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Adult Residential Services

SECTION I

INTRODUCTION

1.1 Introduction and Overview

Adult Residential Services includes Adult Family Care homes and Assisted Living Facilities. These placement options may be an appropriate option 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 (1) 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 Adult Family Care Home may provide care for up to three (3) adults and is certified to provide care by the Department of Health and Human Resources homefinder. Assisted Living Facilities are residential settings for adults that provide supervision, support, protection and security in a group living setting to four (4) or more residents. The residents may need limited and intermittent nursing care. Assisted Living Facilities must be licensed by the Department of Health and Human Resources, Office of Health Facilities Licensure and Certification.

A reasonable attempt will be made to accommodate clients with disabilities and examples of this include: Auxiliary aids for individuals with disabilities where necessary to ensure effective communication with individuals with hearing, vision or speech impairments will be arranged and provided. All offices have the capability to accommodate individuals that utilize TTY equipment. If further assistance is needed, the worker will contact the local Division of Rehabilitation as well as the West Virginia Commission for Deaf and Hard of Hearing at (304) 558-1675. The TTY toll free number is 1-866-461-3578.

Culturally competent practice will be ensured by recognizing, respecting and responding to the culturally defined needs of individuals that we serve. If someone is in need of an interpreter, the worker must contact local resources to locate an interpreter. Examples include, but are not limited to, the Board of Education, local colleges and Division of Rehabilitation. If a local community resource cannot be located, the worker will seek other resources such as the Department of Justice Immigration and Naturalization Service at (304) 347-5766, 210 Kanawha Blvd. W, Charleston, WV 25302.

1.2 Definitions

Abuse: The infliction or threat to inflict physical pain or injury on or the imprisonment of any incapacitated adult or facility resident according to WV Code [§9-6-1](#). (Similar definition is contained in [§61-2-29](#) that addresses penalties for abuse or neglect of incapacitated adult or elder person).

Activities of Daily Living (ADL): Routine activities that people do every day without needing assistance. There are six (6) 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 (3) individuals over the age of eighteen (18) who meet the criteria for Adult Residential Services.

Adult Family Care Provider: An individual or family unit certified by Department of Health and Human Resources. The Provider will provide support, supervision and assistance to adults placed in their home and receive a supplemental payment from DHHR for the adults care.

Advance Directives: Mechanism used by individuals to make health care decisions prior to their potential incapacity. State law recognizes living wills, medical power of attorney and durable power of attorney that include provisions for making medical decisions as advance directives. [WV Code §44A-1-3](#).

Note: DHHR Departmental and Adult Services staff is prohibited to assist with the completion of Advance Directives.

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.

Adult Residential Services: Adult Residential Services is made to encompass all Adult Placement types including Adult Family Care and/or Assisted Living.

Assisted Living Facility: Any living facility, residence or place of accommodation available for four (4) 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 (24) awake supervision of activities of daily living.

Note: Previously defined Personal Care Home and Residential Board and Care Homes are now defined in the Legislative Code of Rules 64-14-3.6 and policy as Assisted Living Facilities.

Attending Physician: A licensed physician who is selected by or assigned to the person and has the primary responsibility for treatment and care of the person.

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 [WV 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.

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 a full conservator, limited conservator or temporary conservator.

- a. **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.
- b. **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.
- c. **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. A temporary conservator is time limited to six (6) months unless terminated or extended by the Circuit Court upon good cause following a hearing.

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

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.

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, I pads, fax machines, etc.

Emancipated Minor: A child over the age of sixteen (16) who has been emancipated by 1) order of the court based on a determination that the child can provide for his/her physical well-being and has the ability to make decisions for him/herself or 2) marriage of the child. An emancipated minor has all the privileges, rights and duties of an adult including the right to contract.

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.

Estate: Any real and personal property or any interest in the property and anything that may be the subject of ownership.

FACTS: Acronym for Family and Children's Tracking System and is the automated client information system used by the West Virginia Department of Health and Human Resources, Bureau for Children and Families.

FACTS PLUS: The Family and Children's Tracking System Provider Look- Up and Update System which allows registered providers to view details of their payments and individuals served on a secured site. Information is available twenty-four (24) hours a day.

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: A type of neglect of an incapacitated adult involving the illegal, unethical and/or improper use of or willful dissipation of an individual's funds, property or other assets by a person, formal or informal caregiver, family member, or legal

representative - either directly (i.e. as the perpetrator) or in-directly (i.e. by allowing or enabling the condition which permitted the financial exploitation).

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.

- a. **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.
- b. **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.
- c. **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 (6) months unless terminated or extended by the circuit court upon good cause following a hearing.

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.

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.

Health Care Surrogate: An individual eighteen (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.

Incapacitated Adult: Any person, by means of physical, mental or other infirmity is unable to physically carry on the daily activities of life necessary to sustaining life and reasonable health. (**NOTE:** Incompetence of an adult is determined by a legal proceeding and is not the same as a determination of incapacity. Similar definition "incapacitated adult" is contained in [WV State Code. §61-2-29](#), abuse or neglect of incapacitated adult or elder person regarding criminal penalties).

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.

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: A person who is the subject of a guardianship or conservator proceeding, an appointed guardian or conservator, or any other person with an actual and substantial interest in the proceedings either generally or as to a particular matter.

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.

Legally Unlicensed Home: Any residence in this state that provides accommodations, personal assistance and supervision, whether for compensation or not, for a period of more than twenty-four (24) hours, to one (1) to three (3) persons who are not related to the operator by blood or marriage within the degree of consanguinity of second cousin. These persons may be dependent upon the services of others by reason of physical or mental impairment or may require limited and intermittent nursing care, including those individuals who qualify for and are receiving services by a licensed hospice.

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 procedure deemed necessary to provide comfort or alleviate pain.

Limited and Intermittent Nursing Care: Direct hands on nursing care of an individual who needs no more than two (2) hours of nursing care per day for a period of time no longer than ninety (90) 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.

Living Will: A written, witnessed advanced directive governing the withholding or withdrawing of life prolonging intervention, voluntarily executed by a person in accordance with the provisions of [WV Code §16-30-3](#).

Medical Power of Attorney: A written, witnessed advanced directive that authorizes an individual that is at least 18 years of age to make medical decisions on behalf of another individual. A medical power of attorney must be duly executed prior to the individual becoming incapacitated and duly executed in accordance with the provisions of [WV Code §16-30-3](#), or existing and executed in accordance with the laws of another state.

Missing Person: An adult individual, eighteen years of age or older, who is absent from his/her usual place of residence in the state and whose whereabouts are unknown for a period of six (6) months or more.

Most Integrated Setting: Is defined in the Olmstead Decree as a setting which enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

Neglect: A) The unreasonable failure by a caregiver to provide the care necessary to assure the physical, safety or health of an incapacitated adult; or B) The unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult or facility resident.

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 West Virginia Department of Health and Human Resources 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 Physician Orders for Scope of Treatment (POST) is a form developed for the purpose of documenting orders for medical treatment and directives concerning provision of CPR, code/no code, level of intervention, etc. [WV Code §16-30-25](#).

Protected Person: A protected person is an adult, 18 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 to:

- a. Meet the essential requirements for his or her health, care, safety, habilitation, or therapeutic needs without the assistance or protection of a guardian; or
- b. 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

Qualified Physician: A physician licensed to practice medicine who has personally examined the person.

Qualified Psychologist: A psychologist licensed to practice psychology who has personally examined the person.

Representative Payee: An individual appointed by the funding source to handle that individual's benefits.

Substitute Decision Maker – A substitute decision maker can be an Surrogate Decision Maker or Health Care Surrogate or a court appointed Guardian.

Surrogate Decision-Maker: Means an individual identified as such by an attending physician in accordance with the Health Care Decisions Act, [WV Code §16-30-3](#)

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SECTION 2

INTAKE

2.1 Eligibility Criteria

2.1.1 Receive Services

Assisted Living Residence and Adult Family Care services 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 Residence provides twenty-four (24) hour awake care. In addition to the income and assets requirement listed below, eligibility for placement and supplemental payment by DHHR in this type of setting requires that an individual must meet at least one (1) of the following criteria:

- a. He/she must be age sixty-five (65) or older and in need of supportive living;
- b. He/she must be at least eighteen (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 Adult Service worker that this medical evaluation does indicate the need for supervised care; or,
- c. Currently receiving Adult Protective Service or APS Preventive Services from the Department.

Supplemental payment by the Department for placement in an Adult Residential Services placement 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 of Health and Human Resources and the clients' assets cannot exceed the established level, currently \$2,000.

In the case of eligibility based on an active APS or APS Preventive Services case, Adult Residential Services placement must be needed to eliminate the abuse, neglect or exploitation that was verified during the APS investigation. The identified problem area(s) and placement in the Adult Residential Services placement must be documented in the client's Service Plan in the APS case and Adult Residential case.

2.1.2 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/or assistance being requested, the specific needs of the individual, and other relevant information. At a minimum, the following must be included:

- a. Name of client;
- b. Date of birth or approximate age of the client;
- c. Social security number;
- d. Client's current living arrangements;
- e. Client's current location;
- f. Household composition;
- g. Physical and/or mailing address of client;
- h. Directions to client's home;
- i. Telephone number of client;
- j. Significant others - relatives, neighbors, friends;
- k. Legal representative(s), if known;
- l. Reporter/caller information, if different than client;
- m. Physical, mental or emotional limitations of the client;
- n. Description of how needs are currently being met;
- o. Any known income or assets;
- p. Any known DHHR benefits; and,
- q. Other relevant information.

2.1.3 Referent Information

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

- a. Referent name;
- b. Referent address;
- c. Referent telephone number;
- d. Relationship to the client;
- e. How they know of the client's needs;
- f. Referent's expectations of the Department; and,
- g. Other relevant information.

2.1.4 Services Requested

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

- a. The specific type(s) of assistance being requested;
- b. Why assistance is being requested;
- c. How needs are currently being met; and,
- d. Other relevant information.

Determine if the referral is to be assigned for an Adult Services Initial Assessment or screened out.

2.2 Referral Triage/Disposition

The disposition provides for referrals to be assigned for assessment and assigned a response time or allow for the referral to be screened out.

2.2.1 Accept/Screen Out

A. Considerations in determining whether to accept or screen out the referral:

- 1. The presence of factors which do/could present a risk to the adult;
- 2. Determine if allegations of abuse, neglect or exploitation are indicated, then an APS referral may be required;
- 3. The information related to the identified client and their current circumstances;

4. Whether the information collected appears to meet the eligibility criteria for Adult Residential Services placement;
5. The sufficiency of information in order to locate the individual/family; and,
6. Client's wishes and capacity to make their own decisions.

B. After Referral is Accepted and/or Screened Out

1. If the referral is accepted; a response time and a primary worker will be assigned for Initial Assessment.
2. If the referral is Screened Out – any necessary referrals will be completed and the intake will be closed.

2.2.2 Response Times

Depending on the degree of risk to the client's health, safety and well-being, contact with the adult may require a face-to-face contact in less than fourteen (14) days. The policy rules for determining response time are as follow:

A. Response Time Options:

1. **Response - 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 (Example - 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 (5) days). A face-to-face contact with the identified client must be made within 5 days. This contact is to occur in the adult's usual living environment whenever possible.
2. **Response - 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/or is not expected to develop without immediate intervention. A face-to-face contact with the client must be made within fourteen (14) days. This contact is to occur in the adult's usual living environment whenever possible.

B. Considerations in Determining Response Time

1. To assist with the determination of the appropriate response time for initiation of an Adult Residential Services Initial Assessment; the following will be considered.
 - a. Whether the information reported indicates the presence of a situation requiring prompt attention;
 - b. The location of the adult at the time the intake is received;
 - c. Whether the circumstances that exist could change rapidly;
 - d. Whether the living arrangements are life threatening or place the adult at risk;
 - e. Determine if allegations of abuse, neglect or exploitation are indicated, then an APS referral may be required;
 - f. Whether the adult requires medical attention;
 - g. Whether the adult is without needed assistance and supervision;
 - h. Whether the adult is capable of self-preservation/protection;
 - i. Whether the adult is currently connected to any formal support system;
 - j. Whether there are any family or friends available for support;
 - k. Whether there is a caregiver(s) and if so, are they physically, cognitively and emotionally able to provide needed care to the adult;
 - l. Whether there is a past history of referrals or current referrals requesting assistance;
 - m. Whether there are injuries; and,
 - n. Other relevant information.

SECTION 3

ASSESSMENT

3.1 Adult Initial Assessment

Completion of the Initial Assessment involves gathering a variety of information about the client and his/her current status. Information is gathered by conducting interviews with the client, caregiver (if applicable), legal representative (if any), family member(s), or others having knowledge of the situation. The information gathered will be focused on determining 1) the level of risk the client's circumstances present to their well-being and safety, 2) whether or not Adult Residential Services are indicated based on the adult's circumstances, 3) if Adult Residential services are not indicated, what other services may be needed, 4) eligibility criteria, and 5) the role the Department is to play beyond the Initial Assessment.

3.2 Information for the Initial Assessment

Information for completion of the Initial Assessment is obtained by conducting interviews with the client and all other relevant parties during face to face interviews with the client and all other relevant parties.

In addition to the above, information gathering may include documents, reports, records, written statements, etc. These may require a written release from the client and/or legal representative.

3.2.1 Information to Be Collected and Documented

A. Identifying 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):

1. Name;
2. Address (mailing and residence);
3. Telephone number;
4. Date of birth/age;
5. Household members;
6. Other significant individuals;

7. Legal representatives/substitute decision-makers (if applicable);
8. Identification numbers (SSN, Medicaid, Medicare, SSA Claim, etc.);
9. Gender/ethnicity;
10. Marital status
11. Advance Directives in effect; and,
12. Directions to the home.

B. Services Requested

Information regarding the services being requested

This should include information such as the following:

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

C. Living Arrangements

Information regarding the client's current living arrangements:

This should include information about where the client currently resides such as the following:

1. Client's current location (own home, relative's home, hospital, etc.);
2. Is the current setting considered permanent or temporary;
3. Type of setting (private home/residential facility, etc.);
4. Household/family composition;
5. Physical description of the current residence (single family dwelling, duplex, townhouse, apartment, retirement community, foster home, group home, nursing facility, etc.);
6. Interior condition of the residence;

7. Exterior condition of the residence;
8. Type of geographic location (rural, urban, suburban, etc.);
9. Access to resources such as family/friends, transportation, shopping, medical care/services, social/recreational activities, religious affiliations, etc.

D. Client Functioning

Information about how the client's personal needs are currently met, including an assessment of their strengths, needs and supports in areas such as:

1. Activities of daily living (ADL);
2. Whether or not his/her needs are currently being met and by whom;
3. Caregiver functioning, if applicable;
4. Ability to manage finances;
5. Ability to manage personal affairs;
6. Ability to make and understand medical decisions; and,
7. Assessment of decision-making capacity.

E. Physical/Medical Health

Information about the physical condition and description of the client and information about the clients diagnosed health status. Included are areas such as:

1. Observed/reported physical conditions of the client;
2. Primary care physician;
3. Diagnosed health conditions;
4. Current medications;
5. Durable medical equipment/supplies used; and,
6. Nutritional status including special dietary needs, if applicable.

F. Mental/Emotional Health

Information regarding the client current functioning level, current needs and supports and past history of mental health treatment, if applicable. Included are areas such as:

1. Current treatment status;
2. Current mental health provider;
3. Mental health services currently receiving;
4. Medication prescribed for treatment of a mental health condition;
5. Prescribing/treating professional;
6. Observed/reported mental health/behavioral conditions; and,
7. Mental health treatment history.

G. Financial Information

Information regarding the financial resources available and the client's ability to manage the resources independently. The thoroughness and accuracy of financial information is especially critical for clients who will receive Adult Residential Services since the payment calculation is determined utilizing the client's financial information.

1. Financial resources - type, amount and frequency;
2. Other resources available to the client (non-financial);
3. Assets available to the client (cannot exceed a maximum of \$2,000 liquid assets to be eligible for an Adult Residential Services supplemental payment);
4. Outstanding debt(s) owed by the client;
5. Extraordinary expenses;
6. Health insurance coverage(s);
7. Life Insurance Coverage
8. Pre-need burial agreement in effect
9. Court ordered obligation for child support/alimony;

10. Income Maintenance benefits received from DHHR; and,
11. Information about the client's ability to manage their own finances.

H. Educational/Vocational Information

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

1. Last grade completed;
2. Field of study;
3. History of college attendance/graduation; and,
4. History of special licensure/training.

I. Employment Information

Information about the client's past and present employment, including but not limited to sheltered employment. Information should include:

1. Current employment status;
2. Current employer;
3. Type of employment; and,
4. Prior employment history.

J. Military Information

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

1. Branch of service;
2. Type of discharge received;
3. Date of discharge;
4. Any veteran's benefits (such as, pharmacy, medical, financial, etc.); and,
5. Service related disability, if applicable.

K. Legal Information

Information about all known legal representatives, and the specific nature/scope of that relationship, such as:

1. Assessment of the client's decision-making capacity by the Adult Service worker;
2. Information about legal determination of competence, if applicable;
3. Information about efforts to have the client's decision-making capacity formally evaluated; and,
4. Identification of specific individuals who assist the client with decision-making.

3.2.2 Critical Questions that must be Considered

In addition to gathering information, several critical questions must also be considered:

These include the following:

- a. Is the adult safe or can his/her safety be arranged/assured through resources available to him/her? (Resources include financial, social, family, etc.)
- b. Does the adult appear to meet eligibility criteria for Adult Residential services?
- c. Has there been a medical determination that the adult does/does not have decision-making capacity?
- d. 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.)\
- e. Does the adult have any advance directive in effect? (Living Will, DNR, Power of Attorney, Medical Power of Attorney, etc.) and,
- f. If Adult Residential Services are not to be provided, are referrals to other resources needed?

3.3 Time Frames

The Initial Assessment process will provide face to face interviews within assigned time frames not to exceed 14 days. The Initial Assessment will be completed within thirty (30) calendar days from the date intake received.

3.4 Assessing Eligibility

In order for an individual to be eligible to receive Adult Residential Services provided by the Department, **1)** the individual must be a resident of West Virginia; **2)** their liquid assets cannot exceed \$2000.00 **3)** they must be a US citizen **4)** must be willing to apply their income (less the allowable amount for personal needs) to the Department's established cost of placement in the Adult Residential Services Placement.

Client must meet one of the following criteria:

- a. Age sixty-five (65) or older and be in need of supportive living;
- b. Be at least eighteen (18) years of age or an emancipated minor and be physically and/or mentally incapacitated and be in need of supportive living; or,
- c. Be a recipient of APS or APS Preventive services and in need of supportive living.

3.4.1 Client Assessment for Adult Residential Services Placement

A thorough assessment of the client in order to determine if an Adult Residential Services placement is an appropriate placement option will be completed. If so, a client who is being considered for this type of placement setting must meet the following criteria:

- a. In need of supportive living in order to remain in or return to a community living setting;
- b. 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 he/she is able to remove themselves from the home by his/her own power);
- c. Able to care for his/her own personal needs such as bathing and dressing with minimal assistance or has the capacity to develop these skills with training from the Adult Residential Placement provider and/or other professional;
- d. 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 Adult Residential Services and able to benefit from placement;

- e. Able, or have a legally appointed representative who is able, to understand what Adult Residential Services placement is and expresses a desire for this type of placement;
- f. Unable to live alone as a result of physical or mental incapacity;
- g. No other suitable living arrangements are available;
- h. Able to meet the established admission criteria for the facility being considered; and,
- i. Free from communicable disease that would endanger the health of others.
- j. Willing to contribute to their cost of care to the extent possible;

In addition, they must NOT:

- a. Be incontinent at time of admission or if incontinent, the provider must be willing to accept the client in their facility;
- b. Be in need of nursing home care or highly structured institutional care;
- c. Be in need of acute medical or psychiatric care;
- d. Be intoxicated by alcohol or drugs; and,
- e. Be dangerous to themselves or others (“dangerous” means a person who currently exhibits or has exhibited behavior that can or is likely to result in infliction of injury or damage to other persons or property).

Note: If a client requires an assistive medical support, such as oxygen, this would not necessarily disqualify the individual from participation in the Adult Residential Services program.

3.5 Short-Term Service Planning

Consideration is to be given to both short and long term planning including planning for eventual discharge from Adult Residential Services as appropriate.

These two (2) situations are described below:

- a. Department will provide social services beyond Initial Assessment
- b. Department will NOT provide social services beyond Initial Assessment

3.6 Conclusion of Initial Assessment

Whether or not Adult Residential Services provided by the Department are needed and a case opened. In order for a case to be opened, the adult must have been determined to meet the applicable eligibility criteria.

3.7 Initial Assessment Disposition Options

The possible dispositions available are:

- a. Open an Adult Residential case;
- b. Refer to other resources (internal/external to Department); or,
- c. No additional action needed.
- d. Incomplete assessment - in rare instances it will not be possible to complete an assessment.

The disposition shall be based on all the information gathered during completion of the Initial Assessment.

SECTION 4

CASE REVIEW

4.1 Comprehensive/Global Assessment

Completion of the Comprehensive Assessment involves interviews with the client and other significant individuals.

4.2 Time Frames

This assessment will be completed within the first thirty (30) calendar days following the date the case is opened and annually thereafter.

4.3 Case Management Activities

Once a client has been opened as a recipient of Adult Residential services through the department, various case management activities must occur.

These include tasks such as:

- a. Advising the client of their approval to receive Adult Residential services.
- b. Location and selection of an appropriate provider; including pre-placement visits when appropriate.
- c. Furnish the provider with any special considerations/information about the client/client needs necessary for the provider to meet the client's needs.
- d. Facilitate the client to move into the Adult Family Care home.
- e. Explaining the payment process to the provider, client, and/or decision maker; and completing Payment Agreement.
- f. Complete all necessary paperwork and documentation
- g. Review and monitor the case as required.

4.4 Placement

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

WV 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 Adult Residential Services placement, as defined in section two of this article, which is being operated without a valid license from the secretary. Therefore, DHHR cannot place or cannot authorize, recommend or facilitate placement in an unlicensed Assisted Living Residence or a legally unlicensed home.

4.4.1 Selection of the Provider

The successful placement of a client in an Adult Residential Services will depend largely on assuring a good “match” between the client being placed and the Assisted Living facility.

4.4.2 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 an Adult Residential Services setting. In order to ensure a smooth adjustment, it is important for the Adult Residential Services 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 the Adult Residential Residence.

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/with an Adult Residential Services provider per [WV Code §27-7-2](#). Clients who are coming from this type of placement in a mental health facility are required to be released from the mental health facility on Convalescent Status and placed on a provisional basis into the Adult Residential Services placement. This provisional placement may last for a period of up to six (6) months.

4.4.3 Trial Visit - General

If possible a trial visit, can last up to seven (7) days between the client and the prospective Adult Residential Services provider.

4.4.4 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.

4.5 Client Medical Evaluation

A current medical evaluation is required to document the current health status of the client and it verifies that he/she is free of communicable diseases to the best of the physician’s knowledge for both Adult Family Care and Assisted Living.

4.6 Ongoing Medical Care for Adult Residential Services clients

All clients placed in an Adult Residential Services are to receive ongoing medical care through their placement. They are also to receive an annual client medical evaluation.

4.7 Initial Placement Period

During the first several weeks following placement, the client and provider will need regular guidance and support.

4.8 Resident Agreement for Participation

At the time of placement in the Adult Residential Services program, the client must be able to understand and agree with the terms set forth and to signify his/her agreement by his/her signature.

4.9 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.

4.10 Complaint Against the Provider

When a complaint is received against Adult Residential Services provider appropriate information will be obtained and appropriate referrals made. If it is against an adult family care home; the home finding supervisor must be notified.

4.11 Placement When No Supplemental Payment Made by Department

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.

4.12 Service Planning

Following completion of the comprehensive assessment or review process, a service plan shall be developed to guide the provision of services; to provide the milestones for assessing progress and success in the implementation of the plan.

4.12.1 Inclusion of the Incapacitated Adult in Service Planning

Inclusion of incapacitated adults in the service 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 service plan and should be permitted and encouraged to participate in the development as well as signing of the completed document.

4.12.2 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.

4.12.3 Required Elements - General

The service plan is part of the assessment/review process and developed based on the information gathered during the assessment/review.

Other important considerations for the service planning process are:

1. the client's real and potential strengths;
2. attitudes, influences and interpersonal relationships and their real or potential impact on implementation of the service plan; and,
3. Levels of motivation of both the client and the Adult Residential Services provider.

4.12.4 Developing a Plan to Reduce Risk/Assure Safety

When developing a plan to assure safety of the client, it is important to involve them in the discussion of the behaviors which are problematic, options for managing the behaviors and, the formalization of a plan to address the behaviors and their cause(s).

4.13 Case Review

Evaluation and monitoring of the Adult Residential Services case and the progress being made should be a dynamic process and ongoing throughout the life of the case. For Adult Residential Services cases, regular monitoring is essential in order to evaluate progress, identify potential problems and seek prompt resolution. A case review should occur, at a minimum, of every six (6) months or when there is a substantial change in the client's functioning.

4.13.1 Purpose

The purpose of case review is to consider and evaluate progress made toward achievement of identified goals in the service plan. Re-examination of the service plan is a primary component of the review process.

4.13.3 Time Frames

However, the service plan is required to be reviewed, at a minimum, during the case review process. However, may be reviewed and modified as necessary.

4.13.4 Conducting the Review

The review process consists of evaluating progress toward the goals identified in the current service plan.

Information that may be considered during review process:

- a. summary of changes in the individual or family's circumstances;
- b. summary of significant case activity since the last review;
- c. evaluate need for clothing allowance;
- d. if applicable, collect receipts/bills for any co-pays which may be eligible for a reimbursement/payment via a demand payment;
- e. if applicable, assess the need for continued Special Medical Card;
- f. assessment of the extent of progress made toward goal achievement;
- g. whether or not the identified goals continue to be appropriate and, if not, what changes and/or modifications are needed;
- h. barriers to achieving the identified goals; and,
- i. other relevant factors.

4.13.5 Review of Personal Expense Allowance Use

The accounting records for the client's personal needs allowance maintained by the facility or Adult Family Care Provider are reviewed to ensure that the client is receiving the benefit of their personal needs allowance. If it is believed the Adult Residential Services provider is negligent, exploitive, or is mismanaging the client's personal expense allowance; a referral will be made to Adult Protective Services and law enforcement will be notified in writing.

4.13.6 Documentation of Review

The review process will include reviewing the service plan, completing a case summary and determination of whether the case will continue or will be closed.

4.13.7 Record Keeping

Upon placement of the client in the Adult Residential Services or shortly thereafter, information about the client's service needs will be provided to the Adult Residential Provider to be placed in the client's individual file.

Information that must be provided to the Adult Residential Provider and maintained in the client file by the provider includes the following:

- a. identifying information about the client;
- b. information about significant others such as family members, friends, legal representatives, etc.;
- c. information about the client's interests, hobbies and church affiliation;
- d. medical status including current medications, precautions, limitations, attending physician, hospital preference;
- e. advance directive(s) in force;
- f. information about client's burial wishes, plans and resources;
- g. the Social Evaluation (this form may contain much of the required/client identifying information)
- h. copy of the signed Resident Agreement for Participation;
- i. copy of the current and previous Payment Agreements for their facility; and,
- j. Copy of the current Service Plan.

SECTION 5

CONFIDENTIALITY

5.1 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. Additionally, requirements related to confidentiality specifically related to Adult Protective Services cases are contained in [§9-6-8](#).

5.1.1 When Confidential Information May be Released

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

A. Records Maintained by the Department

In many instances courts will seek information for use in their proceedings. The process by which a court commands a witness to appear and give testimony is typically referred to as a subpoena. The process by which the court commands a witness who has in his/her possession document(s) which are relevant to a pending controversy to produce the document(s) at trial is typically referred to as subpoena duces tecum.

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 his/her client record and should be permitted to do so; although, certain information contained in the record may not be accessible.

B. 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: medical information to medical providers, income information if eligibility is based on financial information, allergies/dietary needs to day treatment provider, etc.).

5.2 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 1) subpoena, 2) subpoena duces tecum, or 3) court order. Upon receipt of any of these, the department MUST respond. Failure to comply is contempt of court and could result in penalties.

- a. Subpoena
A subpoena commands a witness to appear to give testimony. Subpoenas may be court ordered or administrative (ordered by a party other than the court). Though all subpoenas must be responded to, the manner in which this response occurs is somewhat different dependent on who issues the subpoena.
- b. Subpoena Duces Tecum
While a subpoena duces tecum commands a witness, who has in his/her possession document(s) that is relevant to a pending controversy, to produce the document(s) at trial.
- c. Court ordered Subpoenas
These include subpoenas issued by the circuit court, the magistrate court or the mental hygiene commissioner. There may be times when a questionable court order or a subpoena requesting that confidential information be provided is received.
- d. Administrative Subpoenas
These include subpoenas issued by an attorney or administrative law judge (other than a DHHR administrative law judge). These subpoenas generally request that the Adult Service worker appear to provide testimony and/or produce the case record.

5.3 NONDISCRIMINATION, GRIEVANCE PROCEDURE & DUE PROCESS STANDARDS, REASONABLE MODIFICATION POLICIES, AND CONFIDENTIALITY

5.3.1 Nondiscrimination

As a recipient of Federal financial assistance, the Bureau for Children and Families (BCF) 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, 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 BCF directly or through a contractor or any other entity with which BCF 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 Children and Families 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, BCF will make all reasonable modifications to policies and programs to ensure that people with disabilities have an equal opportunity to enjoy all BCF programs, services, and activities. For example, individuals with service animals are welcomed in Department of Health and Human Resources, Bureau for Children and Families, 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 BCF program, service, or activity, please contact:

WV DHHR: Children and Adult Services
Contact Person: Health and Human Resources Specialist
Telephone number: (304) 558-0955

5.4 Grievance Procedure and Due Process Standards

It is the policy of the Bureau for Children and Families (BCF) not to discriminate on the basis of disability. BCF has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. § 12131 *et seq.*, and/or Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. These statutes prohibit discrimination on the basis of disability. In addition, the Bureau for Children and Families does not discriminate against individuals due to race, color, national origin, disability, age, sex, sexual orientation, gender identity or religion. 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>.

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. It is against the law for any Bureau for Children and Families official to retaliate in any way against anyone who files a grievance or cooperates in the investigation of a grievance.

A. PROCEDURE:

Grievance requests due to alleged discriminatory actions must be submitted to the Department of Health and Human Resources, Equal Employment Opportunity (EEO)/Civil Rights Officer, within 180 business days of the date the person filing the grievance becomes aware of the alleged discriminatory action. To file the grievance, the grievant must complete form [IG-CR-3](#) and mail to West Virginia Department of Health and Human Resources, Office of Human Resources Management, EEO/Civil Rights Officer, One Davis Square, Suite 400, Charleston, WV 25301. The grievant may also contact the WV DHHR, EEO/Civil Rights Officer, for more information.

WV DHHR: Office of Human Resource Management
Contact Person: EEO/Civil Rights Officer
Telephone number: (304) 558 – 6811
Fax: (304) 558-6051

A grievance must be in writing, containing the name and address of the person filing it. The grievance must state the problem or action alleged to be discriminatory and the remedy or relief sought.

EEO/Civil Rights Officer shall conduct an investigation of the grievance. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the grievance. EEO/Civil Rights Officer shall maintain the files and records of Bureau for Children and Families relating to such grievances.

The EEO/Civil Rights Officer shall issue a written decision on the grievance no later than thirty (30) calendar days after its filing, unless the Coordinator documents exigent circumstances requiring additional time to issue a decision.

The person filing the grievance may appeal the decision by contacting the U.S. Department of Health and Human Service, Office for Civil Rights.

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 disability with the:

Office for Civil Rights
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 Bureau for Children and Families will make appropriate arrangements to ensure that individuals with disabilities are provided reasonable modifications, if needed, to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The EEO/Civil Rights Officer will be responsible for such arrangements.

B. GRIEVANCES REGARDING THE ADULT SERVICES WORKER OR CASEWORK PROCESS

At any time that the Bureau for Children and Families (BCF) is involved with a client, the client (adult or child), or the counsel for the child 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 parent, child or counsel for the parent or child 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 BCF 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", SS-28, found in Appendix A of this policy.
- Assist the client with completing the SS-28, if requested.
- Complete the form IG-BR-29 CPS/APS (to be completed by Bureau staff)
- Submit the form immediately to the Chairman, state board of Review, DHHR, 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 WV 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.

5.5 Reasonable Modification Policy

A: 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 Children and Families (BCF) shall not discriminate against qualified individuals with disabilities on the basis of disability in its services, programs, or activities. The BCF 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 BCF can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

B: POLICY

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

The Bureau for Children and Families 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 Children and Families 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 BCF will conduct individualized assessments of qualified individuals with disabilities before making Youth Services application and retention decisions.

The Bureau for Children and Families 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. BCF will confidentially maintain the medical records or other health information of Adult Services program applicants and participants.

The Bureau for Children and Families upon request, will make reasonable modifications for qualified Adult Service program applicants or participants with disabilities unless BCF can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

BCF must consider, on a case-by-case basis, individual requests for reasonable modifications in its Adult Services program, 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.

The Bureau for Children and Families 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 Children and Families Grievance Procedure. To request reasonable modifications, or if you have questions, please contact:

WV DHHR: Children and Adult Services
Contact Person: Health and Human Resource Specialist
Telephone number: (304) 558-0955

SECTION 6

CASE MANAGEMENT

6.1 Introduction

Once an individual has been approved for Adult Family Care, various case management activities must occur. These activities may include: identification of available homes based on the characteristics of individual needing placement, monitoring of the placement setting, follow-up on complaints related to compliance with program

standards, providing and/or arranging needed training, and completion of annual provider reviews.

6.2 Responsibilities of the Client

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

SECTION 7

PAYMENTS

7.1 Determination of Rate of Payment

Determination of the rate of payment due to an Adult Residential Services 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 DHHR. If the supplemental payment made by DHHR is eliminated, the case must be closed.

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 DHHR.

Key areas used in calculating the rate of payment include:

- a. employment information, including sheltered employment;
- b. income and asset information; and
- c. Debt and expense information.

7.2.1 Resource Deductions

In unique situations the client may be allowed to redirect a portion of his/her monthly resources rather than using these to pay for his/her care. These should not typically be for routine requests, but rather for necessary expenditures that are extraordinary. (Examples: 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.). 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 the contact screen in FACTS. 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 FACTS to remove the resource deduction.

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

- a. client has a special need (if a medical need - must be documented by their physician);
- b. All potential resources must be thoroughly explored and documented; to validate no resources are available to meet this need. The adult service worker should explore community/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.
- c. There are no potential resources to meet this need
- d. If the resource deduction is for a prescription need, a statement from the client's physician stating why this particular medication is needed.

After a thorough search, if alternate resources are not available, a resource deduction may be considered. When the Payment Agreement is completed with a resource deduction request, the contract becomes a two-tiered approval.

If the resource deduction is not being applied to the approved expense, the resource deduction must be discontinued and reimbursement recouped for each month the resource deduction was not used for the allowable expense.

If an alternate source is located that will pay part, but not all of the monthly amount, the worker will indicate the amount on the contract that is to be considered as a resource deduction. Example total debt amount is \$100.00, and \$40.00 of this will be paid by a civic organization, then \$60.00 is the amount to be requested as a resource deduction.

7.2.2 Personal Expense Allowance

The personal expense allowance is the amount a client placed in an Adult Residential Services placement 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 the Bureau for Children and Families and may be adjusted periodically. All clients placed by the Department in an Adult Family Care Home shall receive the full personal expense allowance amount each month or have this amount readily available for their use. An exception to this would be when the client enters placement after the first day of the month. In this situation, the personal expense allowance is to be pro-rated. 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 (serve 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.

Note: OHFLAC regulations require an Assisted Living Residence to set up an accounting system so as not to co-mingle resident's funds with the facility funds or with the funds of any other person. If the resident's fund exceeds two-hundred dollars (\$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 \$10.00, along with payment receipts for these items. This record must be available for review by the resident, his/her legal representative, any authorized entity and to the department at any time

The client may use his/her personal expense allowance to purchase any item(s) they choose so long as the purchases do not conflict with established house rules or regulations applicable to operation as an Adult Residential Services placement. The allowance must be available to the client and used as he/she desires.

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.

Examples of items that **may** be purchased:

- a. Tobacco products;
- b. Hair styling/permanents;
- c. Hair spray, cologne, aftershave;
- d. Extra clothing;

- e. Jewelry;
- f. Radio or television;
- g. Games, books and other recreational items of interest to the client;
- h. Postage stamps and stationary;
- i. Long distance telephone calls;
- j. Cosmetics;
- k. Pre-need burial trust fund; and,
- l. 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:

- a. Basic personal hygiene articles (toothbrush, toothpaste, soap, deodorant, towels, wash cloths, etc.);
- b. Regular hair cut (applies to all clients, male and female);
- c. Basic recreational needs;
- d. Medications, including over the counter drugs prescribed by the client's physician; and,
- e. Co-pay 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, alternative resources will be explored 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, etc.).

Note: If the client has a court appointed legal representative, the legal representative 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.

7.2.3 Income

Adults who have been placed in an Adult Family Care setting by the Department who 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 Adult Residential Services provider. Therefore, if the in earnings exceed \$65.00 a new contract will need to be completed.

7.3 Payment Agreement

When placing a client in an Adult Residential Services a supplemental payment by DHHR 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. DHHR will supplement the cost of care as a last resort.

If the client receives services from Title XIX Waiver program, the client is not eligible for a Supplemental Adult Family Care payment and the client's AFC case may be closed. In addition, the Adult Family Care Home must be evaluated for closure. If the Adult Family Care Home 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. 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 DHHR or remains eligible for AFC placement.

Note: 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 Adult Residential Services provider.

Specifically:

- a. The total monthly rate of payment due to the provider for a full month of care;
- b. The total daily rate due to the provider for a partial month's care;

- c. The portion of the monthly payment which is to be paid by the client for a full month of care;
- d. The portion of the daily rate that is to be paid by the client for a partial month's care;
- e. The portion of the monthly payment, if any, which is to be paid by the Department for a full month of care;
- f. The portion of the daily rate, if any, that is to be paid by the Department for a partial month's care; and,
- g. 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 Adult Family Care 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 FACTS based on a variety of information entered in FACTS by the social worker. Specifically, information from the following areas of FACTS is used in creating the Payment Agreement: 1) financial, 2) debt/expenses and 3) employment.

7.3.1 Payment For Individuals With No Available Income

a. No Income

If a client who is being placed in an Adult Residential Services has no income, all potential financial resources must be explored including preparation of referral(s) 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 in order to secure the necessary resources to pay for their cost of care. However, if the client requires that an application be made on their behalf and there isn't anyone to assist with this, the worker may need to have a petition filed for Guardianship and/or Conservatorship appointment in order 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. In addition, payment will be included in the provider's reimbursement for the client's personal expense allowance, which the provider is then responsible to make available for the client's use. If, at

some point, the client begins to receive income, the Payment Agreement will need to be reevaluated.

b. Income not available

If a client has income but it is not presently available to him/her, it must be determined 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 individual(s) who are assisting the client in making their personal and financial decisions.

If the client has income but it is not available for their use at the time of placement, the Payment Agreement developed between the Adult Service worker, provider and the client will reflect that the department will reimburse the provider for the full cost of care. In addition, payment will be included in the provider's reimbursement for the client's personal expense allowance, which the provider is then responsible to make available for the client's use. At the point the client's income becomes available for their use; the Payment Agreement will need to be reevaluated

c. Review of the Payment Agreement

The Payment Agreement must be reviewed, whenever there is a change in the client's financial situation and a new payment agreement created (if applicable).

7.3.2 Overpayment

After all reasonable attempts, if the provider does not agree to repay or defaults on monthly payments the provider will be considered for Corrective Action and/or closure of the home.

7.4 Automatic Payments

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

- a. Type of placement;
- b. Client's personal expense allowance;
- c. Client benefit income;
- d. Client employment income;
- e. Client sheltered employment income;

- f. Client assets; and,
- g. Client monthly expenses (in certain circumstances).
- h. Date of placement; and
- i. Date of discharge

Note for Assisted Living: 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 Adult Residential Services Provider.

Based on all these various pieces of information, FACTS will calculate the total rate of the monthly payment due to the provider. In order to assure that monthly payments to the provider are accurate and received by the provider without delay, it is essential that the Adult Service worker enter the required information in a timely manner. Payment information and supervisory approval must be completed by noon on the fourth (4th) working day of the month in order to prevent inaccurate or delayed automatic payment. Payment information that is not entered and approved by noon of the fourth (4th) working day of the month will require the Adult Service worker to request a Demand Payment for the purpose of doing a payment adjustment/correction.

After the total rate of payment is determined by FACTS, the Adult Service worker can create the Payment Agreement. The Payment Agreement will reflect several amounts related to the payment the provider is to receive. These include:

- a. the total monthly rate of payment due to the provider for a full month of care;
- b. the total daily rate due to the provider for a partial month's care;
- c. the portion of the monthly payment which is to be paid by the client for a full month of care;
- d. the portion of the daily rate that is to be paid by the client for a partial month's care;
- e. the portion of the monthly payment, if any, which is to be paid by the department for a full month of care;

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

7.4.1 General Requirements & Information

The Assisted Living Residence 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 DHHR is making a payment. Residents for whom the department is NOT making a supplemental payment are NOT to be included on the invoice.

7.4.2 Invoicing Procedures

An original, signed invoice must be submitted by the provider to the Bureau for Children and Families, Office of Financial Services, by the 5th working day of month following services provided. A faxed invoice is not acceptable. The invoice must be on the agency's letterhead.

7.5 Demand Payments

Most costs associated with the care of an adult placed in an Adult Residential Services will be included in the monthly reimbursement paid to the provider by automatic payment. There are, however, 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/on behalf of clients placed in Adult Residential Services by the Department or for specific expenses incurred by the Adult Residential Services provider that are not client specific.

7.5.1 Bed Hold

There may be times when an adult who has been placed in an Adult Residential Services placement 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 a bed and to prevent disruption of a stable placement whenever possible and appropriate.

A. Medical

A bed may be held for a resident for up to fourteen (14) days per episode when it is necessary for the client to be absent from the facility or adult family care placement for inpatient hospitalization/treatment. Payment at the established rate will continue for up to fourteen (14) days, or until such time as it is determined that the client will not be returning to the facility, not to exceed the fourteen (14) day limit. 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:

1. 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);
2. the adult for whom payment is being continued was placed in the Assisted Living Facility or Adult Family Care Home by the department and the department is currently making a supplemental payment for their care;
3. the adult's absence from the Adult Residential Services is to be temporary and short-term, not to exceed fourteen (14) days per episode;
4. the resident is expected to continue to be appropriate for placement in an Adult Residential Services upon discharge from treatment/hospital; and,
5. The resident will be returning to the Adult Residential Services placement upon discharge.

B. 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 the facility for these types of events for up to fourteen (14) days per calendar year. During the resident's absence, the Adult Residential Services provider will continue to receive payments uninterrupted. In order to grant a bed hold for social purposes,

ALL the following criteria must be met:

1. the activity must be scheduled in advance;
2. 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;

3. the adult's absence from the Assisted Living Residence is to be temporary and short-term, not to exceed 14 days per calendar year; and,
4. The resident will be returning to the Adult Residential Services Placement.
5. All overnight absences for this purpose must be approved in advance.

7.5.2 Respite Care

Respite care can be arranged to provide temporary care to elderly or disabled adults in order to offer short term relief to regular Adult Family Care 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 in with an unapproved respite provider. Household members cannot be paid for providing respite care.**

7.5.3 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 fourteen (14) days per calendar year per client for whom DHHR is making a supplemental payment.

Prior to payment for respite care, the respite provider must submit a written signed/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 fourteen (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 fourteen (14) days is the Adult Family Care Provider's responsibility.

7.5.4 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 assure 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 would have to be set up in FACTS and the trial placement reflected on the Service Log in FACTS. 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 his/her 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 social 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 social worker shall request payment for the days the client is in the trial home (i.e., 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 (3) full days.

7.5.5 Payment Adjustment

This demand payment type is to be used for the purpose of correcting an under payment to an Adult Residential Services 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.

7.5.6 Specialized AFC Payment

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

7.5.7 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.

7.5.8 Annual Client Medical Evaluation

Each client placed by the Department in an Adult Family Care Home must receive an annual medical examination. The Adult Family Care provider is to arrange for this examination to be completed. If the Department is going to reimburse for this, the cost cannot not exceed Medicaid rates.

7.5.9 Co-Payment on Prescription Medications

The cost incurred for co-payments for medications may be reimbursed at Medicaid and/or Medicare D rates for adults whom have been placed in an Adult Residential Services placement by the Department and for whom the Department is making a supplemental payment.

7.5.10 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 Adult Family Care providers. Training that would be acceptable in order to qualify for this payment would include training provided by the Department or training that is furnished by another agency/entity that has been approved **IN ADVANCE** by the Department. For the Assisted Living Provider this reimbursement is available for up to five (5) designated staff to attend.

Adult Family Care providers are required to attend a minimum of two (2) hours of training per quarter. However, in order to be eligible to receive this training allowance, the Adult Family Care provider or the Assisted Living staff member for whom reimbursement is being requested must attend a minimum of six (6) hours of approved training during the quarter for which reimbursement is being requested. The two (2) 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.

Note: The training allowance cannot be pro-rated. If a full six (6) hours of training is not completed within the quarter, the provider is not eligible for this payment. Also this demand payment type is not to be used for required training materials. Instead the "other demand payment" type is to be used. Respite providers are not eligible for the training incentive payment.

7.5.11 Annual Adult Family Care Provider Medical Report

After an Adult Family Care Home is approved, the person(s) in the household who is primarily responsible for furnishing care to the clients placed in the home is required to have a medical evaluation completed at a minimum of every three (3) years; however, the homefinder has the flexibility of requesting an updated medical prior to the expiration of the three (3) year time frame, if they question the provider's ability to care for the incapacitated adult(s). The purpose of this evaluation is to ensure that the person(s) who has responsibility for providing care remains in good health and able to provide the necessary care and support to adults placed in their home.

The provider is to arrange for completion of the medical report with their physician. When arranging for completion of this evaluation, providers are to be encouraged to request that their physician complete this evaluation during a regularly scheduled medical appointment whenever possible.

If the provider has no other resources or insurance to pay for the medical report, reimbursement, the provider must submit a receipt, along with the completed medical report, to the Department and indicate that reimbursement is being requested. Reimbursement for completion of the medical report by the physician may not exceed the current Medicaid rate for a medical report.

07.5.12 Durable Medical Equipment and Supplies

In certain situations the cost of obtaining durable medical equipment or supplies may be reimbursed for adults who have been placed in an Adult Residential Services by the Department and for whom the Department is making a supplemental payment.

The following must be considered:

- a. Be prescribed by the adult's physician (written statement must be filed in the client's paper record);
- b. Meet an identified need on the adult's Service Plan;
- c. Be necessary to prevent the need for a higher level of care;
- d. Be a one (1) time only expense rather than a reoccurring cost; and,
- e. Not exceed the current Medicaid rate.
- f. 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.

7.5.13 Food Supplements

In unique situations, food supplements may be required by an adult placed by the department in an Adult Residential Services placement type in order to maintain sound nutritional status. In certain situations the cost of obtaining these food supplements 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 resource that can meet this need. In addition, the food supplements for which payment is requested must:

- a. be prescribed by the adult's physician or deemed medically necessary by the adult's physician (written statement of need required);
- b. meet an identified need on the adult's service plan;
- c. be necessary to prevent the need for a higher level of care;
- d. not in violation of OHFLAC requirements; and

7.5.14 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 Adult Residential Services 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 resource that can meet this need.

In addition, the medications for which payment is requested must:

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

Prior to any expense being incurred, this expense must be and the provider must submit the receipt for the medication after it has been purchased.

Note: 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.

7.5.15 \$1,000 Incentive Payment

The intent of this incentive payment is to reward a provider who has been primarily responsible for a client improving to the point that they no longer require Adult Residential services 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.

In order for a provider to be considered for nomination to receive this incentive payment, all the following criteria must be met:

- a. 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);
- b. The provider must have provided full time care to the client for a minimum of twelve (12) consecutive months;
- c. A multi-disciplinary team, such as a Community Planning Team (CPT) used with Guardianship cases, must have been involved in the establishment of the goal of independent living and the development/monitoring of the Service Plan that was implemented;
- d. Independent living must have been the planned objective on the client's Service Plan and progress toward the achievement of this goal must be well documented in the six (6) month case review;
- e. The provider must have been assigned, as part of the Service Plan, key/measurable tasks toward the achievement of the client's goal of independent living;
- f. The social worker must be able to demonstrate the client's return to the level of independence was primarily due to the efforts of the provider;

- g.** An after care plan must be in place to identify the tasks to be accomplished, and by whom, during the six (6) month period the client is living in their own home; and,
- h.** Once the client has returned to their home, they must remain there independently for at least six (6) months before the bonus can be given.

Note: Placement in the Adult Residential Services Placement will be end dated when discharge occurs. However, the Adult Residential Services case is to remain open until the end of the After Care period and the incentive payment has been made.

7.5.16 Other Demand Payment - Not Specified

In certain situations the cost of obtaining needed supplies or services may be reimbursed for the provider or for adults who have been placed in an Adult Residential Services Placement by the Department and for whom the Department is making a supplemental payment. Reimbursement by the Department may only be considered after it has been determined there are no other personal or community resource 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:

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

7.6 Special Medical Authorization

Most clients who are placed in Adult Residential Services 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 are identical. If the client does not have coverage for necessary medical care, the social 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 sixty-five (65) years of age OR, if under sixty-five (65) years of age, the individual must be receiving disability Social Security benefits and must have been receiving disability Social Security benefits for two (2) years.

Lack of resources means that:

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

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 social 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 (6) months. At the end of the approved eligibility period, if continuation of services is necessary, a new authorization must be requested.

Note: In a situation where a client needs services from more than one vendor (i.e., an office visit with a physician and prescriptions from a pharmacy) a separate Special Medical Authorization request will be required for each vendor, with the appropriate eligibility period for each authorization.

A. Allowable Costs

Special Medical Authorization is available for use by adults placed by the Department in Adult Family Care in very limited situations. This authorization may only be used when all the following conditions exist:

1. The client is currently a resident in an Adult Family Care Home;
2. The client was placed by the Department or was placed by another party but the placement was approved by the Department;
3. The treatment, service, or certain supplies for which authorization is being requested is deemed medically necessary by the client's physician;
4. The medical treatment, service or certain supplies are needed to remedy an emergency medical situation or to prevent a medical emergency from developing; and,
5. The Department is making a supplemental payment to the Adult Family Care (except for private pay clients that have approval of a policy exception for the Special Medical Card).

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.

The Special Medical Authorization is to be used to provide for medical care needed to treat an emergency or to prevent a medical emergency from occurring (limited to prescriptions and limited doctor visits).

B. Examples of costs that are typically covered:

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

5. Combination of pads and adult disposable briefs - 250/month.

C. Examples of costs that are NOT covered (not all inclusive):

1. Hospitalization;
2. Nursing home placement;
3. Psychiatric treatment;
4. Behavioral health day treatment;
5. Dental work;
6. Glasses;
7. Outpatient surgery; and,
8. Diagnostic testing.

Note: The Special Medical Authorization may be used to cover costs; however, all Medicaid eligible services are not necessarily covered by this certain medical authorization (i.e., hospitalization IS NOT covered by the Special Medical Authorization; nor is Case Management services at behavioral health centers).

D. Required Procedures

If a client, who has been placed in an Adult Family Care Home by the Department, 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:

1. Identify client's goal(s) related to the request services on the Adult Service Plan;
2. Explanation of how provision of the requested services will prevent movement the client to a higher level of care;
3. List the specific service(s) payment is being requested for and associated cost (cannot exceed current Medicaid rate);

4. 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;
5. Anticipated duration of request;
6. Name of provider;
7. Income amount and source;
8. Amount of supplemental payment being made by the Department; and,
9. Any other relevant information.

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 Family Care Home, minus the personal needs allowance this amount must be applied towards the cost of the medical need before using the Special Medical card.

7.6.1 Approval Process

A. 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.

B. If denied

Additional information may be resubmitted, if the request if 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 Special Pharmacy Program for individuals who cannot meet a Medicaid spend down and who meet certain other criteria.

7.7 Clothing Allowance

7.7.1 Purpose

The purpose of providing a clothing allowance is to ensure that all clients placed by the Department of Health and Human Resources, 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. Rather, it is to be based upon the individual client's need for clothing. There are two (2) types of clothing allowance available for eligible adults: an initial placement allowance, and a re-placement clothing allowance.

7.7.2 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 (2) criteria. These are: 1) they must reside in an Adult Residential Services Placement and 2) the Department must be making a supplemental payment to the residential placement provider for the client's care. Private pay clients in the home **ARE NOT** eligible for a clothing allowance from the Department.

7.7.3 Initial Placement Allowance

In order to ensure that the adult has sufficient and adequate clothing at the time of the original placement, an initial placement clothing allowance may be requested. Eligibility for the initial placement allowance begins on the date of placement and ends on the day prior to the date of the six (6) month review or the date of discharge, whichever occurs first. A lifetime maximum of \$100 is available for the initial placement clothing allowance. It is not necessary to use the entire amount permitted at one time, however, purchases do need to be completed prior to the six (6) 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 (6) month period.

The initial placement allowance is available at the first placement of the adult in an adult residential placement and is a one (1) time only allowance. In the event the adult would move from one residential placement setting to another, the adult is not again eligible for an initial placement allowance. The discharging provider is to send the adult's clothing with them at the time of removal from their home.

7.7.4 Replacement Allowance

In order to ensure that the adult has sufficient and adequate clothing throughout their placement, a replacement clothing allowance may be requested every six (6) months. Eligibility for a replacement clothing allowance begins on the date of the six (6) month review and ends on the day preceding the date of the next six (6) month review or upon discharge, whichever occurs first. A maximum of \$75 is available for each six (6) month period. It is not necessary to use the entire

amount allowed at one time, however, purchases must be completed prior to the six (6) month case review. Any unspent portion of the client's clothing allowance will be forfeited and may not be carried over to the following six (6) month period.

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

7.7.5 Required Procedures

To request an initial or replacement clothing allowance for an eligible client, the AFC provider may contact the client's social worker.

7.7.6 Reimbursement to the Adult Residential Services Provider

- a. The Adult Residential Services provider must purchase clothing. The adult must be encouraged to assist with selection and purchase of their clothing whenever possible;
- b. If the adult is unable to assist, the provider is to purchase the needed clothing for the adult, taking into consideration the adults wishes and preferences; and,
- c. The Adult Residential Services provider must submit the itemized receipts to the Department's District Office for approval and reimbursement.

7.7.7 Payment to the Vendor

A BA-67 payable to the vendor, indicating the maximum amount for the purchase is to be provided.

7.8 Record Keeping by Provider

Upon placement of the client in the home or shortly thereafter, information about the client and his/her needs is to be given to the 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.

7.8.1 Client Information

- a. Identifying information about the client;
- b. Information about significant others such as family members, friends, legal representatives, etc.;
- c. Information about the client's interests, hobbies and church affiliation;

- d. Medical status including current medications, precautions, limitations, attending physician, hospital preference, allergies, special diet, etc.;
- e. Advance directive(s) in force; and,
- f. Information about client's burial wishes, plans and resources.

7.8.2 Client Documents

- a. Copy of the signed Resident Agreement for Participation;
- b. Copy of the current and all previous Payment Agreements; and,
- c. Copy of the current Service Plan.

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.

ARCHIVED

SECTION 8

CLOSURE

8.1 Case Closure

The Adult Residential Services case must be closed when the client is no longer in Adult Residential placement. If the client is an Adult Guardianship or Health Care Surrogate case; they can remain open for those services.

8.2 Notification of Case Closure

If the Adult Residential Services case is closed for any reason other than client death, written notification to the client or his/her legal representative must be provided.

A client or his/her 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 his/her 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 of Application for Social Services" (Negative Action Letter) and submit this to the supervisor within ninety (90) days following the date the negative action letter was generated.

8.3 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 bottom portion of the "Negative Action Letter" (SS-13) and submitted to the supervisor within thirty (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 for further review and consideration.

8.4 Grievances

The Adult Residential 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 9

REPORTS

9.1 Adult Initial Assessment

The Adult Initial Assessment is a summary of information gathered during the assessment focus. The report compiles several elements from the assessment and combines the information into the report.

9.2 Application to Provide AFC/ESC

The AFC/ESC Application is part of the Application Packet and is to be furnished to potential providers upon request. It is to be completed by the applicant and returned within thirty (30) days.

9.3 Client Medical Evaluation

Clients who are placed in Adult Family Care by the Department are required to have a medical evaluation completed during the placement process if one has not been completed recently and annually thereafter. This process is completed during the case management phase of the case work process.

9.4 Comprehensive Assessment

The Comprehensive Assessment Screen is a summary of information gathered during the case management process. The report compiles several elements from the assessment and combines the information into the report.

9.5 Credit Reference Letter

The Credit Reference Letter/Questionnaire is part of the Application Packet. The applicant is to make arrangements for this letter to be completed and returned to the local office within thirty (30) days. It must be completed by a current utility provider or bank/lending institution.

9.6 Fire Safety Checklist

The Fire Safety Checklist is part of the Application Packet and is to be furnished to potential providers upon request. It is to be completed by the applicant and returned within thirty (30) days.

9.7 Physician's Letter (Provider)

Providers who furnish Adult Family Care and all members of the household are required to have a Physician's Letter completed as part of the application process. A new Physician's Letter must be completed thereafter at a minimum of every three (3) years, unless there are questions regarding the provider's health.

9.8 Personal Reference Letter

The Personal Reference Letter/Questionnaire is part of the Application Packet. The applicant is to make arrangements for these letters to be completed and returned to the local office within thirty (30) days.

9.9 Social Evaluation

This form is used to provide information to the provider concerning this client. The report is provided to the Adult Residential Provider and is to be filed by the provider in the record they maintain for the client. Information included on this form is: identifying information, activities of daily living (ADL's), functioning capacity, medications, and characteristics, formal and informal support systems.

9.10 Payment Agreement

The Payment Agreement is to be completed during the case management phase of the case work process and, is the document which sets forth the terms of payment for placement in Adult Residential Services.

The Payment Agreement Specifies:

- a. Total Payment Rate: Amount for full month and per day amount for partial month
- b. Clients Payment Rate: Amount for full month and per day amount for partial month.
- c. The DHHR Supplemental Payment Rate: Amount for full month and per day amount for partial month.
- d. Client Personal Expense Allowance Amount

9.11 Resident Agreement for Participation

Resident Agreement for Participation is a standardized set of guidelines and regulations required for Adult Residential Services participation; outlining the rules and expectations while in placement and the adult residential clients agreement to abide by the guidelines and regulations.

9.12 Client Information Report

The form, report which includes demographic and other information about the client, is to be used to furnish necessary information about the client to the Adult Residential Services provider at the time the client is placed in the facility

9.13 Service Plan

The report is a compilation of task, goals, time frames and responsible parties set for the client.

9.14 Case Review Summary

The case review process occurs during the case management phase of the case process. A formal review of the case will be completed during standardized intervals and at any time there is a significant change in the client's circumstances

9.15 Negative Action Letter

Notification Regarding Application for Social Services (SS-13) is the report that should be used for a negation action when required for an Adult Residential Services Provider. The report would be used in the event of case closure and/or a reduction in services; requiring written notification to the client or legal representative. The letter clearly and specifically states the action being taken, the reason(s) for the action and client/legal representative.

9.16 Medicare Part D Letter

When the client is receiving the Special Medical Card and becomes sixty-four (64) years of age, the Medicare Part D Letter will be sent to the client or their legal representative notifying them that an application for Medicare Part A, B and D must be made prior to the client's sixty-fifth (65th) birthday. Also, the letter notifies them that an application for QMB, SLIMB and QI-1 must be made through Income Maintenance, as well as Extra Help through Social Security. When the client becomes eligible for Medicare, **regardless of whether they are receiving it or not**, the Special Medical Card can only be issued for prescriptions and limited doctor's visits that are not covered by Medicare Part D.

9.17 W-9

The W - 9 is part of the Application Packet. The applicant is to complete the form and return it to the local office within thirty (30) days. The provider's name, address and tax number (social security or federal identification) must be exactly as shown on income tax forms filed with the IRS by the provider.

9.18 Annual Fire and Safety Review

This form is to be completed annually to determine fire safety and continued certification for the Adult Family Care provider. The homefinder may request the Fire Department to provide additional follow-up in those situations where he/she feels unable to make this determination.

9.19 Annual Sanitation Review

This form is to be completed annually to determine sanitation compliance and continued certification for the Adult Family Care Provider. The homefinder may request the County Health Department to provide additional follow-up in those situations where he feels unable to make this determination.

9.20 Home Study Summary

This form is to be used to document the results of the entire Home Study Process. Included are areas such as: all interviews, information about the home and neighborhood, characteristics of the provider and household members, results of references, homefinder's evaluation and recommendations, etc.

9.21 Provider Agreement for Participation

This is an agreement between the Adult Residential Provider and the Department outlining the guidelines and expectations of a provider and the provider's agreement to follow the guidelines.

9.22 Respite Provider Agreement for Participation

This is an agreement between the Adult Residential Respite Provider and the Department outlining the guidelines and expectations of a provider and the provider's agreement to follow the guidelines.

9.23 Insurance Loss Notice

When the client does property damage to the provider's home and/or other negligent acts, the Insurance Loss Notice is to be completed by the provider.

9.24 Approval Letter

The Approval Letter is used to inform the applicant that his/her home has been approved to provide Adult Family Care Home services to a specific number of individuals.

9.25 Certificate of Approval

Once the home is approved a Certificate of Approval is presented to the provider indicating the number of adults the provider is approved to care for and the period of certification.

9.26 Re-certification Letter

This letter is used to inform the Adult Family Care provider that they have been re-certified to continue providing Adult Family Care Home services for another year.

9.27 Notification of Application for Social Services

Any time a negative action is taken in an Adult Family Care case, such as case closure or a reduction in services, the provider must be provided with written notification of the action being taken. This notification must be clearly and specifically stated, advising the provider of the action being taken and the reason(s) for the action. In addition to notification of the negative action, the provider must be made aware of their right to file a grievance on the decision and advised of what they must do to request a grievance hearing.

9.28 Payment Agreement

The Payment Agreement, which is completed during the Case Management phase of the case work process, is the document which sets forth the terms of payment for placement in the Adult Family Care Home. Within this document, the following are specified: 1) the payment amount due to the provider, 2) the portion of payment to be paid by the client, and 3) the portion of the payment to be paid by the Department. The agreement further identifies the monthly rate (for full month of placement) and the daily rate (for a partial month of placement). Finally, the agreement identifies the amount that is to be available to the client as Personal expense allowance and whether the client is to retain this amount from their funds or if the provider is to furnish this amount from their reimbursement by the Department.

9.29 Annual Review Summary

A formal review of the provider must be completed every twelve (12) months or at any time there is a significant change in the provider's circumstances.

9.30 Adult Residential Services Corrective Action Letter

The Corrective Action Letter is to be issued after the provider has been verbally notified of deficiencies. Deficiencies may be identified either: (1) during the regularly scheduled review or 2) at any other time deficiencies are observed. This letter is to be sent to the provider within seven (7) calendar days of the verbal notification. The deficiencies to be corrected are to be listed and a time frame for the completion of the corrections specified.

**Appendix A West Virginia Department of Health and Human Resources
Office of Social Services
Client/Provider Grievance Form**

I, _____, wish to file a grievance with the West Virginia Department of Health and Human Resources, Office of Social Services.

I am dissatisfied for the following reasons:

I understand this form will be forwarded to the State Office, Chairman, Board of Review. A Grievance Hearing will be scheduled by a State Hearing Officer.

Signature of Client/Provider _____

Address _____

Phone _____

Signature of Worker _____ Date _____

Signature of Supervisor _____ Date _____

Orig: Chairman, State Board of Review
CC: Case Record
Client/Provider
SS-28