costs for which reimbursement is requested must not be reimbursable by any other source and must be related to enhancing or completing their educational program. Examples of costs that may be reimbursable include graduation fees and reasonable special fees for school trips/functions.

Provider Training Incentive Payment

Adult Family Care providers who are currently receiving a supplemental payment for a client(s) placed in their home by the department are entitled to receive reimbursement for approved training they receive. This reimbursement is offered as an incentive to encourage providers to participate in relevant training opportunities to enhance their skills and knowledge as AFC providers. To qualify for this payment, AFC providers will complete training that is provided by the department or by another agency/entity that has been approved in ADVANCE by the department. Reimbursement for Assisted Living providers is available for up to five designated staff to attend.

Adult Family Care providers are required to attend a minimum of two hours of training per quarter. To receive training allowance, the AFC provider or the assisted living staff member for whom reimbursement is being requested must attend a minimum of six hours of approved training during the quarter for which reimbursement is being requested. The two hours of required training may be included in the total hours required for the incentive payment. The quarters to be used for determining this allowance are based on the calendar year. Specifically, the quarters to be used are January - March,

April - June, July - September, and October - December. Upon completion of the required hours of approved training, the provider may request payment of the training allowance by the department. Verification of attendance of the approved training must be submitted at the time reimbursement is being requested. Without verification that training was attended, payment shall not be made.

The training allowance cannot be prorated. If a full six hours of training is not completed within the quarter, the provider is not eligible for this payment. Respite providers are not eligible for the training incentive payment.

$1,000 Incentive Payment

The intent of the incentive payment is to reward a provider who has been primarily responsible for a client improving to the point that they no longer require ARS and consequently can return to their own home to live. This payment is not intended to provide additional compensation for providers who have provided short term care to clients with short term needs. The following criteria must be met:

- The client must have been income eligible and the provider having received a monthly supplemental payment from the department for the service they rendered. Private pay clients are not to be considered.
- The provider must have provided full time care to the client for a minimum of 12 consecutive months.
- Independent living must have been the planned objective on the client's case plan and progress toward the achievement of this goal must be well documented in the six month case review.
- The provider must have been assigned, as part of the case plan, measurable tasks toward the achievement of the client's goal of independent living.
- The APS worker must be able to demonstrate the client's return to the level of independence was primarily due to the efforts of the provider.
- An aftercare plan must be in place to identify the tasks to be accomplished, and by whom, during the six month period the client is living in their own home; and,
- Once the client has returned to their home, they must remain there independently for at least six months before the bonus can be given.

Note: Placement in ARS will be end dated when discharge occurs, but, the ARS case is to remain open until the end of the aftercare period, and the incentive payment has been made.

6.6 Bed Hold

There may be times when an adult who has been placed in ARS by the department must be out of the facility for a brief period of time for client hospitalization or scheduled social activities. The intent of the bed hold is to ensure the availability of the bed and to prevent disruption of a stable placement whenever possible and appropriate.

Medical

A bed may be held for a resident for up to 14 days per episode when it is necessary for the client to be absent from the ARS placement for inpatient hospitalization/treatment. Payment at the established rate will continue for up to 14 days, or until such time as it is determined that the client will not be returning to the placement, not to exceed the 14 day limit. A leave of absence must be documented within CCWIS.

Payment by the department and/or the client will continue in accordance with the terms of the payment Agreement in effect. In order to grant a bed hold for medical treatment purposes ALL the following criteria must be met:

- The provider must notify the department of the adult's need for out of facility treatment (in advance whenever possible, the next working day whenever out of facility care is required on an emergency basis).
- The adult for whom payment is being continued was placed in ARS by the department, and the department is currently making a supplemental payment for their care.
- The adult's absence from ARS placement is temporary and short-term, not to exceed 14 days per episode.
- It is expected that the resident will continue to be appropriate for placement.
- The resident will be returning to the adult residential services placement upon discharge.

Social

Providers are to encourage residents to engage in appropriate social and recreational activities. Examples include natural family visitation, natural family vacations, special camps, overnight field trips, etc. A client may be absent from placement for these types of events for up to 14 days per calendar year. During the resident's absence, the ARS provider will continue to receive payments uninterrupted. The worker must document the leave of absence in CCWIS.

ALL the following criteria must be met:

- The activity must be scheduled and approved in advance.
- The adult for whom payment is being continued was placed in the facility by the department and the department is currently making a supplemental payment for their care.
- The adult's absence from ARS is to be; temporary and short-term, not to exceed 14 days per calendar year; and,
- The resident will be returning to the ARS placement.

6.7 Respite Care

Respite care can be arranged to provide temporary care to adults in order to offer short term relief to regular AFC providers. The purpose is to allow these full-time providers to have planned times for vacations or other activities and to provide emergency care in the event of illness of the provider or a provider's family member. Clients are not to be placed with an unapproved respite provider. Household members cannot be paid for providing respite care.

Planning and Paying for Respite Care

All paid respite is to be planned and approved in advance, with the exception of respite which is needed as a result of an emergency involving the provider or a member of the provider's household. When respite is needed in an emergency, verbal approval must be obtained prior to placement of the client with an approved respite provider. The respite is not to exceed 14 days per calendar year, per client, for whom the department is making a supplemental payment. Prior to payment for respite care:

- The respite provider must submit a written signed and dated statement or invoice, verifying dates respite care was provided and the client's name(s) that care was provided to, with the name of the respite provider and the regular AFC provider's name.
- Upon receipt of this written invoice/statement, the payment process will be started. In the event respite care would continue beyond the allowed 14 days, respite payment to the provider would be discontinued.
- The per diem rate paid to the respite provider will be based on the per diem rate for the regular AFC provider. Payment beyond the annual 14 days is the AFC provider's responsibility.

6.8 Trial Visit

If a client who is currently an active adult services client is planning to move to another home or a different type of setting, a trial placement is recommended to ensure a good match between the prospective provider and the client. If an overnight stay is planned as part of a trial visit, the department may reimburse the prospective provider. In order to generate this type of demand payment, the provider must be set up in CCWIS and connected to the client's case. The current provider will continue to receive payment, with the trial visit provider being paid for the number of days for the trial visit. If the client is being discharged from an institutional setting or coming from the community and is not an active adult services client at the time of the trial visit, the client must be encouraged to use their resources to make payment to the prospective provider. If it is determined that the client does not have resources to pay the provider for the trial visit, the client's worker is to request that payment to the provider be made by the department as a demand payment. Reimbursement made by the department for a trial visit is to be at the current daily rate for the type of provider involved in the trial visit. The worker shall request payment for the days the client is in the trial home. If the client goes to "trial home visit" on Friday at 6:00 p.m. and comes back on Sunday at 12:00 p.m. the provider will be paid for three full days.

6.9 Special Medical Authorization

Most clients who are placed in ARS will be eligible for Medicaid or some other type of medical insurance to cover the cost of needed medical care. If a client currently receives Medicaid, the special medical card must not be issued. The coverage for Medicaid and the special medical card is identical. If the client does not have coverage for necessary medical care, the worker must thoroughly explore all potential options for securing appropriate medical coverage.

Examples include, but are not limited to, community/civic organizations, family members, churches, Medicare Part D, drug company assistance programs, samples from physicians, mental health agencies, health right clinics, etc. If, after this exploration, the client does not have the resources to pay for needed medical care, use of the special medical authorization may be requested to pay for specific medical

expenses. For clients that are eligible for Medicare, the special medical card will not cover any prescriptions that are covered under Medicare Part D, regardless of whether the client is enrolled in Medicare Part D or not; therefore, the special medical card must not be issued for any prescriptions covered by Medicare Part D for individuals eligible for Medicare. Eligibility for Medicare Part D is based upon the following:

The individual must be receiving either Medicare part A or B. To be eligible for either Medicare Part A or B, the individual must be 65 years of age OR, if under 65 years of age, the individual must be receiving disability Social Security benefits and must have been receiving disability Social Security benefits for two years.
Lack of resources means that:

- The client does not have funds to pay for medical care.
- No other resources available, such as family, friends, community/civic organizations, etc..
- Not eligible for any type of medical coverage; and,
- Eligible for medical coverage but benefits are not currently available (recent application not yet approved for coverage), with the exclusion of Medicare Part A&D.
- Allowable costs.

Regardless of the reason(s) resources are not available, use of the special medical authorization may only be used to meet an emergent need or to prevent an emergency from occurring. When this is the case, the APS worker may request use of the special medical authorization to cover the cost of certain medical care or services. The special medical authorization may only be issued for a period of up to six months. At the end of the approved eligibility period, if continuation of services is necessary, a new authorization must be requested.

In a situation where a client needs services from more than one vendor, an example would be: an office visit with a physician and prescriptions from a pharmacy and a separate special medical authorization request will be required for each vendor, with the appropriate eligibility period for each authorization.

Special medical authorization is available for use by adults placed by the department in ARS in very limited situations. This authorization may only be used when all the following conditions exist:

- The client is currently a resident in an ARS setting.
- The client was placed by the department or was placed by another party but the placement was approved by the department.
- The treatment, service, or certain supplies for which authorization is being requested is deemed medically necessary by the client's physician.
- The medical treatment, service or certain supplies are needed to remedy an emergency medical situation or to prevent a medical emergency from developing; and,
- The special medical authorization may be used to cover certain medical costs; however, all Medicaid eligible services are not necessarily covered by this authorization. The special medical card will not cover any prescription that is not on the Medicaid Drug Formulary. In addition, if the client is in a category that should be eligible for Medicare Part D, the special medical card will

not cover any prescription costs that are covered by Medicare Part D. Therefore, the special medical card must not be issued for individuals in this category.

Examples of Costs that are Typically Covered

- Medication (must be prescribed by a physician).
- Limited doctor visit.
- Pads/Chux only - 150/month.
- Adult disposable briefs only - 200/month; and,

Examples of Costs that are NOT Covered (not all inclusive)

- Hospitalization.
- Nursing home placement.
- Psychiatric treatment.
- Behavioral health day treatment.
- Dental work.
- Glasses.
- Outpatient surgery.
- Diagnostic testing.
- Required procedures.

The special medical authorization may be used to cover costs; however, all Medicaid eligible services are not necessarily covered by this certain medical authorization. Hospitalization is not covered by the special medical authorization; nor is case management services at behavioral health centers.

If a client is in an adult residential placement, has no medical coverage, does not have the resources to pay for, and is determined by their physician to be in need of medically necessary treatment or services, special medical authorization may be requested to cover the cost. When requesting a special medical authorization, the following information will be considered:

- Identify client's goals related to the case plan.
- Explanation of how provision of the requested services will prevent movement of the client to a higher level of care.
- List the specific service(s) payment is being requested for and the associated cost (cannot exceed current Medicaid rate).
- Statement of verification that all potential resources have been explored and the amount of resources that will be paid through another source (if any) or that there are no other resources available to meet the cost.
- Anticipated duration of request.
- Name of provider.
- Income amount and source.
- Amount of supplemental payment being made by the department.

In addition to the above information, private pay clients must be paying the current state rate and must not have any resources to pay for the medical need. If a private pay client has any excess income after paying current state rate to the adult residential provider, minus the personal needs allowance this amount must be applied towards the cost of the medical need before using the special medical card.

If Approved

A copy of the authorization must be furnished to the vendor providing the service with this authorization. If at any time during the approval period, the authorized services are no longer required, written notification will be provided to the vendor advising them to discontinue provision of the authorized services.

If Denied

Additional information may be resubmitted if the request of the denial was based on insufficient information. Otherwise alternate resources must be located and secured.

Note: Clozaril or an equivalent is covered by Medicare Part D. If the client is not eligible for Medicare Part D, Medicaid covers this for recipients of Medicaid. There is also a Special Pharmacy Program for individuals who cannot meet a Medicaid spend down and who meet certain other criteria.

6.10 Non-Medicaid Covered Services

Clients placed in ARS by the department may, at times, incur expenses that are medically necessary but are not reimbursable by Medicaid. The worker will obtain the necessary documentation and consult with their APS supervisor and program manager prior to entering the demand payment.

6.11 Clothing Allowance

Purpose

The purpose of providing a clothing allowance is to ensure that all clients placed by the department, and for whom the department is making a supplemental vendor payment, have adequate clothing while in placement. Provision of a clothing allowance is not to be considered an automatic payment. It is to be based upon the individual client's need for clothing. There are two types of clothing allowance available for eligible adults: an initial placement allowance, and a replacement clothing allowance.

Determination of Eligibility

Certain adults in residential settings are eligible to receive a clothing allowance. In order to be eligible for this allowance, the client must meet two criteria. These are:

- The client must reside in ARS.
- The department must be making a supplemental payment to the provider for the client's care. Private pay clients in the home ARE NOT eligible for a clothing allowance from the department.

Initial Clothing Allowance

Clients may receive a one-time clothing allowance upon their first adult residential placement, not to exceed $100.00 to acquire a sufficient wardrobe. Eligibility f begins on the date of placement and ends on the day prior to the date of the six month review or the date of discharge, whichever occurs first.

Replacement Allowance

The worker may request a clothing allowance in CCWIS every six months to ensure the adult has adequate clothing. Eligibility for a replacement clothing allowance begins on the date of the six month review and ends on the day preceding the date of the next six month review or upon discharge, whichever occurs first. A maximum of $75 is available for each six month period. *It is not necessary to use the entire amount permitted at one time, however, purchases do need to be completed prior to the six month case review following placement. Any unspent portion of the client's initial clothing allowance will be forfeited and may not be carried over to the following six month period.*

*Note**:** In cases where it is verified that the clothing allowance was not used for the benefit of the client, a replacement voucher can be reissued.*

Required Procedures

A clothing allowance can be issued through two avenues at the convenience of the placement provider who will be purchasing the items for the individual. The first option is to issue a BA-67 voucher payable to the vendor. The worker will indicate the maximum amount for the purchase on the voucher. The second option is to provide reimbursement to a provider who purchases clothing allowance items using their own funds. The provider will send all receipts to the worker who will upload a copy into CCWIS and maintain the original in the paper file.

SECTION 7 - CASE CLOSURE

7.1 Introduction

The ARS case must be closed when the client is no longer in ARS placement. If the client is receiving substitute decision making services they can remain open for those services.

7.2 Notification of Case Closure

If the ARS case is closed for any reason other than client death, written notification to the client or their legal representative must be provided.

A client or their legal representative has the right to appeal a decision by the department at any time for any reason. To request an appeal, the client or their legal representative may make a verbal or written request. If the request is written it is recommended to complete the bottom portion of the *Notification Regarding Application for Social Services, SS-13,* and the IG-BR-29 and submit this to the supervisor within 90 days following the date the negative action letter was generated.

7.3 Provider’s Right to Appeal

A provider has the right to appeal a decision by the department at any time for any reason. To request an appeal, the provider must complete the IG-BR-29 and submit it to the supervisor within 30 days following the date the action was taken by the department.

If the provider is dissatisfied with the decision rendered by the supervisor, the appeal and all related information is to be forwarded by the supervisor to the hearings officer at the board of review for further review and consideration.

The ARS provider needs to be aware of the grievance procedure and their ability to file a grievance if they are dissatisfied with the services provided by the department.

SECTION 8 - NONDISCRIMINATION, PROCEDURE & DUE PROCESS STANDARDS, REASONABLE MODIFICATION POLICIES, AND CONFIDENTIALITY

8.1 Nondiscrimination

As a recipient of Federal financial assistance, the Bureau for Social Services (BSS) does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, national origin, disability, age, sex, sexual orientation, gender identity, religion or creed in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by BSS directly or through a contractor or any other entity with which BSS arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964 (nondiscrimination on the basis of race, color, national origin) (“Title VI”), Section 504 of the Rehabilitation Act of 1973 (nondiscrimination on the basis of disability) (“Section 504”), the Age Discrimination Act of 1975 (nondiscrimination on the basis of age) (“Age Act”), regulations of the U.S. Department of Health and Human Services issued pursuant to these three statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

The Bureau for Social Services shall not retaliate against, intimidate, threaten, coerce, or discriminate against any individual for the purpose of interfering with any right or privilege secured by Title VI, Section 504 or the Age Act, or because she or he has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing.

In addition, BSS will make all reasonable modifications to policies and programs to ensure that people with disabilities have an equal opportunity to enjoy all BSS programs, services, and activities. For example, individuals with service animals are welcomed in the Department of Human Services, BSS**,** offices even where pets are generally prohibited.

In case of questions, or to request an auxiliary aid or service for effective communication, or a modification of policies or procedures to participate in a BSS program, service, or activity, please contact:

Children and Adult Services
Section 504/ADA Coordinator
350 Capitol St. Rm 691
Charleston, WV 25301
(304) 558-7980

8.2 Non-Discriminatory Placement Protocol

The department ensures that all parties involved in adult welfare programs have equal opportunities. All potential placement providers for vulnerable adults, are afforded equal opportunities, free from discrimination and protected under the Americans with Disabilities Act (ADA). The department will not deny a potential placement provider the benefit of its services, programs, or activities due to a disability.

Under the Americans with Disabilities Act it defines a person with a disability as:

> "An individual with a disability is defined by the ADA as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment."

The ADA does not specifically name all the impairments that are covered. The ADA does not allow a person to be discriminated against due to a disability in employment, state and local government activities, public transportation accommodations, telecommunication relay services, fair housing, air carrier access, voting accessibility or education. Examples of disabilities include physical disabilities which require auxiliary aids and mental health issues. Those persons with substance use disorders, including opioid use disorder, currently participating in a treatment option such as Medication Assisted Treatment (MAT), are also covered by the ADA. Participation in a MAT program is not considered the illegal use of drugs. Qualifying MAT programs are defined in W. Va. Code §16-5Y-1, *et seq.* The ADA also addresses the civil rights of institutionalized people and architectural barriers that impact people with disabilities.

When making diligent efforts to locate and secure appropriate placement for vulnerable adults, a worker cannot discriminate against a potential placement based upon a person with a disability according to the Americans with Disabilities Act (ADA) Title II. The department shall determine if the potential placement for the vulnerable adult represents a direct threat to the safety of the adult. Safety threat decisions will be based on assessment of the individual and the needs of the vulnerable adult, as the safety of the adult always remains at the forefront of the determination of the best interest of an adult, when placing a vulnerable adult in anyone's home. This determination cannot be based on generalizations or stereotypes of individuals.

If a provider protected under the ADA is identified as an appropriate and best interest placement for a vulnerable adult they may, at some point, require services specific to their disability in order to preserve the placement. In such situations, consideration for services must be given if it is in the best interest of the adult to preserve the placement. Any specific auxiliary aids or services should be determined by the worker at no cost to the provider and should be considered on a case by case basis.

8.3 Complaint Procedure and Due Process Standards

Complaints Based on Disability or other Forms of Discrimination

It is the policy of the department not to discriminate on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, religion, or creed. The department has adopted an internal complaint procedure providing for prompt, equitable resolution of complaints alleging discrimination. Laws and Regulations, 28 C.F.R. Part 35 and 45 C.F.R. Part 84, may be examined by visiting https://www.ada.gov/reg3a.html. Additional laws and regulations protecting individuals from discrimination in adult welfare programs and activities may be examined by visiting the U.S Department of Health and Human Services website at https://www.hhs.gov/civil-rights/for-individuals/special-topics/adoption/index.html.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, religion, or creed may file a complaint under this procedure. It is against the law for the Bureau for Social Services, including employees, contracted providers or other BSS representatives, to retaliate in any way against anyone who files a complaint or cooperates in the investigation of a complaint.

Procedure

Complaints due to alleged discriminatory actions must be submitted to the Department of Human Services, Equal Employment Opportunity (EEO)/Civil Rights Officer within sixty calendar days of the date the person filing the complaint becomes aware of the alleged discriminatory action.

The complainant may make a complaint in person, by telephone, by mail, or by email. To file the complaint by mail or email, a Civil Rights Discrimination Complaint Form, IG-CR-3 (See Appendix A) must be completed and mailed or emailed to the West Virginia Department of Human Services, Office of Human Resources Management, EEO/Civil Rights Officer, One Davis Square, Suite 400, Charleston, WV 25301 or email at DHHRCivilRights@WV.Gov. If the complainant requires assistance completing the IG-CR-3 form, they may request assistance from the department. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought. The complainant may also contact the WV DoHS, EEO/Civil Rights Officer, for more information.

West Virginia Department of Human Services
Office of Human Resource Management
EEO/Civil Rights Officer
(304) 558-3313 (voice)
(304) 558-6051 (fax)

DHHRCivilRights@WV.Gov (email)

The EEO/Civil Rights Officer shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The EEO/Civil Rights Officer will maintain the files and records of Bureau for Social Services relating to such complaints. To the extent possible, and in accordance with applicable law, the EEO/Civil Rights Officer will take appropriate steps to preserve the confidentiality of files and records relating to complaints and will share them only with those who have a need to know.

The EEO/Civil Rights Officer shall issue a written decision on the complaint, based on the preponderance of the evidence, no later than 30 calendar days after its filing, including a notice to the complainant of his or her right to pursue further administrative or legal remedies. If the EEO/Civil Rights Officer documents exigent circumstances requiring additional time to issue a decision, the EEO/Civil Rights Officer will notify the complainant and advise them of his or her right to pursue further administrative or legal remedies at that time while the decision is pending. The person filing the complaint may appeal the decision of the EEO/Civil Rights Officer by writing to the Director of Human Resources within 15 calendar days of receiving the EEO/Civil Rights Officer's decision. The Director of Human Resources shall issue a written decision in response to the appeal no later 30 calendar days after its filing.

The person filing the complaint retains the right to file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, regardless of the decision made by the West Virginia Department of Human Services.

The availability and use of this procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, religion or creed in court or with the US Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf or by mail or by phone at:

U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
800-368-1019 (voice) 800-537-7697 (TDD)
OCRComplaint@hhs.gov

For complaints to the Office for Civil Rights, complaint forms are available at: https://www.hhs.gov/ocr/complaints/index.html. Complaints shall be filed within one hundred and eighty (180) calendar days of the date of the alleged discrimination.

The Bureau for Social Services will make appropriate arrangements to ensure that individuals with disabilities and individuals with Limited English Proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed, to participate in this process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing recorded material for individuals with low vision, or assuring a barrier-free location for the proceedings. The EEO/Civil Rights Officer will be responsible for such arrangements.

Grievances Regarding the Adult Services Worker or Casework Process

At any time that the Bureau for Social Services is involved with a client, the client, or the counsel for the vulnerable adult has a right to express a concern about the manner in which they are treated, including the services they are or are not permitted to receive.

Whenever a vulnerable adult or counsel for the vulnerable adult has a complaint about Adult Services or expresses dissatisfaction with Adult Services the worker will:

- Explain to the client the reasons for the action taken or the position of the BSS which may have resulted in the dissatisfaction of the client.
- If the situation cannot be resolved, explain to the client his/her right to a meeting with the supervisor.
- Assist in arranging for a meeting with the supervisor.
-

The supervisor will:

- Review all reports, records and documentation relevant to the situation.
- Determine whether all actions taken were within the boundaries of the law, policies and guidelines for practice.
- Meet with the client.
- If the problem cannot be resolved, provide the client with the form "Client and Provider Hearing Request", IG-BR-29 .
- Assist the client with completing the IG-BR-29, if requested.

Submit the form immediately to the Chairman, state board of Review, DoHS, Building 6, Capitol Complex, Charleston, WV 25305.

For more information on Grievance Procedures for Social Services please see Common Chapters Manual, Chapter 700, and Subpart B or see W. Va. code §29A-5-1.

Note: Some issues such as the decisions of the Circuit Court cannot be addressed through the Grievance Process. Concerns about or dissatisfactions with the decisions of the Court including any approved Case plan must be addressed through the appropriate legal channels.

8.4 Reasonable Modification Policy

Purpose

In accordance with the requirements of Section 504 of the Rehabilitation Act of 1973 (Section 504) and Title II of the Americans with Disabilities Act of 1990 (ADA), the Bureau for Social Services shall not

discriminate against qualified individuals with disabilities on the basis of disability in its services, programs, or activities. The BSS shall make reasonable modifications in Adult Services program policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless BSS can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

Policy

The department is prohibited from establishing policies and practices that categorically limit or exclude qualified individuals with disabilities from participating in the BSS Adult Services program.

The Bureau for Social Services will not exclude any individual with a disability from the full and equal enjoyment of its services, programs, or activities, unless the individual poses a direct threat to the health or safety of themselves or others, that cannot be mitigated by reasonable modifications of policies, practices or procedures, or by the provision of auxiliary aids or services.

The Bureau for Social Services is prohibited from making Adult Services program application and retention decisions based on unfounded stereotypes about what individuals with disabilities can do, or how much assistance they may require. The BSS will conduct individualized assessments of qualified individuals with disabilities before making Adult Services application and retention decisions.

The Bureau for Social Services may ask for information necessary to determine whether an applicant or participant who has requested a reasonable modification has a disability-related need for the modification, when the individual's disability and need for the modification are not readily apparent or known. BSS will confidentially maintain the medical records or other health information of Adult Services program applicants and participants.

The Bureau for Social Services upon request, will make reasonable modifications for qualified Adult Service program applicants or participants with disabilities unless BSS can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity. Individuals do not need to reference Section 504 or Title II or use terms of art such as "reasonable modification" in order to make a request. Further, BSS staff are obligated to offer such reasonable accommodations upon the identification of a qualifying disability or to an individual with Limited English Proficiency.

BSS must consider, on a case-by-case basis, individual requests for reasonable modifications in its Adult Services programs, including, but not limited to, requests for substitute caregivers, respite caregivers, more frequent support from a case worker, additional classroom and/or online training, mentorship with an experienced foster/adoptive parent, note takers, and other auxiliary aids and services. When auxiliary aids or language interpretation services to ensure effective communication for individuals with hearing, vision, speech impairments, or Limited English Proficiency (LEP) are needed, they shall be provided to the participant at no additional costs. The department evaluates individuals on a case by

case basis to provide auxiliary aids and services as necessary to obtain effective communication. This would include but not be limited to:

- Services and devices such as qualified interpreters, assistive listening devices, note takers, and written materials for individuals with hearing impairments.
- And qualified readers, taped texts, and Brailed or large print materials for individuals with vision impairments.
- Access to language and interpretation services.

For more information on obtaining auxiliary aids, contact:

Center for Excellence in Disabilities (CED)
959 Hartman Run Road
Morgantown, WV 26505
Phone: 304-293-4692.
Toll Free: (888) 829-9426
TTY: (800) 518- 1448

For language translation and interpretation services Adult Services may Contact 911 Interpreters or the Section 504/ADA Coordinator (see also section 11.5 Limited English Proficiency). To contact 911 Interpreters, utilize the information below:

911 Interpreters Inc.
1-855-670-2500
BSS Code: 16233

When requesting language translation services directly through 911 Interpreters, staff must report the accommodation to the Section 504/ADA Coordinator by completing the *Reasonable Accommodation Reporting Form*.

The Bureau for Social Services will not place a surcharge on a particular qualified individual with a disability or any group of qualified individuals with disabilities to cover the cost of measures, such as the provision of auxiliary aids and services or program accessibility, that are necessary to provide nondiscriminatory treatment required by Title II of the ADA and Section 504.

To address any violations of this Reasonable Modification Policy, consult the Bureau for Social Services Grievance Procedure. To request reasonable modifications, or if you have questions, please contact:

Children and Adult Services
Section 504/ADA Coordinator
350 Capitol St. Rm 691
Charleston, WV 25301
(304) 558-7980
DHHRCivilRights@WV.Gov (email)

Staff who make reasonable accommodations for an individual must be reported to the Section 504/ADA Coordinator utilizing the *Reasonable Accommodation Reporting Form*.

8.5 Limited English Proficiency

The Bureau for Social Services (BSS) will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of BSS is to ensure meaningful communication with LEP clients and their authorized representatives involving their case. The policy also provides for communication of information contained in vital documents, including but not limited to, information release consents, service plans, etc. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and clients and their families will be informed of the availability of such assistance free of charge. Language assistance will be provided through use of contracted vendors, technology, or telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in the effective use of an interpreter and the effective use of technology including telephonic interpretation services. The Bureau for Social Services will conduct a regular review of the language access needs of our population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

PROCEDURES:

<u>1. IDENTIFYING LEP PERSONS AND THEIR LANGUAGE</u>

The Bureau for Social Services will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or "I speak cards," available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with clients or family members, the language used to communicate with the LEP person will be included as part of the record.

2. OBTAINING A QUALIFIED INTERPRETER

911 Interpreters Inc. has agreed to provide qualified interpreter services. The agency's telephone number is 1-855-670-2500 (BSS Code:16233). Interpretation services are available 24 hours a day. Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, BSS will provide qualified interpreter services to the LEP person free of charge. Children and other clients will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

3. PROVIDING WRITTEN TRANSLATIONS

When translation of vital documents is needed, BSS will submit documents for translation to 911 Translators Inc. or the Section 504/ADA Coordinator***.*** BSS will generally provide language services in accordance with the following guidelines:

A. BSS will provide written translations of vital documents for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. Translation of other documents, if needed, can be provided orally; or
B. If there are fewer than 50 persons in a language group that reaches the five percent threshold in (a), BSS will not translate vital written materials but will provide written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials, free of cost.

Additionally, when making a determination as to what languages services will provided, BSS may consider the following factors:

(1) the number and or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee;

(2) the frequency with which LEP individuals come in contact with the program;

(3) the nature and importance of the program, activity, or service provided by the program to people's lives; and

(4) the resources available to the grantee/recipient and costs.

Documents being submitted for translation will be in final, approved form with updated and accurate information. Staff who utilize 911 Translators must report the utilization using the *Reasonable Modification Reporting Form* to the Section 504/ADA Coordinator.

Documents being submitted for translation will be in final, approved form with updated and accurate information. Staff who utilize 911 Translators must report the utilization using the *Reasonable Modification Reporting Form* to the Section 504/ADA Coordinator.

4. PROVIDING NOTICE TO LEP PERSONS

The Bureau for Social Services will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand. At a minimum, notices and signs will be posted and provided in DoHS office lobbies and waiting areas. Notification will also be provided through one or more of the following: outreach documents and program brochures.

5. MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, BSS will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures. In addition, BSS will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from clients and community organizations, etc.

APPENDIX A - DoHS CIVIL RIGHTS DISCRIMINATION COMPLAINT FORM

STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR SOCIAL SERVICES

Civil Rights Discrimination Complaint Form

Complainant First Name		Complainant Last Name
Home Phone *(include area code)*		Work Phone *(include area code)*
Street Address		City
State	Zip Code	Email *(if available)*

Is this complaint being completed by someone other than the complainant? ☐ Yes ☐ No

If yes, please provide your information below:

First Name	Last Name	Telephone Number (include area code)

The complainant feels they have been discriminated against on the basis of:

☐ Race/Color/National Origin ☐ Religion/Creed ☐ Sexual Orientation/Gender Identity

☐ Disability ☐ Age ☐ Sex

Who or what bureau within the West Virginia Department of Health and Human Resources is believed to have been discriminatory?

Name/Bureau/Office		
Street Address	City	County
Zip Code	Telephone	

Date(s) discriminatory action is believed to have occurred: ______

Which program(s) is the complainant alleging the discriminatory action took place in?

☐ Child Welfare *(includes CPS, Youth Services, Foster Care, Adoption, home finding, and Legal Guardianship)*

☐ Adult Welfare *(includes APS, Guardianship, Health Care Surrogate, Residential Services Request to Receive and Request to Provide)*

☐ Low Income Energy Assistance Program (LIEAP)

☐ Temporary Assistance for Needy Families (TANF)

☐ School Clothing Voucher

☐ Indigent Burial

Complaints involving the Supplemental Nutrition Assistance Program (SNAP) must be sent directly to the U.S. Department of Agriculture. See below for more information.

Describe briefly what happened. How and why does the complainant believe they have been discriminated against? What is the relief or remedy sought by the complainant?

(*Attach additional pages as needed.)*

Please sign and date this form. If submitting by email, you may type your name and date. Your email will represent your signature.

Signature	**Date** (mm/dd/yyyy)

The West Virginia Department of Human Services shall not retaliate against, intimidate, threaten, coerce, or discriminate against any individual for the purpose of interfering with any right or privilege secured by Title VI, Section 504 or the Age Act, or because she or he has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing.

EEO/Civil Rights Officer shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. EEO/Civil Rights Officer will maintain the files and records of DoHS relating to such grievances. The EEO/Civil Rights Officer shall issue a written decision on the complaint no later than thirty (30) calendar days after its filing, unless the Coordinator documents exigent circumstances requiring additional time to issue a decision. To submit this complaint or request additional information, please contact:

West Virginia Department of Human Services
Office of Human Resource Management
EEO/Civil Rights Officer
(304) 558-3313 (voice)
(304) 558-6051 (fax)
DHHRCivilRights@WV.Gov (email)

The person filing the grievance retains the right to file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, regardless of the decision made by the West Virginia Department of Human Services. The availability and use of this grievance procedure does not prevent a person from filing a private lawsuit in Federal court or a complaint of discrimination on the basis of being a member of a protected class, with the:

U.S. Department of Health & Human Services
200 Independence Ave., S.W.
Room 509F HHS Bldg.
Washington, D.C. 20201

800-368-1019 (voice)
202-619-3818 (fax)
800-537-7697 (TDD)
OCRComplaint@hhs.gov (email)
The complaint form may be found at https://www.hhs.gov/ocr/complaints/index.html

For SNAP complaints, please contact the U.S. Department of Agriculture.

The USDA Program Discrimination Complaint Form, can be found online at: https://www.ocio.usda.gov/document/ad-3027, or at any USDA office. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form by mail, email, or fax to:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW Washington, D.C. 20250-9410
(202) 690-7442 (fax)
(866) 632-9992 (telephone)
program.intake@usda.gov (email)