# PART II – Chapters 600 to 1000

## POLICIES and PROCEDURES
## For
## ELDERLY AND DISABLED WAIVER PROGRAM
## (EDWP)-(CCSP and SOURCE)
## GENERAL SERVICES MANUAL



## GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: October 1, 2023

| Policy Revisions included in the January 2023 Edition of the CCSP and SOURCE Policy Manuals | | | | |
|---|---|---|---|---|
| **Revision Date** | **Section** | **Description of Revision** | **Revision Type** | **Citation** |
| **10/01/2023** | **Chapter 1200 EDWP (CCSP and SOURCE) Alternative Living Services Manual** | **Updates address for HFR and MAPS in various sections** | **Policy Clarification/Update** | **DCH Policy** |
| **10/01/2023** | **Chapter 1203.10D + 1253.12D EDWP (CCSP and SOURCE) Alternative Living Services Manual** | **Updates policy regarding ALS medicaid payment during hospital and nursing home stay.** | **Policy Clarification/Update** | **DCH Policy** |
| **10/01/2023** | **1407.2 Chapter 1400 EDWP (CCSP and SOURCE) Personal Support/Consumer Direction/Structured Family Care Services Manual** | **Updates SFC semi-annual in-person meetings for case management.** | **Policy Clarification/Update** | **DCH Policy** |
| **10/01/2023** | **1706 Chapter 1700 EDWP (CCSP and SOURCE) Home Delivered Meals Services Manual** | **Updates policy regarding HDM medicaid payment during hospital and nursing home stay.** | **Policy Clarification/Update** | **DCH Policy** |
| **10/01/2023** | **601.1 W Chapter 600-1000 EDWP General Services Manual** | **Updates policy re hipaa compliance for phone and telehealth.** | **Policy Clarification/Update** | **DCH Policy** |
| **10/01/2023** | **601.2 B NOTE Chapter 600-1000 EDWP General Services Manual** | **Updates new provider enrollment process** | **Policy Clarification/Update** | **DCH Policy** |
| **10/01/2023** | **App GG Chapter 600-1000 EDWP General Services Manual** | **Updates the items necessary for provider applications and service expansions** | **Policy Clarification/Update** | **DCH Policy** |
| **10/01/2023** | **App S Chapter 600-1000 EDWP General Services Manual** | **Updates service rates by .5%** | **Policy Clarification/Update** | **DCH Policy** |

| Policy Revisions included in the July 2023 Edition of the CCSP and SOURCE Policy Manuals | | | | |
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| **Revision Date** | **Section** | **Description of Revision** | **Revision Type** | **Citation** |
| **07/01/2023** | **1103 C Chapter 1100 CCSP and SOURCE Adult Day Health Services Manual** | **Clarifies policy re ADH mobile and HFR permit need.** | **Policy Clarification/Update** | **DCH Policy** |
| **07/01/2023** | **App C Chapter 1100 CCSP and SOURCE Adult Day Health Services Manual** | **Clarifies policy re ADH mobile and items submitted for addition of mobile** | **Policy Clarification/Update** | **DCH Policy** |
| **07/01/2023** | **Appendix F Chapter 1200 EDWP (CCSP and SOURCE) Alternative Living Services Manual** | **Removes App F, ALS evaluation/Care Coordination check list as updated tasks and evaluations are performed.** | **Policy Clarification/Update** | **DCH Policy** |
| **07/01/2023** | **1406 Chapter 1400 CCSP and SOURCE Personal Support/Consumer Direction/Structured Family Care Manual** | **Adds policy clarification re Fiscal Intermediary description of enrollment requirements for CD PSS.** | **Policy Clarification/Update** | **DCH Policy** |
| **07/01/2023** | **1407.4 Chapter 1400 CCSP and SOURCE Personal Support/Consumer Direction/Structured Family Care Manual** | **Updates policy regarding caregiver changes for SFC.** | **Policy Clarification/Update** | **DCH Policy** |
| **07/01/2023** | **1906 and appendix dd Chapter 1900 Policies and Procedures for EDWP (CCSP and SOURCE) Skilled Nursing Services by Private Home Care Manual** | **Updates RN rates.** | **Policy Clarification/Update** | **DCH Policy** |
| **07/01/2023** | **601.1 NOTE Chapter 600-1000 EDWP General Services Manual** | **Updates policy re Service Provider and Case Management conflict of interest** | **Policy Clarification/Update** | **DCH Policy** |
| **07/01/2023** | **601.1 O and 607.3 B Chapter 600-1000 EDWP General Services Manual** | **Updates GCHEXS to Georgia Applicant Processing Service (GAPS)/Fieldprint)** | **Policy Clarification/Update** | **DCH Policy** |
| **07/01/2023** | **6**01.2 B **Chapter 600-1000 EDWP General Services Manual** | **Updates provider enrollment process re uploads to Gammis.** | **Policy Clarification/Update** | **DCH Policy** |
| **07/01/2023** | **606.4 Chapter 600-1000 EDWP General Services Manual** | **Removes language re carepath.** | **Policy Clarification/Update** | **DCH Policy** |
| **07/01/2023** | **Appendix GG Chapter 600-1000 EDWP General Services Manual** | **Adds reference to 1406 PSS manual re Fiscal Intermediary enrollment.** | **Policy Clarification/Update** | **DCH Policy** |
| **07/01/2023** | **Appendix T Chapter 600-1000 EDWP General Services Manual** | **Updates NEMT in policy.** | **Policy Clarification/Update** | **DCH Policy** |

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| **Revision Date** | **Section** | **Description of Revision** | **Revision Type** | **Citation** |
| **04/01/2023** | **1251.1 Chapter 1200 EDWP (CCSP and SOURCE) Alternative Living Services Manual** | **Clarifies policy re ALS Management ownership of property.** | **Policy Clarification/Update** | **DCH Policy** |
| **04/01/2023** | **1403.3 D Chapter 1400 CCSP and SOURCE Personal Support/Consumer Direction/Structured Family Care Manual** | **Adds policy regarding consequences for repeated failure to use the EVV system.** | **Policy Clarification/Update** | **DCH Policy** |
| **04/01/2023** | **1404.3 B Chapter 1400 CCSP and SOURCE Personal Support/Consumer Direction/Structured Family Care Manual** | **Updates policy regarding no reimbursement for family aides that are spouses, guardians or parents of minors as well as 'live in' + 'non relative'** | **Policy Clarification/Update** | **DCH Policy** |
| **04/01/2023** | **1406 Chapter 1400 CCSP and SOURCE Personal Support/Consumer Direction/Structured Family Care Manual** | **Removes reference to 'live in' relative caregiver in Cd pss moving to SFC. Removes reference to family hire in Cd pss being reaffirmed annually.** | **Policy Clarification/Update** | **DCH Policy** |
| **04/01/2023** | **1407 Chapter 1400 CCSP and SOURCE Personal Support/Consumer Direction/Structured Family Care Manual** | **Removes reference to all 'live in' relative caregiver moving to SFC.** | **Policy Clarification/Update** | **DCH Policy** |
| **04/01/2023** | **1407.2 (8) Chapter 1400 CCSP and SOURCE Personal Support/Consumer Direction/Structured Family Care Manual** | **Clarifies policy re criminal record history for SFC.** | **Policy Clarification/Update** | **DCH Policy** |
| **04/01/2023** | **Appendix D Chapter 1400 CCSP and SOURCE Personal Support/Consumer Direction/Structured Family Care Manual** | **Adds rows to clarify for Member, Caregiver and Case Management Name both printed and signature** | **Policy Clarification/Update** | **DCH Policy** |
| **04/01/2023** | **601.2 B Chapter 600-1000 EDWP General Services Manual** | **Clarifies enrollment procedures for new providers.** | **Policy Clarification/Update** | **DCH Policy** |
| **04/01/2023** | **601.4 Chapter 600-1000 EDWP General Services Manual** | **Updates address for the EDWP Waiver Unit and HFR** | **Policy Clarification/Update** | **DCH Policy** |
| **04/01/2023** | **602.4 B (17) Chapter** | **Updates policy re adverse** | **Policy** | **DCH Policy** |

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|---|---|---|---|---|
| | **600-1000 EDWP General Services Manual** | **action for PSS/X failing to use EVV.** | **Clarification/Update** | |
| **04/01/2023** | **1003 Chapter 600-1000 EDWP General Services Manual** | **Updates policy re hiring of relatives in EDWP.** | **Policy Clarification/Update** | **DCH Policy** |
| **04/01/2023** | **Appendix GG Chapter 600-1000 EDWP General Services Manual** | **Removal of 'note' re requesting of additional documents by DCH.** | **Policy Clarification/Update** | **DCH Policy** |
| **04/01/2023** | **Appendix S/SS Chapter 600-1000 EDWP General Services Manual** | **Removes the appendix ss that held the App K, PHE rate increases and updates the appendix s with the waiver approved rates.** | **Policy Clarification/Update** | **DCH Policy** |

| Policy Revisions included in the January 2023 Edition of the CCSP and SOURCE Policy Manuals | | | | |
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| **01/01/2023** | **1103.8 Chapter 1100 EDWP (CCSP and SOURCE) Adult Day Health Services Manual** | **Removes requirement for syrup of ipecac in supply list.** | **Policy Clarification/Update** | **DCH Policy** |
| **01/01/2023** | **1406 CCSP and SOURCE Personal Support/Consumer Direction/Structured Family Care** | **Updates TB screening policy.** | **Policy Clarification/Update** | **DCH Policy** |
| **01/01/2023** | **1701 CCSP and SOURCE Home Delivered Meals Services Manual** | **Clarifies policy regarding HDM provider applicant requirements.** | **Policy Clarification/Update** | **DCH Policy** |
| **01/01/2023** | **601.2 Chapter 600-1000 EDWP General Services Manual** | **Rephrases wording and clarifies the need for both CCSP and Source initial applications.** | **Policy Clarification/Update** | **DCH Policy** |
| **01/01/2023** | **601.2 B, D & G** | **Updates provider application process.** | **Policy Clarification/Update** | **DCH Policy** |
| **01/01/2023** | **607.3 Chapter 600-1000 EDWP General Services Manual** | **Adds reference to 1406 PSS manual re TB screening.** | **Policy Clarification/Update** | **DCH Policy** |
| **01/01/2023** | **Chapter 600-1000 EDWP General Services Manual** | **Removes 'provider specialist' and replaces with 'DCH Unit staff'** | **Policy Clarification/Update** | **DCH Policy** |
| **01/01/2023** | **Appendix B Chapter 600-1000 EDWP General Services Manual** | **Clarifies language re county expansion, service addition and site addition expansions.** | **Policy Clarification/Update** | **DCH Policy** |
| **01/01/2023** | **Appendix GG Chapter 600-1000 EDWP General Services Manual** | **Clarifies language re document requirements.** | **Policy Clarification/Update** | **DCH Policy** |

PART II - POLICIES AND PROCEDURES

**FOR**

**ELDERLY AND DISABLED WAIVER PROGRAM/EDWP- (CCSP/COMMUNITY CARE SERVICES PROGRAM and SOURCE/SERVICE OPTIONS USING RESOURCES IN COMMUNITY ENVIRONMENTS**

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**PREFACE**

Policies and procedures in this manual apply to all EDWP (CCSP/SOURCE) Services Program providers. See Specific Program Requirements Chapters (under separate cover) for additional policies and procedures specific to each service type:

| | | |
|---|---|---|
| Part II | Chapter 1100 | Adult Day Health |
| Part II | Chapter 1200 | Alternative Living Services |
| Part II | Chapter 1300 | Home Delivered Services |
| Part II | Chapter 1400 | Personal Support Services |
| Part II | Chapter 1500 | Out-of-Home Respite Care |
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| Part II | Chapter 1700 | Home Delivered Meals |
| Part II | Chapter 1900 | Skilled Nursing Services By Private Home Care Providers |

All EDWP (CCSP/SOURCE) providers must adhere to Part I - Policies and Procedures for Medicaid/Peachcare for Kids

## PART II CHAPTER 600

## EDWP- (CCSP AND SOURCE) SERVICE OVERVIEW

### 600. Introduction to EDWP (CCSP and SOURCE)

The Elderly and Disabled Waiver Program/EDWP (CCSP and SOURCE) operates under a Home and Community-Based Waiver (1915c) granted by the Centers for Medicare and Medicaid Services (CMS). This Waiver permits the Division of Medical Assistance to use Title XIX funds to purchase services for EDWP (CCSP and SOURCE) members who meet program requirements.

EDWP (CCSP and SOURCE) assists individuals who are older and/or functionally impaired to continue living in their own homes and communities as an alternative to nursing home placement. Individuals served by the program are required to meet the same level of care for admission to a nursing facility and be Medicaid eligible or potentially Medicaid eligible.

EDWP (CCSP and SOURCE) are consumer-oriented program, with the following goals:

- To provide quality services, consistent with the needs of the individual member, which are effective in improving/maintaining the member's independence and safety in the community as long as possible.
- To provide cost effective services.
- To involve the member or member's representative in the provision and decision-making process regarding member care.
- To demonstrate compassion for those served by treating members with dignity and respect while providing quality services.

Provision of quality services and supervision of member care are vital to preventing premature institutional placement. Service providers are expected to be qualified and to provide services in compliance with the policies, procedures, and goals of EDWP (CCSP and SOURCE) and of any other applicable regulatory agency. (See Section 601.1)

Providers' performance standards must exceed basic licensing requirements; specific areas of accountability include:

- Reliability of service
- Competency and compatibility of staffing
- Responsiveness to members' concerns

- Communicate and coordinate services with care coordination staff

The EDWP (CCSP and SOURCE) Program Policies and Procedures Manuals define standard policies and procedures for services provided in the EDWP (CCSP and SOURCE). All enrolled providers must adhere to the requirements as outlined in these manuals.

600.1 **Structure and Administration of the Program**

Services under EDWP (CCSP and SOURCE) are provided with the cooperation of the following state and local public agencies and private businesses:

A. The Division of Medical Assistance (DMA) of the Department of Community Health (DCH) is responsible for provider enrollment and reimbursement to providers for services provided to those members who have applied and been approved for the Program. DMA conducts utilization reviews of providers to assure that only authorized and appropriate EDWP (CCSP and SOURCE) services are delivered. **Effective July 1, 2016, DMA is also responsible for the overall coordination, administration, and quality assurance of the program. The** EDWP (CCSP and SOURCE) **Unit at DMA reviews and recommends approval of provider enrollment applications, conducts site visits and provider training. It also supervises the care coordination services that are provided to** EDWP (CCSP and SOURCE) **members in the 12 services regions of Georgia. (Rev 7/2016)**

B. The Division of Aging Services (DAS) of the Georgia Department of Human Services (DHS) provides Adult Protective Services (APS) for the prevention of abuse, neglect and exploitation of individuals. **(Rev 7/2016)**

C. The Georgia Department of Behavioral Health / Developmental Disabilities, and Addictive Diseases provides psychological and psychiatric evaluations and therapeutic services through regional boards.

D. The Division of Family and Children Services (DFCS) of the Georgia Department of Human Services determines Medicaid eligibility and member cost share (if any) for potentially Medicaid eligible members entering the EDWP (CCSP and SOURCE).

E. The Office of Information Technology (IT) of the Georgia Department of Human Services provides information technology to the EDWP (CCSP and SOURCE) Unit and Area Agencies on Aging regarding service authorization. (Rev 7/2016)

F. The Healthcare Facility Regulation Division (HFRD) of the Georgia Department of Community Health licenses and monitors personal care homes, private home care providers, **adult day health providers** and home health agencies. **Revised 4/2016**

G. Area Agencies on Aging (AAA)/Lead Agency (12 statewide) are designated in each Planning and Service Area by the Division of Aging Services as the local administrator and points of contact for members or members' representatives, service providers, and potential service providers. The Lead Agency assures program accessibility by serving as the focal point responsible for local administration, coordination and implementation of EDWP (CCSP and SOURCE), including telephone screening of all potential EDWP (CCSP and SOURCE) members.

H. GAINWELL TECHNOLOGIES is under contract with DMA to reimburse Medicaid provider(s) and operate the Provider Enrollment Unit. GAINWELL TECHNOLOGIES distributes information about enrollment, trains Medicaid providers in the billing process, and reimburses them for authorized services. GAINWELL TECHNOLOGIES also operates the Billing Inquiry Unit to assist Medicaid providers with questions related to billing.

I. The Care Coordinator (CC) facilitates the process of assessing, planning, authorizing, arranging, coordinating, and evaluating service delivery to the EDWP (CCSP and SOURCE) member. The care coordinator provides the member and member's representative with a single access of resource information.

J. **Alliant Health (formerly GMCF) reviews the member's assessment documents and validates or denies the member's need for a nursing home level of care. If the level of care is approved, Alliant issues a Level of Care Prior Authorization (LOC PA) for a length of stay of up to 365 days. (Rev 7/2015)**

K. The member's physician or the case management agency's medical director approves the plan of care and attests to the member's need for a nursing home level of care and consults with the care coordinator as requested. **(Rev. 7/2015, 7/2019)**

L. Service Providers enrolled in EDWP (CCSP and SOURCE) deliver services as ordered on the care plan authorized by the care coordinator. By sharing information with the care coordinator, providers serve as a vital component of the member's care team.

600.2 **Services of the Program**

EDWP (CCSP and SOURCE) offer the following services as an alternative to institutional care. Qualified providers may seek enrollment in one or more of the services.

M. Adult Day Health (ADH) provides nursing services, medical supervision, health, therapeutic, and social services activities in a congregate community-based day program.

N. Alternative Living Service (ALS) provides twenty-four-hour supervision, personal care, nursing supervision, and health-related support services in licensed personal care homes.

O. Emergency Response System (ERS) provides two-way verbal and electronic communication with a central monitoring station seven days a week, 24 hours a day to geographically and socially isolated members.

P. Home Delivered Meals (HDM) provide and deliver prepared meals to the EDWP (CCSP and SOURCE) member's home. Each meal meets at least 1/3 of the recommended daily nutritional requirement.

Q. Home Delivered Services (HDS) provide home health services rendered on an intermittent basis by certified, licensed home health agencies to members in their homes.

R. Personal Support Services (PSS) provide personal care tasks such as assistance with eating, bathing, dressing, personal hygiene, preparation of meals, light housekeeping tasks, and other activities of daily living. Extended Personal Support Services refer to those tasks designed for members who need assistance with activities of daily living, as well as relieve those person(s) normally providing care and/or oversight.

S. Respite Care (RC) provides for temporary relief of the individual(s) normally providing care. Respite Care is provided in an approved facility such as a personal care home or adult day health center. Respite care may include overnight care.

T. Skilled Nursing Services (SNS) by Private Home Care Providers provide skilled nursing intervention/monitoring when a home health agency is unable to provide service to the member.

U. Structured Family Caregiver (SFC) agencies provide coaching, support and a daily financial stiped to live-in family caregivers.

600.3 **Authority**

In the EDWP (CCSP/SOURCE) and Services for the Elderly Act, (O.C.G.A. 49-6, Article 5). The Georgia General Assembly stated its intent as follows:

- To assist functionally impaired elderly in living dignified and reasonably independent lives in their own homes or with their families
- To establish a continuum of care for such elderly in the least restrictive environment suitable to their needs
- To maximize the use of existing community social and health services to prevent unnecessary placement of individuals in long-term care facilities
- To develop innovative approaches to program management, staff training and service delivery that impact cost avoidance, cost effectiveness and program efficiency.

It is further the intent of the General Assembly that the Georgia Department of Human Services shall serve as the agency responsible for planning and implementing the provision of community-based services to the elderly reimbursable under the "Georgia Medical Assistance Act of 1977."

The Georgia Department of Human Services established a EDWP (CCSP/SOURCE) unit within the Division of Aging Services. **Effective July 1, 2016, this unit was transferred by the Georgia General Assembly to the Division of Medical Assistance (DMA) in the Georgia Department of Community Health (DCH).** The EDWP (CCSP/SOURCE) unit plans and oversees implementation of a system of coordinated EDWP (CCSP/SOURCE) and support services for the elderly. The EDWP (CCSP/SOURCE) unit develops uniform assessment criteria that are used to determine an individual's functional impairment and evaluates on a periodic basis the individual's need for community support services or institutionalized long-term care. **(Rev 7/2016)**

601. **Conditions of Participation**

In addition to the conditions for provider participation in the Medicaid Program which are outlined in Part I - Policies and Procedures For Medicaid and Peachcare For Kids. EDWP (CCSP and SOURCE) providers must meet all the following conditions at the time of initial enrollment and demonstrate continued compliance.

601.1 **General Conditions**

A. Legal Right to Perform Business in the State of Georgia –

B. Authorization Document- The provider agency, if incorporated, must submit to DCH a copy of its Good Standing - Certificate of Existence from the Office of the Secretary of State. **The provider agency must**

**also submit its current business license and/ or other proof of legal authorization to conduct business in the State of Georgia. Rev. 7/1/13, 1/1/14**

C. Licensure - If state or local law requires licensure of the agency, organization, facility or staff for the service the agency wishes to provide, the provider agency must submit proof of licensure to the EDWP (CCSP and SOURCE) **Unit** upon application **and by request thereafter.** The provider agency must post current licensure and

D. permits (if applicable) in a conspicuous location open to public view. Licensure requirements for each service are included in each specific service provider manual. **Rev. 1/1/14, 7/2016**

PLEASE NOTE: Effective July 1st, 2017 - A private home care provider's permanent license must show an effective date of at least 9 months prior to the date the pre-qualification packet is submitted if it is the provider's first permanent license.

**NOTE:** In accordance with Section 105 of Part I Policies and Procedures For Medicaid/Peachcare for Kids, providers must be fully licensed without restriction. **Provisional licenses are not acceptable. Rev. 1/1/14**

E. Compliance with Rules and Regulations - The provider agency must comply with Part I Policies and Procedures For Medicaid/Peachcare For Kids, the EDWP (CCSP and SOURCE) General Manual and the applicable EDWP (CCSP and SOURCE) service-specific manual(s), and with all applicable federal, state and local laws, rules, and regulations. (See Section 600 of the EDWP (CCSP and SOURCE) General Manual).

Compliance - Neither the provider agency nor its owner(s) or management may be currently under suspension from accepting EDWP (CCSP and SOURCE) referrals or delivering services in any Medicaid program.

In addition, the provider agency must have had no deficiencies within the past three years from any licensing, funding or regulatory entity associated with enrollment in any Medicaid, Private Home Care, or Title III-funded services or with the provision of any related business, unless all such deficiencies have been corrected to the satisfaction of the imposing entity **and the** EDWP (CCSP and SOURCE) **Unit**. **Rev. 1/1/14, 7/2016**

F. Sponsor or Parent Organization - If a provider has a sponsor or parent organization, the sponsor or parent organization must maintain full responsibility for compliance with all conditions of participation. Daily operations of the program may be delegated to a subdivision or subunit of the sponsor or parent organization.

G. Disclosure of Ownership - The provider must have available the names and social security numbers of all persons with direct or indirect ownership interest of five percent or more.

H. Reports - The provider must furnish service reports to the DMA as requested. (Rev 7/2016)

I. Organizational Structure - The provider must diagram **a readable** organizational structure, administrative control, and lines of authority for the delegation of responsibility and supervision from the administrative level to the member care level**, to include names and position titles**. **Rev. 1/1/14**

J. Written Member Care Policies and Procedures - The provider agency must have written member care policies and procedures which are reviewed at least annually, revised as needed, and address at a minimum:

1. Scope of Services Offered (See specific service manual)
2. Admission Criteria (See Sections 603.B, 605 and 701)
3. Discharge Criteria (See Sections 606.6-7)
4. Accepting Members Referred by Care Coordination (See Sections 603 and 605.2)
5. Cost Share Determination, Billing, Collection, and Refund (See Sections 606.21 and 606.22 and 702)
6. Member Protection Assurances (See Section 601.1O, 604 and App RR)
7. Documentation in the client's record (See Section 606.17, 606.18 and 606.19)
8. Supervision of Services and Care (See Section 606.17)
9. Emergency Information (See Section 606.12 and App U)
10. Personnel Code of Ethics (See Section 607.3 C)

11. Clinical Records Management (See Sections 601.5 and 606.4, and 606.5)

12. Administrative/Personnel Records (See 607.3 and 609)

13. Use and Maintenance of Supplies and Equipment (if applicable/ 606.10)

14. Medications (if applicable) (See Section 606.9)

15. Coordination of Member Care with Physicians, Care coordinators, and Other Providers (See Section 606.2)

16. Scheduling of Staff, including sufficient coverage when scheduled staff is unable to work (See Sections 601.1I and 607)

17. Staff Orientation, Training, and Development (See Section 607.5)

18. Personnel Policies (See Section 601.1 and 607.3)

19. Member's Rights and Responsibilities (See Section 604.1)

20. Infection Control (Section 607.5, Appendix Q)

21. Program Evaluation (See Section 609)

22. Disaster preparedness (see Section 608)

23. Incident Reporting (See Section 601.6)

**Rev. 1/1/14, 4/1/20, 7/1/20**

NOTE: Refer to specific service manuals for additional required policies and procedures.

Provider agency policies and procedures must be clear and concise with regard to the specific agency guidelines and instruction to agency staff. The provider agency policies and procedures must also reflect a clear understanding of the EDWP (CCSP and SOURCE) and program requirements.

J. Subcontracting - Provider agencies may subcontract for the provision of services as long as the subcontract contains, at a minimum, the following elements:

1. Names of all parties entering into the subcontract

2. A stipulation requiring subcontractors to perform in accordance with all Conditions of Participation which pertain to the service purchased under subcontract, and requiring the contractor to assume responsibility if the selected subcontractor fails to do so

3. A stipulation requiring the contractor agency to maintain responsibility for and assure the subcontractor's performance of administrative, supervisory, professional and service delivery responsibilities relative to meeting all requirements of EDWP (CCSP and SOURCE).

4. A stipulation that the subcontractor will comply with local, state and federal laws, rules and regulations and will adhere to EDWP (CCSP and SOURCE) policies and procedures as they now exist or may hereafter be amended

5. A statement identifying the party responsible for paying employment taxes

6. A stipulation that the persons delivering services meet minimum staff qualifications

7. Identification of the specific EDWP (CCSP and SOURCE) service(s) to be provided

8. A stipulation that the subcontractor will participate as needed in case conferences to coordinate member care

9. Termination procedures, including an escape clause and the subcontractor's signed agreement that they received an explanation of the advantages and disadvantages of a short-term or long-term contract. Rev 9/2011

A sample of all subcontracts for provision of EDWP (CCSP and SOURCE) services must be submitted to the EDWP (CCSP and SOURCE) **Unit** for prior approval and a copy maintained in the provider agency's office. Any changes in above contract terms must be resubmitted to the EDWP (CCSP and SOURCE) **Unit**. **(7/2016)**

K. Service Contracts/Agreements - If providers require members to sign a service contract or other binding written agreement before receiving services, the service agreement will be in a format that the member can read and easily understand. **The agreement may not require members to waive their legal rights**.

NOTE:
A member cannot be held liable for damage caused by normal wear and tear of provider's furniture and equipment.

L. Staff Qualifications - The provider agency must engage a sufficient number of qualified and experienced staff to render services in accordance with currently accepted standards of medical practice. The provider agency must have criteria-based job descriptions that clearly list required minimum qualifications, training, and experience. Criteria-based job descriptions must include specific tasks, job responsibilities, and duties for each staff position. A job description, signed and dated by the employee, must be maintained in each personnel file. (Refer to specific service manuals for program requirements related to staffing.)

M. Staffed Business Hours - The provider agency must be open for business with staff available at least 8 hours per day Monday through Friday.

1. Business Hours - The provider agency must maintain regularly scheduled business hours and must have in place a means to assure easy, **local or toll-free telephone access** to a responsible individual able to assist with information and support as needed. Providers must provide an active on-call service that coordinates dependably with care coordinators, members, and members' families/representatives.

2. Service Availability - The provider agency must be able to provide services 24 hours a day, seven days a week, including holidays, if required or needed by the member. A supervisor must be available at all times to staff members who are rendering services. If a provider is unable to provide services as indicated in the member's care plan or when requested by the member, the care coordinator will broker/re-broker services with another provider who can meet the member's needs. Exception: Adult Day Care Centers and Home Delivered Meal providers are not required to deliver services 24 hours a day.

3. Access -All providers must have a **local or toll-free published telephone number** for members and care coordinators to access and report problems with service delivery. PSS, RC, ALS, HDS, SNS and ERS providers must provide telephone access to enable members to call 24 hours a day, seven days a week, including holidays. Toll free numbers that require an access code may not be used.

4. 30-Minute Response - The provider agency must respond to calls from members/representatives and/or families requesting assistance within 30 minutes of the contact.

N. Office Space - Each provider, **with the exception of Emergency Response Services (ERS) providers and Structured Family Caregiver (SFC) providers**, must maintain business premises within the State of Georgia. The provider is responsible for ensuring compliance with all local zoning ordinances. The business premises must be appropriate to conduct the EDWP (CCSP and SOURCE) program and must include the following **(Rev 7/12, 7/19)**:

1. A separate office which provides privacy for visitation by members, member's families/ representatives, employees, program auditors, care coordinators and other business visitors.

2. The office provides for the maintenance and storage of confidential member records.

3. A designated separate, professional office, if located in a personal residence that is used exclusively as a business office with a separate business telephone line.

- The office must have a designated means of public access, remote from the personal residence entrance/exit, and must ensure adequate parking for visitor.

- Branch offices must meet the same physical requirements as those described above. Branch offices are not required to have full-time staff, but the provider must be accessible to members, employees and the general public by telephone at the primary office.

O. Member Protection Assurance – All EDWP (CCSP and SOURCE) providers, their employees, subcontractor's, and volunteers are mandated reporters of suspected or actual abuse, neglect, exploitation, elopement, unexpected death, serious injury and any other incident/ event/situation that has or may place a member's health, safety, and welfare in jeopardy or at risk. Refer to Section 604.1 of the EDWP (CCSP and SOURCE) General Services Manual.

All EDWP (CCSP and SOURCE) providers are required to:

- Have written policies and procedures that address steps the agency takes to prevent abuse, neglect, and/or exploitation; action the agency takes when such incidences are reported;

and action the agency takes to prevent future occurrences of such incidences
- Screen each potential employee for criminal background history (Georgia Applicant Processing Service (GAPS)/Fieldprint)
- Prohibit individuals with a prior conviction on charges of abuse, neglect, mistreatment or financial exploitation from performing direct member care duties
- Provide training at least annually to all employees, subcontractor's, and volunteers on how to recognize situations of possible abuse, neglect, exploitation, and/or the likelihood of serious physical harm to individuals who receive services through the EDWP (CCSP and SOURCE)
- Observe at least annually staff providing direct care to members
- Require all critical and non-critical incidents, as outlined in Section 601.6, to be reported within 24 hours or one (1) business day of the incident or discovery of the incident to the Department. Notify all appropriate parties in accordance with state law. Investigate the incident with involvement of appropriate parties while taking immediate steps to protect the waiver participant's health, safety and welfare. Submit the Follow-Up and Interventions Report to the Department within seven (7) business days of submitting the incident report. Participate in regulatory agency investigations, when applicable and take appropriate a corrective action if alleged violation is verified.
- Provide for thorough investigation of all alleged member protection violations
- Prevent further potential abuse while the investigation is in progress
- Prevent further potential abuse, etc., while the investigation is in progress
- Take appropriate actions if alleged violation is verified

Providers, their employees, subcontractor's and volunteers shall be familiar with and shall be able to recognize situations of possible abuse, neglect, exploitation, and/or likelihood of serious physical harm to individuals who receive services through EDWP (CCSP and SOURCE). See appendix CC for Incident Reporting definitions

**NOTE: ALS** and **ADH** providers will complete an incident report of any event/situation that has placed the client's health, safety, and/or welfare in jeopardy or at risk. **If an incident that occurs in an ADH involves a member who resides in an ALS,**

**the provider must also notify the ALS. (Rev. 10/14)** All other service providers will complete an incident report of such events/situations if any of their staff were present at the time of the incident or were a part of the incident. Interventions must be specific to the client's cognitive, physical or mental impairment and target reduction of risk for client injury and reduce risk of recurrent incidents. ALS Family management agencies are required to communicate their incident reporting policy with their registered homes that indicates the party responsible for accessing the online reporting system. (1/2021)

P. Standard Assurances - The provider agency may not discriminate or permit discrimination against any person or group of persons on the grounds of age, race, sex, color, religion, national origin, handicap, or member's failure to execute advance directives. All providers are required to submit a signed and dated Standard Assurance, Assurance of Compliance with *Title VI of the Civil Rights Act of 1964* and Letter of Understanding signed by the person legally authorized to act for the agency or person to whom responsibility for these assurances is delegated. The necessary forms are included in the enrollment packet. (See Appendix RR of this manual. Rev. 7/2019)

Q. Communication with Area Agencies on Aging (AAA) – The applicant agency must conduct a face-to-face visit with the Area Agency on Aging Director(s) of each Planning and Service Area (PSA) where the applicant is seeking to initiate services. The applicant agency will consult with the AAA in order to learn about the aging network in the PSA and to gain assistance with the provider's market analysis. (See Appendix Y.) Providers enrolled in EDWP (CCSP and SOURCE) are required to attend two web-x type AAA Network Meetings during the state fiscal year (July 1 – June 30) hosted by the Department of Community Health. (Rev. 7/1/13, 10/1/13, 4/1/14, 1/1/2015 and **10/1/2019**)

NOTE:
Refer to Section 601.3 D if applicant is a current EDWP (CCSP and SOURCE) provider.

R. Accepting Referrals - The provider agency must accept all appropriate referrals from EDWP (CCSP and SOURCE) care coordinators, including members who are currently Medicaid eligible or potentially Medicaid eligible.

S. Member Referrals - The provider agency must understand that approval for enrollment in the EDWP (CCSP and SOURCE) does not guarantee referrals. **Care coordinators make referrals to enrolled providers based on member choice and availability of** EDWP (CCSP and SOURCE)**.** Providers are encouraged to secure funding sources other than Medicaid. **Rev 4/2019**

T. Disclosure - If any agency knowingly fails to disclose all requested information or provides false information, the EDWP (CCSP and SOURCE) **Unit** will not recommend approval of enrollment to the DMA. If at any time following enrollment a provider agency is found to have falsified or knowingly failed to disclose application information, the Division has the right to recommend that provider's termination from the EDWP (CCSP and SOURCE). **(Rev 7/2016)**

U. Alzheimer's Disclosure Form - Any provider agency that advertises, markets, or offers to provide specialized care, treatment, or therapeutic activities for one or more persons with a probable diagnosis of Alzheimer's Disease or Alzheimer's-related dementia is required to complete the Alzheimer's Disclosure Form. (Refer to Appendix H.)

V. Enrollment Training – **The applicant must attend Provider Orientation Training**. See Section 601.2 of this manual. **Rev. 1/1/14, 4/1/14, 10/1/16, 7/1/2019**

W. HIPAA Compliance – All applicants/providers must demonstrate compliance with the Health Insurance Portability and Accountability Act of 1996. (For additional information refer to www.dch.georgia.gov and https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-audio-telehealth/index) for guidance to use remote communication technologies.

Provider/member telehealth communication in EDWP will involve a camera telehealth modality encrypted (end to end encryption) software product with established business agreement that protects PHI (protected health information). PHI is information about health status, provision of health care, or payment for health care that is created or collected by a covered entity and can be linked to a specific individual. Applicant/member or Provider with access to landline phone (one way) can be utilized in place of the software requirement. Landline/non internet use is appropriate (copper wires that carry their own power and work during blackouts). Calls not involving billable service work requires I phone or Android encryption cell settings use or landline. Use of electronic health records, member portal access or app use are to be encrypted (end to end encryption) with business agreement as well.

X. Business Experience – **All applicants must submit proof of business experience.** All applicants must have been in the business for which application is being made for a minimum of twelve (12) consecutive months prior to making application for enrollment in the EDWP (CCSP and SOURCE). **Rev. 4/11, 1/14, 4/14, 10/2019, 10/2022**

Y. **Insurance Coverage- The applicant must submit proof that the provider agency has at least $1,000,000 in general liability**

**insurance coverage. Private home care providers must submit proof of their agency's worker's compensation insurance coverage. Rev. 1/1/14**

Z. Electronic Mail- The applicant must maintain a professional, business electronic mail address.

NOTE: Agents that conduct functional assessments and/or case management are not permitted to also provide direct services to members in EDWP, both structurally or operationally. DCH uses case management agencies to serve as the filter to ensure the service provider is complying with policy. DCH will not allow a service provider to apply to enter or expand into the arena of Case Management services unless no other service providers exist for that county or there is documented reason regarding specialized service for a client population.

Conflict free policy is a federal requirement from the Centers for Medicare and Medicaid Services/CMS. CMS does not allow case management providers to be direct service providers within the same HCBS waiver unless there is a demonstrated need due to lack of other providers or other extenuating circumstances. In the instances where a State Medicaid Agency does allow a case management provider to be a direct service provider the state is required to have enhanced monitoring of the provider to include quarterly auditing of the provider including onsite provider record review. The audits are done to ensure there is no conflict of interest in enrollment and delivery of services.

**601.2 New Provider Enrollment** (revised 4/1/14, 1/1/2015, 7/1/2017, 1/1/2019)

New provider enrollment is accomplished in a multi-step process, all of which is detailed below:

A. Information Session – Mandatory effective with the Sept 2017 enrollment cycle.
B. Application submission
C. Review by the Credentialing Verification Organization (CVO)
D. Review of the application by a DCH Unit staff
E. Site Visit (if applicable)
F. New Provider Training
G. Enrollment Decision
H. Notification of Enrollment Decision

Open Enrollment cycles occur two (2) times per year in March and September.

**A. Information Session for Potential Providers**

The EDWP (CCSP and SOURCE) Unit will host a EDWP (CCSP and SOURCE) Enrollment Information Session prior to the beginning of each recruitment cycle in February and August of each year. The information session includes a review of enrollment requirements and a question and answer session. **Attendance is required.** E-mail **ccsp.messages@dch.ga.gov** request a seat/web x invitation in the information session for the upcoming recruitment cycle, as space in each session is limited. **You must attend an information session within the 18 months immediately prior to the month your online application is submitted. (Rev 7/2017, 1/1/2019, 7/1/2019, 1/2020)**

## B. Application Submission

Submit an online facility enrollment application using the "Enrollment Wizard" under the "Provider Enrollment" menu at www.mmis.georgia.gov. New applications can be entered online between the following dates, which coincide with the open enrollment dates for EDWP (CCSP and SOURCE):

- March 1st- March 31st
- September 1st – September 30th

When entering the application, choose "Facility" as the Enrollment Type, "Home and Community Based Services" as the Provider Type, and "Community Care Services Program" as the Provider Contract. See Appendix GG in this manual for a list of the required attachments for each specialty, which must be uploaded to Gammis during application entry based on the specialty you indicated on the application. Providers are required to submit applications for BOTH CCSP and SOURCE, 590 and 930 categories of service.

Print the 'submitted' PDF application for your records after it is completed. Upload a signed copy of Appendix FF, Notice of Intent to Become a EDWP (CCSP and SOURCE) Provider, noting the TWO different ATN numbers from Gammis. The Appendix FF is at the end of this manual and should be uploaded to Gammis. **All remaining applicable items from the appendix GG need uploaded to gammis, into each ATN number.** The applications will be assigned to a DCH Enrollment and Waiver Unit staff in the EDWP (CCSP and SOURCE)/Enrollment Unit at DCH. **The Appendix FF and all applicable Appendix GG documents must be submitted between March 1 and March 31 or September 1 and September 30, depending on the enrollment cycle**. (Rev 1/2019, 7/2019, 1/2023, 4/2023, 7/2023, 10/2023)

NOTE: Initial applications (Providers without previous EDWP experience) are limited to one service at time of application, Example- Adult Day Health or Alternative Living Service etc. No combination of services for initial applications except PSS/X and SNS.

## C. Review of the Application by the Credentialing Verification Organization (CVO)

The CVO will review the required documents, including the validity of all required attachments. If the CVO requests additional documents from you during this process, provide

them by the requested deadline to avoid denial of your application. The CVO review can take up to 51 business days to complete.

**D. Review of the Application by a DCH Unit Staff**

a. If ALL required documents are not submitted and the CVO denies the application**,** the application will be withdrawn without further review and cannot be resubmitted until the next open enrollment cycle. (Rev 1/2015, 1/2017, 1/2019)
b. If the CVO approves the application, the application process will continue under review by the DCH unit staff, reviewing all items required in the Appendix GG. DCH reserves the right to request any documents deemed necessary to ensure your qualifications as a provider of the service under which you filed your application. See Appendix GG in this manual for a list of documents that are required for the application process. (Rev 7/2016, 1/2019, 1/2023)
c. When the application is determined to be free of deficiencies, a site visit will be arranged if deemed necessary by the DCH Unit staff.
d. If the applicant fails to return/upload all documents requested by the DCH Unit staff by the stated deadline, the application will be withdrawn without further review. Application withdrawal preserves the provider's right to re-apply during the next open enrollment cycle. (Rev 1/2019)

**E. Site Visit**

Applicants may have a site visit of their facility conducted by a EDWP (CCSP and SOURCE) Program Specialist. The only exception is for ERS provider agencies located out of state. The site visit may include but is not limited to the following:

a. A tour of the facility
b. A review of organization's policy and procedure manual
c. Observation of the client and personnel record storage system
d. Interviews with available agency staff
e. Observation of general operations

**F. New Provider Training**

a. Prior to being assigned your Medicaid provider number, you will be required to attend a training session for new providers. You will receive an invitation to this training from the EDWP (CCSP and SOURCE) Unit once you have completed the enrollment process and the decision has been made to recommend enrollment. **Failure to attend New Provider Training will result in a recommendation to deny enrollment**. (Rev 1/2017)

b. Existing EDWP (CCSP and SOURCE) providers applying for a new EDWP (CCSP and SOURCE) service may have this training requirement waived at the discretion of the EDWP (CCSP and SOURCE) Unit. (Rev 7/2016)

**G. Enrollment Decision**

a. If the EDWP (CCSP and SOURCE) DCH Unit staff determines the applicant organization is qualified to be a provider after a careful review of the application packet, a successful site visit, and the provider's attendance at New Provider Training, the DCH Unit staff will send a letter of recommendation of enrollment to the Department of Community Health's (DCH) Provider Enrollment Section, along with all documents from the application packet that are required to assign a Medicaid provider ID. (Rev 1/2017)
b. If the EDWP (CCSP and SOURCE) DCH Unit staff determines the provider has not completed the application process, the application will be withdrawn. If the DCH Unit staff determines that the provider is not qualified, the application will be denied. (Rev 10/2016)

**H. Notification of Enrollment Decision**

a. The EDWP (CCSP and SOURCE) Unit will notify the Area Agencies on Aging and Care Coordination agencies of the approval of the application, with a copy of the notification sent to the applicant. This notification will include the newly assigned Medicaid provider ID and the effective date.
b. The Department of Community Health will notify the organization if the application is denied. This notification will include the reason for denial and appeal rights, as stated in Part I, Policies and Procedures for Medicaid/Peachcare for Kids Manual.
c. If the application is denied, the applicant will not be permitted to re-apply for a period of one (1) year from the date of the denial.
**d.** If at any time during the enrollment process or <u>following enrollment</u> a provider agency is found to have falsified or knowingly failed to disclose application information, the EDWP (CCSP and SOURCE) Unit will exercise their right to recommend the provider agency be denied enrollment or terminated as a EDWP (CCSP and SOURCE) Medicaid provider. (Rev 7/2016)

**601.3 <u>Expansion Procedures for Active</u>** EDWP (CCSP and SOURCE) **<u>Medicaid Providers</u> (revised 4/1/2014, 1/1/2015)**

A. **Adding a** EDWP (CCSP and SOURCE) **Service or an Additional Location for an Existing Service**

1. Active EDWP (CCSP and SOURCE) Medicaid service providers must submit an enrollment application in accordance with Section 601.2 of this manual for each additional service.
2. A provider who is requesting to expand into a new service must have been an active EDWP (CCSP and SOURCE) Medicaid Provider for a minimum of 12 months.
3. A provider who is requesting expansion into a new service or applying for an additional location must not be under corrective or adverse action in any Medicaid program. (Rev 10/2016)
4. **Case management providers who add case management under a new contract (**EDWP (CCSP and SOURCE)**) or expand their service area are subject to an audit of their current case management operations by DCH. (Rev 7/2019)**
5. Active EDWP (CCSP and SOURCE) Medicaid service providers who are adding an additional service location for an existing service must submit a Department of Community Health Facility Enrollment Application or Additional Location Application (online), plus a copy of the current HFRD license or permit for the service requested, most recent clean HFRD inspection report, local business license and proof of current liability/worker's comp insurance coverage. (Rev 1/2015, 10/2016)

B. **Expanding the Service Area of an Existing Service**

1. Providers wishing to expand the geographical area that an existing, Medicaid enrolled office serves must submit a **Service Expansion Application** (Appendix B). This application must be submitted according to the guidelines identified here.
2. A Medicaid Facility Enrollment Application must be completed if the expanded area will be served from an office that is not currently enrolled.

    a. Service Area Expansion applications are **not accepted** during new the provider enrollment review months of March, April, September and October.
    b. Applications received in months these months will be **withdrawn** without review. **Rev 1/ 2015**
    c. Providers seeking expansion of county coverage for an existing service must have been EDWP (CCSP and SOURCE) providers for a minimum of six (6) months.
    d. Neither the provider agency nor its owner(s) or management may be currently under adverse action in any Medicaid program.
    e. The provider agency must have no deficiencies within the past three years from <u>any</u> licensing, funding or regulatory entity associated with Medicaid, Private Home Care or Title III-funded services. If deficiencies are cited, they must be corrected to the satisfaction of the imposing entity.

f. A private home care provider must submit a copy of the letter issued by DCH's Healthcare Facility Regulation Division that approves the addition of the counties in the service area expansion request to the service area associated with the provider's state license. Revised 4/2016
g. A case management company must submit a business plan to show how they will staff the expanded service area. Revised 1/2019
h. Case management companies are subject to an audit by DCH of their client records before approval of any expanded service area. Revised 1/2019
i. Requests for expansion of a provider's service area are limited to no more than 2 per calendar year. Revised 4/2016

C. **Service Expansion Application Review**

a. Within 3 business days of receipt of the Application documents, the EDWP (CCSP and SOURCE) Unit will send an emailed acknowledgment of receipt.
**b.** If ALL required documents are not submitted, the application will be **withdrawn without review. Rev 1/ 2015**
c. Within 30 calendar days of receipt of the application documents, the EDWP (CCSP and SOURCE) Unit will notify the applicant of any deficiencies.
d. Applicants will be notified of their ONE (1) opportunity to submit any needed corrections and will be given at least 2 weeks (14 days) from the date of notification to submit corrections.
e. The agency may receive a site visit as part of the application review process.
f. Within 45 days of receipt of the Application documents, a decision regarding the submitted documents will be made, with notification to the applicant following the procedures outlined in section 601.2 C 7 of this manual. Final decisions on whether to approve a request to expand a service area are made by the Department of Community Health.
g. If the expansion is denied, the applicant will not be permitted to re-submit a service area expansion application for a period of 6 months from the date of the denial.

601.4 **Change in Enrollment Data**

A. Change of Ownership or Legal Status or Buy Out
1. New Providers purchasing an existing business with a current provider number
a. The purchasing entity must **first** become an enrolled EDWP (CCSP and SOURCE) provider by following the policies and procedures as set forth in Chapter 600, Section 601.2 while also following Federal Guidelines as stipulated 42 C.F.R. § 442.14 (further clarification can be found in Part I Medicaid/PeachCare for Kids Policies and Procedures, Chapter 100, Section 105.)

Rev. 10/09 **NOTE**

If the existing business is currently serving EDWP (CCSP and SOURCE) clients, please refer to #3-Interim Reimbursement found in this section.

2. Required Notification:

Any enrolled provider undergoing a change (including, but not limited to, dissolution, incorporation, re-incorporation, reorganization, change of ownership of assets, merger or joint venture) that results in the provider either becoming a different legal entity or being replaced in the EDWP (CCSP and SOURCE) by another provider, must:

Give the Division of Medical Assistance ten (10) day prior **written** notice before affecting a change such as dissolution, incorporation, re-incorporation, and reorganization, change of ownership of assets, merger, or joint venture whereby the provider becomes a different legal entity or is replaced in the program by another provider. The successor provider must submit an executed Statement of Participation to become effective at the time of the above-described change. Failure of the successor to execute a new Statement of Participation will prevent the Division from reimbursing any further services as of the date of the change.

Provide **written** notice of intent to sell or change ownership or legal status must be given within ten (10) days of the change to: (Rev 1/1/2022)

EDWP (CCSP and SOURCE) Members
Care coordinators
Area Agency on Aging
The EDWP (CCSP and SOURCE) Unit at DCH/Medicaid
Healthcare Facility Regulations Division, if applicable

Refer to Sections 105.8 and 105.9 of Part I Policies and Procedures for notifying the Division of Medical Assistance of a change of ownership or legal status.

NOTE:If the new legal entity chooses not to enroll in the EDWP (CCSP and SOURCE), services will be re-brokered to an enrolled EDWP (CCSP and SOURCE) provider within thirty (30) days of the effective date of the change for those members who wish to continue receiving EDWP (CCSP and SOURCE) services.

3. Interim Reimbursement:

   Medicaid reimbursement for the current provider will terminate on the effective date of the sale. The new provider must complete a change of ownership/CHOW application with new payee ID/EIN and provide the Department with appropriate banking information for proper Medicaid reimbursement. Upon approval of the CHOW, Medicaid reimbursement will be effective the date of ownership and approval to enroll in the EDWP (CCSP and SOURCE) if the following conditions are met:

   - The new owner/applicant submits a Letter of Intent to the EDWP (CCSP and SOURCE) Unit, prior to the effective date of ownership, **with assurance that it will provide** EDWP (CCSP and SOURCE) **services according to all** EDWP (CCSP and SOURCE) **Policies and Procedures.**

   - The new owner/applicant submits HFR license in the new owner/applicant name **or** evidence that application for this HFR license has been made, if license is required.

   - The new owner/applicant submits to the EDWP (CCSP and SOURCE) Unit enrollment applications (EDWP (CCSP and SOURCE) and Medicaid) within thirty (30) days of the letter of intent. If the enrollment applications are not acceptable, the applicant will have thirty (30) days to make revisions. If, after the revision period, the revisions are not acceptable, the EDWP (CCSP and SOURCE) Unit will recommend denial of the application to DCH.

   - The new owner/applicant completes 180 days of operation of the existing business during which time, no EDWP (CCSP and SOURCE) member will be admitted to the agency.

     The EDWP (CCSP and SOURCE) Unit will review the applications and provider enrollment documents, HFR survey reports, provider complaint logs, Utilization Review documents, and Ombudsman recommendations and care coordination provider check lists, if applicable. Enrollment or denial in EDWP (CCSP and SOURCE) will be recommended to DCH. DCH will notify the applicant in writing the approval or denial of the application

     EXCEPTION: If the new owner is currently an enrolled EDWP (CCSP and SOURCE) Medicaid service provider in good standing, please refer to policies and procedures found in this chapter, section 601.3

NOTE: A completed CHOW involving active waiver members will have the members consulted by Case Management regarding the purchase/new agency. The members will be consulted regarding the right of agency choice.

4. Participation Contingency:

   Participation of the new owner in EDWP (CCSP and SOURCE) will be contingent upon the following conditions being met:

   - Satisfactory completion of applications
   - Satisfactory site visit by EDWP (CCSP and SOURCE) Unit staff members, if applicable

     New management will be **required** to attend mandatory EDWP (CCSP and SOURCE) Provider Trainings.

     Failure to meet above contingencies will result in the EDWP (CCSP and SOURCE) Unit's recommending recoupment of all Medicaid funds and recommending termination from the EDWP (CCSP and SOURCE).

NOTE:

Medicaid Provider Numbers, Personal Care Home permits, Private Home Care Licenses, and Certificates of Need, are <u>not</u> automatically transferable. Providers are required to notify the licensing/permitting agency of any changes in ownership, legal status, or location.

Purchase of an existing enrolled provider agency requires that the purchaser complete the enrollment process and obtain a Medicaid Provider Number. Without a Medicaid Provider Number, Medicaid reimbursement will not occur.

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B. <u>Change of Provider Data</u>

   A provider must ensure that EDWP (CCSP and SOURCE) are provided updated, accurate information, which includes but is not limited to:

   - correct address of the agency/business location
   - correct street address of the service location, if different from above
   - current phone number(s)
   - name of contact person(s)

- data on subcontractor's providing direct member care
- Electronic Mail Address (e-mail)

Enrolled providers are required to furnish written notice to the EDWP (CCSP and SOURCE) Unit at the Division of Medical Assistance, the Healthcare Facility Regulations Division (if applicable), the Area Agency on Aging, the Care Coordination agency and the EDWP (CCSP and SOURCE) members, within ten (10) days of the change in provider data. (See Section D for addresses.) Changes requiring written notice include, but are not limited to: (Rev 1/1/2022)

- address of the provider agency administrative/business office
- address of the service location
- telephone numbers
- subcontractor data changes
- change in permit/license issued by the Healthcare Facility Regulations Division

If the contact person for the administrative or service location changes, the provider must notify the EDWP (CCSP and SOURCE) Unit within ten (10) days of the change. (See Section D below for addresses).

Alternative Living Services, Adult Day Health, and Out-of-Home Respite Care facilities may not relocate without:

- A satisfactory site visit
- Submission of the required permits and inspections from the regulating agencies
- Submission of business license and certificate of occupancy
- Approval of the proposed location from the EDWP (CCSP and SOURCE) Unit.

NOTE

EDWP (CCSP and SOURCE) will not accept a change of address notice unless the agency produces (or submits) evidence that the change of address has been validated by the Georgia Department of Community Health, Healthcare Facility Regulations Division (HFRD), if applicable, the county business office, and/or Secretary of State's Office, prior to the request with EDWP (CCSP and SOURCE).

C. Termination of Provider Number/Enrollment in EDWP (CCSP and SOURCE)

1. Provider-Initiated Termination

- A provider seeking to terminate enrollment in the EDWP (CCSP and SOURCE) must provide written notice to the EDWP (CCSP and SOURCE) Unit at the Division of Medical Assistance, the Healthcare Facility Regulations Division, if applicable, and Area Agency on Aging and Care Coordination no less than 30 calendar days prior to termination date, stating that it intends to cease accepting EDWP (CCSP and SOURCE) referrals and terminate participation in the EDWP (CCSP and SOURCE). (See Section D for addresses).

- The provider must provide written notice of discharge to EDWP (CCSP and SOURCE) members at least thirty (30) calendar days prior to the effective date of termination.

NOTE:
Even when the change in ownership and/or legal status results in no visible change in services to the member, the provider must inform members and care coordinators.

2. Termination of Provider Number/Enrollment by the DMA

- The DMA may suspend or terminate a provider as described in Part I, Chapter 400.

  - Failure to correct conditions that warrant suspension will result in termination from the EDWP (CCSP and SOURCE).

D. Notice - Send notices of change in ownership/legal status, change of provider data or notices of intent to voluntarily terminate provider number/ enrollment in EDWP (EDWP (CCSP and SOURCE)) to:

***Emailed information is preferred- ccsp.messages@dch.ga.gov**

Georgia Department of Community Health
2 MLK Jr Dr SE
Twin Towers East
Medical Assistance Plan
19th Floor
Atlanta Ga 30334

and if applicable, to:

Georgia Department of Community Health
2 MLK Jr Dr SE
Twin Towers East
Healthcare Facility Regulation
17th Floor
Atlanta Ga 30334

E. Response from State Agencies - The EDWP (CCSP and SOURCE) Unit will acknowledge receipt of notice of a change in ownership/legal status within ten business days of receipt. The Unit will send copies of the acknowledgment to Area Agencies on Aging Director(s). The EDWP (CCSP and SOURCE) Unit will forward all changes to GAINWELL TECHNOLOGIES.

## 601.5 **Records Management**

Providers must maintain clinical records related to the provision of EDWP (CCSP and SOURCE) services in accordance with accepted professional standards and practice and with the standards in this manual. Records must be made available to DCH and their agents as requested. The provider must maintain all EDWP (CCSP and SOURCE) records within the state of Georgia. Records are maintained in a manner that is:

- secure
- accurate
- confidential
- accessible

A. Records Retention

1. The provider must maintain current clinical records for active members and organize the clinical records for easy reference and review. For discharged members, the provider must maintain the clinical record for a minimum of six years from the last date of service. This policy applies even if the provider ceases operation (Refer to Part I, Policies and Procedures). Providers who utilize electronic signatures to validate supervision of services should refer to

Part I, Policies and Procedures, **Definitions #60** and Section 106 (R). **(Rev. 10/2011, 1/2015)** Additionally, EDWP (CCSP and SOURCE) permits electronic signatures and/or computer-generated signatures only if the supervisor's access codes and electronic script is generated on the documents required in the member file.

2. In accordance with 45 CFR Part 17, the state and federal governments shall have access to any pertinent books, documents, papers, and records for the purpose of making audit examinations, excerpts, and transcripts. The provider must retain records for six years after submission of the final claims for payment. If any litigation, claim, or audit is initiated before the expiration of the six - year period, the provider must retain records until all litigation, claims, or audit findings involving the records are resolved.

B. Destruction of Records

1. A provider may destroy records not required to be maintained. The destruction of records must be conducted in such a way that member confidentiality is preserved.

2. When records are accidentally destroyed, the responsible party must in a timely manner reconstruct them to the extent possible. Each reconstructed case record must be clearly labeled "reconstructed".

## 601.6 **Reporting and Investigating Incidents**

It is recommended that each provider should designate an authorized individual to review the incident report, the results of the Follow-Up and Interventions report, and corrective action plans for accuracy and completeness prior to submission to the Department.

One form may be used to record multiple incident types if they relate to the same overall incident.

When an incident involves more than one waiver member, an incident report must be completed for each waiver member.

See Appendix CC for definitions of reportable incident types.

**Reporting of Incidents**

*Note: The responsibility for submission of an incident report falls on the first person to witness or discover the incident regardless of location or whether during the point of service. If the reporting provider is the direct service provider, the case manager will be notified of the*

*incident by the confirmation email of the submission of the incident. The case manager is responsible for completing the follow-up and interventions report.*

1. Providers must immediately take steps necessary to protect the waiver member's health, safety and welfare upon witnessing or discovering an incident.
2. The provider will immediately notify:
    a. The individual's guardian and/or next of kin, as legally appropriate:
        i. Notification of incident with a severity ranking of 3 and above shall occur within two (2) hours.
        ii. Notification of all other incidents shall occur within twenty-four (24) hours.
    b. If the event occurred in an unlicensed facility/agency, Law enforcement and Adult Protective Services in instances of suspected abuse, neglect and/or exploitation of the member.
    c. If the event occurred in a licensed facility/agency, Law enforcement, Healthcare Facilities Regulation Division, and the Long-term Care Ombudsman in instances of suspected abuse, neglect and/or exploitation of the member.
    d. If instances of suspected abuse, neglect and/or exploitation of a member who is a minor, Law enforcement and the Child Protective Services.
3. The provider will submit the Incident Report electronically via the webform located at: [https://medicaid.georgia.gov/ under Provider links] within twenty-four (24) hours of the incident, or the discovery of the incident, but no later than one (1) business day if the incident occurred after business hours or on a weekend or holiday.
4. A confirmation email with a summary of the incident will be sent to the reporting provider, the contact person identified, and the member's case manager if they are not the reporting provider.
5. In all cases of suspected abuse, neglect or exploitation follow-up on referrals to law enforcement and regulatory authorities until resolution.

**Follow-Up and Intervention Reporting**

Used to provide additional information learned about the reported incident and to describe actions taken to resolve the incident and action steps taken to reduce or prevent the reoccurrence of the incident.

In collaboration with the appropriate providers, the case manager submits the follow-up and interventions report electronically via the link provided in the confirmation email within seven (7) business days of submission of the Incident Report.

a. Investigate the cause of the incident
    i. Ensure that no other incidents or abuse takes place while the investigation is ongoing.
    ii. Determine if risk factors existed prior to the incident, which may have identified potential for incident occurrence.
    iii. Identify interventions to reduce or prevent a similar incident in the future.

iv. Identify the individual responsible for implementation of the interventions and the process for evaluating the effectiveness of the plan.

b. DCH will confirm within seven (7) business days if the interventions identified are acceptable and provide on-going monitoring until completion of the identified activities.
   i. If the interventions and/or corrective action are deemed to require modification, the provider will have three business days to resubmit the agency's plan to address the deficiencies cited in the follow-up and interventions report.

c. Interventions Types include, but not limited to:
   i. Staff related – staff training, review, changes to staffing patterns, or supervision
   ii. Individual related – review of protocols, new/additional assessments (behavioral or medical), coordination of care, review of service plan, increased observation
   iii. Equipment/Supplies related – purchase or repair equipment or supplies, obtain new devices
   iv. Environment related – evaluate the area, make physical modifications for mobility or safety, temporary or permanent relocation
   v. Policy and Procedure related – review or update written provider policies, procedures, and/or guidelines
   vi. Provider Quality Improvement related – internal investigation, internal corrective action plan, systematic assessment or change
   vii. Referral to other agencies or community services
   viii. Other – any action not identified above

d. Participate in regulatory agency investigations, if applicable

e. In all cases of suspected abuse, neglect or exploitation follow-up on referrals to law enforcement and regulatory authorities until resolution.

f. Maintain documentation of all reports and associated documentation in the client record.

## 602. <u>Corrective Action</u>

### 602.1 **Corrective Action taken by the AAA or the** EDWP (CCSP and SOURCE) **Unit at DCH/Medicaid**

**(Rev 7/2016, 7/2019)**

A. <u>Suspension of Referrals as Corrective Action</u> Rev 4/2019

- The Care Coordination agency may recommend to the Area Agency on Aging that a provider have referrals suspended. The AAA or the EDWP (CCSP and SOURCE) may suspend referrals when appropriate documentation supports this action.

B. Reasons for Suspending Referrals

A provider may have referrals suspended for reasons including, but not limited to:

- Provider fails to accept referrals
- Provider fails to provide services as required by the comprehensive care plan
- Provider refuses to accept member because one or more of other needed services are brokered to another provider
- Provider overcharges members for services
- Provider fails to refund fees
- Provider has a documented history of confirmed complaints related to member care/issues
- Provider agency has allegations of member abuse, neglect, exploitation, and/or fraud
- Healthcare Facility Regulations Division imposes sanctions against the provider that result in limitation, suspension, restriction, or revocation of the license/permit
- Provider fails to submit requested plan of correction or required reports.
- Failure to report an incident as defined in Section 601.6, failure to cooperate with an investigation and development of interventions related to an incident, or failure to prevent an incident from occurring may be grounds for corrective action or other adverse actions.
- Failure of the provider to comply with Utilization Review or failure of the provider to correct deficiencies cited as the result of an audit.
- Provider fails to attend a minimum of two (2) AAA network meetings per year.

C. Definition of Suspension of Member Referrals

When a provider agency has referrals suspended, care coordination agencies will not broker any EDWP (CCSP and SOURCE) members to the provider agency and will not refer new EDWP (CCSP and SOURCE) referrals to the provider agency for a specific period of time. The provider agency may continue providing services to EDWP (CCSP and SOURCE) members currently brokered to the agency.

NOTE:
Care coordinators may inform members currently receiving services from the provider that the EDWP (CCSP and SOURCE) has sanctioned the provider agency. The member may choose to continue receiving services from the provider agency or may request a new provider.

D. Procedure for suspension of referrals

The AAA or EDWP (CCSP and SOURCE) Unit will notify the provider in writing that the provider agency that all referrals have been suspended and the reason(s) for the corrective action. The written notice will include the effective date of the suspension of referrals, the duration of the corrective action, the request for a written plan of correction within fifteen (15) working days, the time frame in which the provider is to correct the deficiencies, and the **administrative review process** should the provider disagree with the corrective action imposed. **(Rev 10/2016)**

**Failure to submit the written plan of correction may result in additional adverse action.**

The duration of the suspension of referrals will be imposed for a specific time period. For the first offense, a minimum of three (3) months will be imposed; for subsequent offenses, a minimum of six (6) months will be imposed. The AAA or EDWP (CCSP and SOURCE) Unit may shorten or lengthen the duration of the corrective action, depending upon the reason for the action.

NOTE:
If a provider agency has had referrals suspended two or more times within a twelve (12) month period, **the** EDWP (CCSP and SOURCE) **Unit will determine the appropriate adverse action.**

E. Due Process

The provider shall have ten (10) days from the date of the written notice of suspension of referrals from the AAA or EDWP (CCSP and SOURCE) Unit to submit a written request for an Administrative Review. All requests for reviews must be submitted to the address

specified in the corrective action notice to the provider. The written request for an Administrative Review must include all grounds for appeal and must be accompanied by any supporting documentation and explanations that the provider wishes the EDWP (CCSP and SOURCE) Unit to consider. Failure of the provider to comply with the requirements of administrative review, including the failure to submit all necessary documentation, within ten (10) days shall constitute a waiver of any and all further appeal rights, including the right to a hearing, concerning the matter in question.

The EDWP (CCSP and SOURCE) Unit shall render the Administrative Review decision within thirty (30) days of the date of receipt of the provider's request for an Administrative Review.

Following an evaluation of any additional documentation and explanation submitted by the provider, a final written determination regarding suspension of referrals will be sent to the provider. If the provider wishes to appeal this determination regarding suspension of referrals, the provider may appeal the decision **of the** EDWP (CCSP and SOURCE) **Unit**. The appeal must be in writing and received by the Unit within ten (10) business days of the date the Administrative Review decision was received by the provider. The appeal shall be determined within forty-five (45) days of the date on which the EDWP (CCSP and SOURCE) **Unit manager's** office received the request to appeal.

The request for the appeal must include the following information:

- A written request to appeal the decision of the Administrative Review
- Identification of the adverse administrative review decision or other Division action being appealed
- A specific statement of why the provider believes the administrative review decision or other Division action is incorrect; and
- Submission of all documentation for review

**An appeal shall not stay the action appealed.**

The EDWP (CCSP and SOURCE) **Unit manager** will reach a decision within forty-five (45) days of receiving the appeal. If the manager's decision upholds that of the EDWP (CCSP and SOURCE) Unit, suspension of referrals shall remain in effect for the time specified.

The decision of the EDWP (CCSP and SOURCE) Unit manager is final. No further appeal rights will be available to the provider.

F. Reinstating Referrals

If the provider submits the required plan of correction within the time frame specified in the written notice of suspension of referrals and demonstrates that the deficiencies have been corrected, the AAA or EDWP (CCSP and SOURCE) Unit will notify the provider that the agency has been reinstated and may receive referrals. The AAA or EDWP (CCSP and SOURCE) Unit will notify the care coordination agency when the provider has been reinstated and may receive referrals.

G. Failure of Provider to Correct Deficiencies

If the provider fails to submit the required plan of correction and fails to demonstrate that deficiencies have been corrected, the provider will remain suspended from receiving referrals, and **the** EDWP (CCSP and SOURCE) **Unit will consider further corrective or adverse actions,** including re-brokering of services with another provider and termination of the provider's enrollment in the EDWP (CCSP and SOURCE).

## 602.2 Complaints (Rev 7/2016, 10/2016)

If a complaint is referred to the EDWP (CCSP and SOURCE) Unit and, after initial scrutiny, appears to involve criminal activity or lack of program integrity, the EDWP (CCSP and SOURCE) **Unit manager** shall have the discretion to refer the complaint to the Department of Community Health's Program Integrity Section, law enforcement agencies, and other regulatory entities.

## 602.3 Serious and Unusual/Unexpected Incidents/Emergencies

**(Rev 7/2016, 4/1/20)**

- In the event of a reported incident, as outlined in section 601.1, of allegations of abuse neglect, exploitation, fraud, and/or member health and safety are at risk or in immediate jeopardy, and the provider agency has failed to act appropriately, the Care Coordination agency will immediately notify the Department for further investigation.

- When there is the threat of immediate jeopardy to the health and safety of a member, the Department will immediately notify the Care Coordination agency to relocate EDWP (CCSP and SOURCE) members, if appropriate. As outline in Section 602.4(B)(16), the EDWP (CCSP and SOURCE) Unit will then consider additional appropriate adverse action.

- Depending upon the nature of the incident, the provider may be asked to submit specific policies and procedures for review by the EDWP (CCSP

and SOURCE) at DCH to determine if the provider agency followed policy and standard of practice.

| NOTE: See Appendix W |
|---|

602.4 **Adverse Action (Rev 7/2016)**

A. Conditions of Adverse Action

**The** EDWP (CCSP and SOURCE) **Unit at DCH/DMA** can take action that requires enrolled providers to correct deficiencies before the action can be ended. Adverse actions may be imposed independently or in conjunction with other regulatory agencies. (Refer to Part I, Policies and Procedures, and Section 601.1D of the EDWP (CCSP and SOURCE) General Services Manual.

**The** EDWP (CCSP and SOURCE) **Unit** at DCH determines the adverse action and notifies the provider agency and EDWP (CCSP and SOURCE) of its decision and notice of action.

B. Reasons to Impose Adverse Action

**The** EDWP (CCSP and SOURCE) **Unit at DCH will determine the adverse action(s) it believes will most likely achieve correction of the deficiencies cited**. The Unit can take an adverse action for reasons including, but not limited to:

1. Failure to Accept Referrals – The provider agency fails to accept referrals made for approved planning and service areas, in accordance with stated service hours, or the agency fails to provide the Area Agency on Aging written reasons for failure to accept referrals.

2. Pattern of Non-Compliance with Policies and Procedures – A pattern of non-compliance is established if the provider agency is cited for policy violations within the previous three (3) years. A pattern of non-compliance is determined through:

    - Utilization Review Reports or other audits conducted by the Division of Medical Assistance;

    - reviews and site visits conducted by the Department of Community Health, Healthcare Facility Regulations Division (HFR) and/or its agents;

- and/or reports from members, members' representatives, member families, Area Agencies on Aging, and/or care coordination.

**The provider agency must notify the** EDWP (CCSP and SOURCE) **Unit at DCH in writing of any non-compliance, even if temporary, as soon as it occurs (i.e., resignation of a required staff member) to request a temporary written waiver from the Unit.**

3. Failure to Render Services – Failure of a provider agency to provide services as required by the care plan in accordance with currently accepted standards of medical practice, including the provision of nursing supervision.

   If the provider agency experiences temporary staffing problems and is unable to provide services as required by the member's care plan, the provider must immediately notify the care coordinator. If the problem is expected to continue more than ten (10) business days, or the member's condition is such that a delay/interruption of service would be a disservice to the member, the care coordinator will re-broker the member's services with another provider.

4. Failure to Maintain Quality of Care – Care and/or services provided are of such quality that the health, safety and/or welfare of members are placed at risk.

5. Refusal to Accept Member – Refusal by a provider agency to accept a member because of one or more of the other services needed by the member is brokered to another provider or because the member has cost share liability.

6. Failure to Maintain Current Licensure – Failure of provider agency to maintain current licenses for the agency and personnel as required by Georgia law. **(Rev. 10/2015)**

7. Failure to Act on Charges of Abuse, Neglect, and/or Exploitation of Members – Failure of a provider agency to take measures to stop identified known abuse, neglect, and/or exploitation of members.

8. Relocation Without Prior Approval and Notification – Moving members from an Adult Day Health Center, a Respite Care Facility, or an Alternative Living Services facility without obtaining prior approval of the EDWP (CCSP and SOURCE) **Unit** at DCH or without furnishing sufficient prior notice to the EDWP (CCSP and SOURCE) member(s), member representative(s), and care coordinator(s).

9. Failure to Respond to an Adverse Action – Failure of a provider agency to submit a timely plan of corrective action or any other reports or documentation as requested or required by the EDWP (CCSP and SOURCE) Unit at DCH.

10. Refusal of Access to Member and Member Records – Failure of a provider agency or its subcontractor(s) to permit staff or contracted personnel acting on behalf of the State of Georgia access to members, member records or other documentation required for participation in the EDWP (CCSP and SOURCE).

11. Falsification of Records or other Acts of Fraud/Abuse

12. Inappropriate Charging – Willful overcharging of members and/or their representative(s) for services.

13. Failure to Refund Fees – Failure of a provider agency to refund fees to members after a determination that a member is due a refund

NOTE:
Retroactive Medicaid eligibility and/or other reasons may cause a provider to owe refunds to a member.

14. Failure to Notify Prior to Termination – Failure of a provider agency to provide required notice prior to termination of services. Providers who abruptly discontinue services may not request re-enrollment for a period of one (1) year from the date services were discontinued. (See Section 404.2 Part I Medicaid/PeachCare for Kids).

15. Failure to Respond to Member's Needs for 24-Hour Service – (See Section 601.1M of the EDWP (CCSP and SOURCE) General Manual).

16) Failure to report an incident as defined in Section 601.6, failure to cooperate with an investigation and development of interventions related to an incident, or failure to prevent an incident from occurring may be grounds for corrective action or other adverse actions.

17) Failure of Personal Support /CD PSS Providers to record daily aide work in the (EVV) Electronic Visit Verification system. (see Section 1405 of the Part II Chapter 1400 Policies and Procedures for EDWP (CCSP and SOURCE) Personal Support Service/Consumer Direction/Structured Family Caregiver manual.

C. Types of Adverse Action(s)

Types of adverse action the EDWP (CCSP and SOURCE) Unit at DCH may impose include but are not limited to:

1. Suspension of Provider – The provider agency will be suspended from participating in the Medicaid program for a defined period of time not to exceed one year.

2. Termination of Provider Enrollment

3. Re-Brokering of Member Services – When the health, safety, and/or welfare of EDWP (CCSP and SOURCE) members is at risk and/or in immediate jeopardy, the EDWP (CCSP and SOURCE) Unit will notify the care coordination agency to immediately re-broker services of EDWP (CCSP and SOURCE) members to another approved EDWP (CCSP and SOURCE) provider. The EDWP (CCSP and SOURCE) Unit may consider further adverse action.

4. Delaying the processing of pending and additional provider enrollment applications and expansion requests.

NOTE:

Even in the absence of any adverse action, care coordination may re-broker service(s) to another provider at any time the member requests a change in providers.

602.5 **Duration of Adverse Action**

The adverse action letter will stipulate the time frame within which the provider is required to correct deficiencies. The DCH shall determine the period of adverse action.

NOTE:

The EDWP (CCSP and SOURCE) Unit may conduct an unannounced site visit prior to removal of the adverse action to determine whether the provider has achieved compliance. Failure to achieve compliance by the end of the adverse action period will result in a recommendation to continue the adverse action and/or impose additional adverse action.

602.6 **Provider Notification of Adverse Action and Appeal Rights**

The DCH will send to the provider a Notice of Adverse Action in accordance with Part I, Chapters 400 and 500 of Policies and Procedures. The notice will include:

A. Reason for imposing the adverse action

The effective date and duration of the proposed adverse action(s) will be determined by DCH. The provider may appeal the action taken by DCH, but appealing the action will not stay the action appealed.

B. The address to which requested information is to be sent and the name of a DCH contact person to call for clarification regarding the notice.

C. The actions and time frame necessary to oppose/appeal the adverse action. If the provider fails to request an Administrative Review or fails to submit the requested information within the time frame specified in the Notice of Adverse Action, the adverse action becomes final and no further administrative or judicial review will be available. If the provider fails to respond to the notice or to correct the deficiencies, the DCH will make a determination on the adverse action, including re-brokering of services with another provider and termination of the provider's enrollment in the EDWP (CCSP and SOURCE).

NOTE:

EDWP (CCSP and SOURCE) providers under adverse action are subject to the provisions of Part I, Policies and Procedures For Medicaid/Peachcare for Kids, Georgia Department of Community Health, Division of Medical Assistance, Chapter 400 – Adverse Action, and Chapter 500 –Appeals.

603. **Admissions**

A. Each provider must maintain written policies, procedures and criteria for accepting members referred by the care coordinator. The policies, procedures and criteria apply uniformly to all EDWP (CCSP and SOURCE) referrals. (See Appendix C of the EDWP (CCSP and SOURCE) General Manual).

**NOTE: The member must be informed in writing in advance of running any credit checks. Rev 10/14**

B. Admissions policies, procedures and criteria may not discriminate or permit discrimination against any person or group of persons on the grounds of age, race, sex, color, religion, national origin, or handicap, in accordance with Title VI of the Civil Rights Act of 1964, as amended, and Section 504 of the Rehabilitation Act of 1973.

C. The Federal Omnibus Budget Reconciliation Act of 1990 includes provisions known as the Patient Self- Determination Act. The Act requires providers of personal care services who receive reimbursement under Medicare and/or Medicaid to inform members of their right to execute Advance Directives for health care (see Appendix D of the EDWP (CCSP and SOURCE) General Manual). Under the Patient Self-Determination Act, a provider may not discriminate against a member who has or who has not executed an Advance Directive.

Home Delivered Meals Services and Emergency Response System providers are exempt from advance directives requirements.

Providers rendering personal care services (Adult Day Health, Personal Support Services, Home Delivered Services, Alternative Living Services, Respite Care, and Skilled Nursing Services) must:

- Comply with all requirements of law respecting Advance Directives.
- Provide written information to members regarding their rights under law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives.
- Document in the member's clinical record whether an Advance Directive has been executed.
- Maintain in the provider agency file a copy of any executed Advance Directives.
- Provide education for staff on member information concerning Advance Directives.
- Never condition the provision of care or otherwise discriminate against a member who has or has not executed an Advance Directive.

## 604. **Member Assurances**

### 604.1 EDWP (CCSP and SOURCE) **Member Rights and Responsibilities**

A. Refer to Sections 601.1 - O of the EDWP (CCSP and SOURCE) General Manual. Providers must acknowledge that members have rights and responsibilities regarding participation in the EDWP (CCSP and SOURCE). At the time of admission the provider reviews member rights and responsibilities with the member and/or member's representative. After the member reads and signs a copy of the member's rights and responsibilities, the provider gives a copy of the rights and responsibilities to the member and the member's representative if applicable. The provider places a copy in the member's record.

Member rights recognized by the provider include:

1. The right of access to accurate and easy-to-understand information
2. The right to be treated with respect and to maintain one's dignity and individuality

3. The right to voice grievances and complaints regarding treatment or care that is furnished or not furnished, without fear of retaliation, discrimination, coercion, or reprisal

4. The right to a choice of approved service provider(s)

   Members must have the freedom of choice when selecting services and providers. Members cannot be coerced or encouraged to select services from a provider that has the same ownership or other relationship to the provider. Examples- ALS member attending ADH of choice and not an ADH owned by same ALS or Private Home Care Provider cannot serve as waiver provider to a member while also owning residence where member resides and charging rent for space leased by member.

5. The right to accept or refuse services

6. The right to be informed of and participate in preparing the care plan and any changes in the plan

7. The right to be advised in advance of the provider(s) who will furnish care and the frequency and duration of visits ordered

8. The right to confidential treatment of all information, including information in the member record

9. The right to receive services in accordance with the current care plan

10. The right to be informed of the name, business telephone number and business address of the person supervising the services and how to contact that person

11. The right to have property and residence treated with respect

12. The right to be fully and promptly informed of any cost share liability and the consequences if any cost share is not paid

13. The right to review member's records on request

14. The right to receive adequate and appropriate care and services without discrimination.

15. The right to be free from mental, verbal, sexual and physical abuse, neglect, exploitation, isolation, corporal or unusual punishment, including interference with daily functions of living

16. The right to be free from chemical or physical restraints

NOTE:

Providers must be aware of additional member rights and responsibilities required under specific program licensure and must include signed copies of these rights and responsibilities in the member's record.

B. Member responsibilities recognized by the provider include:

1. The responsibility to notify service provider(s) of any changes in care needs

2. The responsibility to treat provider staff in a courteous and respectful manner, as well as cooperate with and respect the rights of the caregivers providing care

3. The responsibility to be as accurate as possible when providing information on health history and personal care needs

4. The responsibility to participate actively in decisions regarding individual health care and service/care plan

5. The responsibility to comply with agreed-upon care plans

6. The responsibility to notify the member's physician, service provider(s), and/or caregiver of any change in one's condition

7. The responsibility to maintain a safe home environment or to inform provider(s) of the presence of any safety hazard in the home

8. The responsibility to be available to provider staff at times services are scheduled to be rendered

9. The responsibility to pay any cost share liability, if applicable

## 605. **Provider's Evaluation of Member's Needs**

### 605.1 **Level of Care**

A. Medical services rendered to a member will be ordered by a physician or nurse practitioner on the Level of Care and Placement Instrument. See Appendix E of the EDWP (CCSP and SOURCE) General Manual.

B. A EDWP (CCSP and SOURCE) member must meet the level of care criteria for intermediate nursing home placement. Alliant Health Solutions (formerly GMCF) must validate the member's level of care (LOC) and assign a length of stay (LOS) not to exceed a maximum of 365 days. The member's physician signs the Form 5588 (EDWP (CCSP and SOURCE) Level of Care Placement Instrument) to attest to the member's need for a nursing home LOC, after which the EDWP (CCSP and SOURCE) care coordinator RN signs the 5588 to certify the LOC. EDWP (CCSP and SOURCE) services may not begin under the LOS indicated on the Form 5588 until the RN signs the form to certify the LOC. (Rev. 7/2015)

C. Providers may render EDWP (CCSP and SOURCE) services only to members with a current level of care. Each EDWP (CCSP and SOURCE) member is given an approved Level of Care (LOC) certification for program participation. A LOC certification is approved for no more than a 365 day length of stay. (Rev 1/2015)

D. If a member needs a change in service within 60 days from the beginning date of the LOS, the care coordinator will document and date the added services on the Comprehensive Care Plan and provide a copy to the member's physician and the service provider(s). No face to face visit or physician letter is required in this situation unless the client is returning to the community from a nursing/rehabilitation facility. See Appendix G of the EDWP (CCSP and SOURCE) General Manual. (Rev 7/2015)

E. If a member with a current LOS under an LOC experiences a change in condition or change in status that requires the addition of new services and/or a change in the level of services, and the change occurs more than 60 days after the beginning date of the LOS, a new LOC assessment (reassessment) is <u>not</u> required. However, approval of the new care/service plan by the member's physician is required. The EDWP (CCSP and SOURCE) nurse must make a home visit to assess the member's condition and service needs. Changes must be documented on the EDWP Modified Reassessment Form (Appendix QQ), and a request for approval of any new services or updated orders must be submitted to the member's physician by way of the Physician Change in Services Letter (Appendix EE) to request his/her approval of the new or revised service plan. Copies of the Appendix EE with the physician's signature and the EDWP Modified Reassessment form must be sent to the provider for the member's file. The following are examples of changes or new services for which physician approval is required:

**The new service to be added is skilled nursing.*

**The member needs a change in their level of Adult Day Health (ADH) services.*

**The change is service is from one category to another, such as from personal support services (PSS) to alternative living services (ALS).*

**A change in service or new service is required for a member after their discharge from a facility that requires an LOC on a DMA-6, such as a nursing or rehabilitation facility.*

**A member transfers from one planning and service area to another and requires new services.*

**The member has a significant illness or injury that requires a change in services. (Rev. 7/2015, 4/2019)*

**NOTE: Completion of the EDWP Modified Reassessment form will serve as a care plan update, which means another updated care plan will not be due until the third month after the month the EDWP Modified Reassessment is completed. The EDWP Reassessment form and the Physician Change in Services Letter also serve as updates/addendums to the current approved Level of Care Form (Appendix E/5588 or Appendix F). (Rev. 4/2019)**

F. ADH therapies, HDS and SNS (skilled services) additions require physicians orders before specific medical procedures can be provided. Orders for therapy services must include specific procedure and modalities used and frequency and duration of services. (Rev. 7/2015)

G. The care coordinator may add Home Delivered Meals, **Out of Home Respite Care**, and Medical Social Services to the Comprehensive Care Plan at any time without completing a reassessment. **(Rev 4/2015)**

H. A member must meet all EDWP (CCSP and SOURCE) eligibility criteria to participate in the program.

**EXCEPTION**: If a member continues to receive services while an appeal of a Level of Care termination is in process, and the LOC expires before the hearing decision is known, the RN does not complete a LOC re-determination. Services may continue to such a member even though there is no current LOC.

## 605.2 Provider's Initial Evaluation of the Member

Individuals participating in the EDWP (CCSP and SOURCE) are at risk for nursing facility placement and thus require timely evaluation and service delivery.

A. Contacting the Provider Agency - Prior to sending a referral packet, care coordinators will telephone provider agencies. Upon receipt of the telephone call, the provider agency must contact the care coordinator

within 24 hours if the provider can conduct a face-to-face evaluation in the member's primary place of residence within three business days. If the member is unavailable for evaluation within three business days, the provider will notify the care coordinator. If the member's needs warrant, care coordinators may request the provider to evaluate the member within a shorter time frame.

B. Face-to-Face Evaluation - A provider agency must conduct a face-to-face evaluation of the member in the member's primary place of residence within **three** business days of receiving the referral from the care coordinator. Within 3 business days of the face-to-face evaluation, the provider will use the EDWP Notification Form to notify the care coordinator of the decision to accept or refuse the referral. If the provider accepts the referral, the provider indicates on the EDWP Notification Form the date that services will begin. If the member is hospitalized, institutionalized, or the home environment is not conducive for evaluation purposes, the provider must evaluate the member in a mutually-agreed-upon setting. Services are to begin within 48 hours, if possible, after the provider evaluates the member. If services are to be provided in the member's residence, the provider also must assess the home to determine if it is an appropriate and safe environment for service delivery. The Adult Day Health Provider may elect to evaluate the client in the Adult Day Health setting or the member's primary place of residence, depending on the mutually –agreed needs of the member. (Rev. 4/10)

C. Evaluating a Member who is Transitioning to the Community under the Money Follow the Person (MFP) Program - When a provider receives a referral to provide services for a member who is preparing to be discharged from a nursing home to the community under the MFP program, the provider should conduct the face-to-face evaluation in the nursing home prior to discharge, as soon as possible after the referral is received. This is done so that services can begin on the first day the member returns home, as authorized by the EDWP (CCSP and SOURCE) care coordinator. A re-evaluation of the member's needs can be conducted when services have started after the member is settled in the community, following the guidelines in Section 605.3 of this manual. (Rev. 01/2013)

D. Additional Provider Information - If the provider accepts the member for service, the provider will gather any information, other than that already contained in the referral packet, necessary to complete the member's data file in accordance with the provider's requirements.

Care coordination will forward a referral packet to the provider agency within 24 hours of brokering services.

E. Care Plan Changes - If applicable, the provider must contact the care coordinator to obtain prior approval of any desired changes in amount, duration, and scope of services in the comprehensive care plan. **The provider must render services to individuals according to the comprehensive care plan**. If the provider determines that the services outlined in the comprehensive care plan are not appropriate for the member, the provider notifies the care coordinator immediately. The care coordinator makes a decision after discussions with the provider.

F. Notifying Care Coordinator - Within three business days from the date the provider evaluates the member, the provider must send to the care coordinator an EDWP Notification Form –See Appendix I of the EDWP (CCSP and SOURCE) General Manual) to advise the beginning date of service. **The provider agency's failure to initiate service as agreed on the EDWP Notification Form may result in the care coordinator's rebrokering the service with another provider and recommending adverse action against the provider agency. When rebrokering from one agency to another, collaborative communication is needed by all parties involved to ensure that there is a smooth transition, no loss of care for the member and no issues with double billing by both parties.**

G. Member Inappropriate for Services or Declines - If, after the face-to-face evaluation, a provider determines that the member is inappropriate for service, or if for any reason a member declines services from the provider, the provider must immediately telephone the care coordinator during regularly scheduled office hours and/or within 24 hours. The provider must return the referral packet with the EDWP Notification Form to the care coordinator within three business days from the date the provider determines that the member is inappropriate or the member declines services.

H. Accepting the Referral and Initiating Services - Services are required to begin within 48 hours of the provider's face-to-face evaluation of the member or at the next appropriate day as dictated by the frequency order unless extenuating circumstances delay the start of services. Within three business days of the initial evaluation visit, the provider must send to the care coordinator a EDWP Notification Form indicating the start date of services and documenting the reason(s) for any delay in starting services.

Care coordinators are required to follow up with providers who do not begin services within 48 hours of the face-to-face evaluation unless the stated reason for not starting services is justified as indicated above.

NOTE: The EDWP Notification Form and the provider referral packet may be submitted electronically using encryption or by means of a secure Web site. Rev. 1/12

### 605.3 Provider's Reevaluation of the Member - After Service Initiation

The provider agency engages a Registered Nurse to conduct initial evaluations and periodic re-evaluations of the member's medical needs during each supervisory visit or more frequently if the member's condition warrants. (Refer to service-specific manuals for frequency of supervisory visits). During the reevaluation the provider RN:

- Reviews the member's problems, approaches to those problems, and identifies responses to the approaches
- Reviews and completes needed updates to the member's care plan
- Communicates problem approaches, updates to care plans and any other pertinent information to appropriate staff caring for a member
- Communicates recommendations for changes in the member's total care and sends the EDWP Notification Form to the care coordinator.

NOTE:

A provider must secure care coordinator approval prior to changing services. Within 3 business days after receiving verbal approval from the care coordinator, the provider must follow up by sending to the care coordinator a completed EDWP Notification Form reflecting the agreed upon change(s) in service.

## 606. Member Services

### 606.1 Care Coordinator

The care coordinator assumes care management responsibilities including member assessment and development of the comprehensive care plan. The care coordinator's basic roles and responsibilities are to:

A. Investigate and refer to appropriate community resources

B. Develop the comprehensive care plan in consultation with the member and service providers

C. Identify desired member outcomes and services needed to restore or preserve member health and safety

D. Serve as a member of a comprehensive care team dedicated to effective delivery of services

E. Certify member's level of care (LOC)

F. Initiate a discharge plan at initial assessment and coordinate discharge of member

G. Implement the comprehensive care plan by recommending and coordinating the delivery of home and community-based services (HCBS)

H. Broker each EDWP (CCSP and SOURCE) service as an individual service

I. Monitor and evaluate service delivery to members to assure that services are rendered as ordered and provided in a timely and cost effective manner

**J.** Determine if services are appropriate and effective, monitor changes in member's health and review and update the comprehensive care plan at least **every 3 months. The next care plan review/update is due by the last day of the third month after the month the previous review/update was completed. (Rev. 4/2014, 7/2019)**

K. Document case activities and service information

L. Coordinate case conferences, as appropriate, with providers and member/ member's representative

M. Communicate with all agencies providing direct services to the member and resolve problems relating to coordination of services

N. Monitor frequency and amount of service in order to ensure that costs are within established limits

**O.** Initiate the Service Authorization Form (SAF) and forward copies to provider(s). ***The SAF is created from the Service Order and reflects the number of days in the month. SAFs are generated initially and when there is a change in services. A copy of the initial SAF and any revised SAFs will be forwarded to the provider(s). Rev 10/14***

P. Make referrals to Protective Services and other non- EDWP (CCSP and SOURCE) services as appropriate

Q. Arrange for emergency services

**R. Schedule and complete an annual level of care (LOC) reassessment within 60-90 days of the expiration of the current length of stay (LOS)**

**S. Arrange and complete a face to face nursing visit with the member when the member experiences a change in condition**

**T. Coordinate transfer to other services when the member needs changes or other services (discharge or transfer to a hospital, nursing home, or other community-based care).**

U. **If the member requests, assist the member with request for a hearing to appeal an adverse action affecting the member's level of services. (R through U revised 7/2015)**

606.2 **Member Care**

A. To assure that their efforts effectively complement one another and support the goals and objectives outlined in both the comprehensive care plan and the Member's Care Plan, there must be ongoing interaction among provider, care coordinator, and member/member's representative. The member's clinical record and provider's notes from case conferences must reflect adequate communication, reporting and effective coordination of services.

B. When a provider communicates with the member's physician, including telephone contacts and medical orders, the provider must adequately document the information in the member's clinical record

606.3 **Change of Member's Residence**

A. If the member changes place of residence but remains within the provider's service area, the provider must remind the member to notify the Social Security Administration of the address change. The provider will use the EDWP Notification Form to notify the care coordinator of the address change within three business days of learning of it.

B. If the member moves to another planning and service area in which the current provider is approved to render EDWP (CCSP and SOURCE) services, the provider must use the EDWP Notification Form to notify the current care coordinator, who transfers the care coordination file to the new care coordinator.

C. If the member moves to another planning and service area in which the current provider is **not** an approved EDWP (CCSP and SOURCE) provider, the provider will use the EDWP Notification Form to notify the care coordinator. **In addition, the provider must send a complete copy or summary of the member's clinical record to the current care coordinator to include in the care coordination case record.** Before placing the record in the inactive file, the provider will check to determine if the original clinical record includes the member's new address and the effective date of transfer. Upon receipt of the EDWP

Notification Form and clinical record information, the current care coordinator will transfer the copy of the member's clinical record and the original care coordination case record to the new planning and service area.

606.4 **Clinical Records**

A. A provider must maintain clinical records on all members in accordance with accepted professional standards and practices. To facilitate retrieving and compiling information, the provider must assure that clinical records are accurately documented, readily accessible, and organized.

B. A provider must protect the confidentiality of member information and safeguard against loss, destruction, or unauthorized use. The provider must have written procedures known to all staff and sub-contractor which govern the use and removal of records and the conditions for release of information.

C. The clinical record for each member must contain sufficient information to identify the member clearly, to justify the comprehensive care plan and treatment, and to document accurately the results of treatment. All provider clinical records must include the following:

1. Referral packet forwarded by the case management. The referral packet includes:

   a. Copy of Level of care and Placement Instrument, signed and dated by the physician

   b. MDS-HC V9 (includes Caps/ILOC and DONR for CCSP)

   c. Client Detail/Demographics (CCSP) or SOURCE Referral Form to include a current list of medications (Rev 10/2019, 07/2021)

   d. Appendix I- SOURCE (Rev 10/2019)

   e. Care Plan assessment including Service Order and Task Lists/initial and as updated **–(CCSP) (Rev 1/2015, 4/2017, 10/2019)**

   f. Copy of signed Authorization for Release of Information and Informed Consent (Signature Page)

   g. If client is MAO or PMAO, copy of the completed Potential EDWP (CCSP and SOURCE) MAO Financial Worksheet, which contains client signed Statement of Intent: Cost Responsibility.

h. Any other relevant information, including:

i. Psychological and Psychiatric evaluations

ii. Information about client that the provider needs before completing an evaluation/assessment

iii. Copy of the DCH Authorization for Release of Information, if applicable (See Appendix L of the EDWP (CCSP and SOURCE) General Manual)

**NOTE: If the level of care is not consistent with the comprehensive care plan, an addendum must be noted on the service order, and a copy of the Physician Change in Services Letter (Appendix EE) must be attached. (Rev. 7/2015)**

2. results of the provider's initial evaluation of the member and the provider's acceptance or reason for non-acceptance of the individual into service

3. notes from case conferences indicating results of all provider's reevaluation of the member

4. current and previously signed and dated Member Care Plans (see Appendix K of the EDWP (CCSP and SOURCE) General Manual) by the provider RN during each supervisory visit.

**EXCEPTION**: ERS and HDM services do not require member care plans.

5. documentation of supervisory visits and clinical notes signed and dated by the person(s) rendering services, and incorporated in the medical record

6. medication, dietary, treatment, and activity orders when ordered on a specific member

7. documentation of all communication (written and verbal) between the provider RN and the member's physician

8. documentation of all communication (written or verbal) between provider staff, care coordinator, and other service providers or persons involved in the member's care

9. instructions for dealing with medical emergencies of the individual member (in accordance with advance directives, if appropriate) and documented on the emergency information plan. (See Appendix U)

10. documentation of member's service on a member service record form

    **EXCEPTION**: ERS providers are not required to complete a service record form.

11. if the service is provided in the member's home, clear and specific directions to the member's home from the provider agency

12. Advance Directives, if applicable (See Appendix D of the EDWP (CCSP and SOURCE) General Manual)

13. discharge plan and, if appropriate, discharge notice

14. **copies of the comprehensive care plan, updated every 90 calendar days (rev 10/1/13)**

15. signed copy of member's rights and responsibilities (See Section 604.1 of the EDWP (CCSP and SOURCE) General Manual)

16. admission or service agreement, if applicable. Such admission or service agreements must be typed in sufficiently large, clear, and commonly used type face to be easily read, and in language which is appropriate for the educational levels and cultural backgrounds of the members.

NOTE:

Home Delivered Services providers refer to the Home Delivered Services Manual for clinical record requirements for EDWP (CCSP and SOURCE) members.

## 606.5 **Authorization for Release of Information**

- A provider is prohibited from disclosing information contained in member records to any person other than authorized representatives of DCH or providers without the expressed written consent of the member.

- A provider must use only the official Georgia Department of Community Health form to authorize release of member information (Appendix L of the EDWP (CCSP and SOURCE) General Manual). This form authorizes the sharing of member information among DCH and providers. The care coordinator will include a copy of the signed form, if applicable, in the initial referral package sent to each provider.

- To share member information with persons other than those specified above, the provider must obtain additional written authorization from the member prior to releasing any such information.

606.6 **Discharge Planning**

A. Providers and care coordinators must maintain a coordinated program of discharge planning to ensure that each member has a planned program of continuing care which meets the member's post- discharge needs.

B. The care coordinator must begin developing the discharge plan during the initial assessment. Thereafter, the provider's RN is responsible for coordinating discharge planning in consultation with the member, the member's care coordinator, the member's physician, other provider staff, other involved service agencies, and other local resources available to assist in the development and implementation of the individual member's discharge plan.

C. Member Care Plans must clearly reflect discharge planning efforts.

D. The care coordinator and providers must consider the following factors in discharge planning:

   - problem identification
   - anticipated progress
   - evaluation of progress to date
   - target date for discharge
   - identification of alternative resources for care after discharge.

E. Upon discharge, the provider will furnish an appropriate discharge summary to those responsible for the member's post-discharge care. The discharge summary must include information concerning:

   - information on current diagnoses
   - an evaluation of rehabilitation potential
   - description of course of prior treatment
   - copy of the most recent Member Care Plan
   - other pertinent information needed by post-discharge caregiver

606.7 **Discharge of Members**

If a care coordinator or UR analyst recommends a reduction or termination of service(s), the member may choose to appeal the adverse action decision and request continuation of services during the appeal process. For services to continue, the member must appeal within 10 days of the adverse action notice. If the member does not appeal, discharge from service occurs 10 days from the member's receipt of the adverse action notice.

| NOTE: |
| --- |
| Payment to the provider for delivered services continues during the appeal process. |

A. Discharge occurs when any of the following occurs:

1. The care coordinator determines that the member is no longer appropriate or eligible for services under the EDWP (CCSP and SOURCE) .

2. DMA's Utilization Review (UR) staff recommends in writing that a member be discharged from service. (See Appendix M of the EDWP (CCSP and SOURCE) General Manual.)

3. **The enrolled member has received no** EDWP (CCSP and SOURCE) **service or other reimbursable waivered service for 60 consecutive calendar days.** If a EDWP (CCSP and SOURCE) member is hospitalized, **receiving rehabilitation services in a nursing facility** or receiving Medicare Home Health Services, the member is considered to have received a reimbursable waivered service. **(Rev 1/2018)**

4. An MAO member fails to pay cost share in accordance with the provider-member agreement.

   **NOTE:** EDWP (CCSP and SOURCE) service providers may discharge a member who fails to pay cost share. However, a member cannot be discharged from EDWP (CCSP and SOURCE) for failure to pay cost share. Discharge from EDWP (CCSP and SOURCE) occurs when there is no provider who is willing to serve the member. **(Rev. 10/2015**)

5. The member/member's representative consistently refuses service(s).

6. The member's physician orders the member's discharge from EDWP (CCSP and SOURCE).

7. The member enters a nursing facility. The provider must send the notice of discharge immediately upon the member's placement in a nursing facility. **EXCEPTION**: ERS services may continue for up to 2 months (62 days) if the member is expected to return home.

8. **The member enters another home and community based waiver, such as SOURCE, ICWP or NOW/COMP. Send notice of discharge based on the discharge date negotiated with the new waiver case manager by the** EDWP (CCSP and SOURCE) **care coordinator, waiving the 30 day advance notice requirement.**
**Rev. 01/2013**

9. member exhibits and/or allows illegal behavior in the home; or member or others living in the home have inflicted or threatened bodily harm to another person within the past 30 calendar days.

10. member/member's representative or care coordinator requests immediate termination of services. The provider must document in the member's record the member's request for a change in provider.

11. member moves out of the planning and service area to another area not served by the provider.

12. member dies.

13. provider can no longer provide services ordered on the comprehensive care plan.

B. When a EDWP (CCSP and SOURCE) member is discharged from the program, the provider must deliver service through the effective date of discharge EXCEPT when any one of the following occurs:

1. member enters a nursing facility

2. **member enters another HCBS waiver program Rev 01/2013**

3. member exhibits and/or allows illegal behavior in the home or member or others living in the home have inflicted or threatened bodily harm within the past 30 calendar days.

4. member/member's representative or care coordinator requests immediate termination of services

5. member moves out of planning and service area

6. member dies.

C. In all discharges, the provider agency must:

a. Send a written notice to the member/member's representative/legal guardian and the care coordinator thirty calendar days prior to actual discharge date.

**EXCEPTION**: When UR or the care coordinator recommends discharge or the member dies.

b. Include in the written discharge notice **the effective date** of discharge **and the reason for discharge**.

c. Send the discharge EDWP Notification Form to the care coordinator.

d. Notify the member's physician

**EXCEPTION**: ERS and HDM providers send only a EDWP Notification Form to the care coordinator.

e. Document the reason for discharge in the member's record.

606.8 **Change in Level of Service**

A. A decrease in the member's level of services is appropriate when the following occurs:

1. The care coordinator, in consultation with the provider determines that the current level of service is no longer appropriate, or

2. DMA's Utilization Review (UR) recommends a reduction in the level of services (see Appendix M of the EDWP (CCSP and SOURCE) General Manual).

NOTE:

If the member files for a hearing within ten calendar days of the date of notice (adverse action letter) of the decrease or termination of services, and the member wishes to continue to receive services until the hearing decision is known, the provider will be reimbursed for services rendered, pending the outcome of the hearing.

3. If the member does not file for a hearing within the 10 days, the order to decrease the level of services will become effective as stated in the notice to the member.

B. An increase in the member's level of services is appropriate when the care coordinator determines that the current level of service is no longer

sufficient. Utilization Review Analysts may recommend an increase in services.

C. When the provider determines that a member needs an increase in level of services, the provider confers with the care coordinator to secure approval prior to increasing the level of services. Within 3 business days after receiving verbal approval from the care coordinator, the provider must follow up by sending to the care coordinator a completed EDWP Notification Form reflecting the agreed upon increase in level of services. If appropriate, the care coordinator then updates the comprehensive care plan and generates a revised Service Authorization Form (SAF).

606.9 **Medications - Monitoring and Administration**

A. Monitoring Member Medications

The provider's supervising RN must monitor all prescription and over-the-counter medications taken by EDWP (CCSP and SOURCE) members. Member records must contain the following information related to medication:

1. A current list of prescription and over-the-counter medications taken by the member, including the name of each medication, dosage, route, and frequency taken.

2. All drug side effects observed by or reported to the provider supervising RN by the member or other provider staff.

3. Documentation that the provider reports to the physician in a timely manner any problems identified with medications. The provider must record the physician's order to change any medication.

B. Administration of Medications

Only the attending physician may prescribe therapeutic or preventive medications. Only licensed nursing staff may administer medication, and only on direct orders from the physician.

**Rev. 10/13**

**EXCEPTION: Unlicensed proxy caregivers are allowed to perform certain health maintenance activities as long as they have the member's full written informed consent and are trained and certified as specified in Chapter 111-8-100 of the Rules of the Georgia Department of Community Health, Healthcare Facility Regulation Division, entitled "Rules and Regulations for Proxy Caregivers used in Licensed Healthcare Facilities."**

**Rev. 10/13**

**If a licensed nursing staff member or a proxy caregiver administers medications, member records must include, in addition to**

**information specified in 606.9A of the** EDWP (CCSP and SOURCE) **General Manual, the following documentation:**

**(1) Physician's authorization for the administration of any medication. The physician may renew this authorization on the Level of Care and Placement Instrument at the time of the member's level of care re-determination or through written physician orders at any other time.**

**(2) When obtaining a physician's verbal authorization, documentation of the consultation, and written follow up within 30 days to confirm the authorization.**

**(3) The name, dosage, route, and frequency of any medications administered by the licensed nursing staff member or proxy caregiver. The person administering the medication must sign and date all notations.**

NOTE:

In the clinical record, the provider must record physician's orders for all prescribed medications and treatments directly related to services being delivered. Over-the-counter medications, supplements, and herbs are reported to the member's pharmacist **and/or** physician by the supervising RN for determination of any possible interaction with the member's prescription/ medications. The label of a prescription medication constitutes the pharmacist's transcription of documentation of the order. Such medications should be noted in the clinical record and listed on the re-certification plan of care (HCFA-4850).

C. Assistance With Self-Administered Medications

An aide may assist the member with physician-prescribed medications that are to be self-administered. Assistance is limited to the following:

1. Reminding the member to take the medicine

2. Reading to the member the correct dosage and frequency indicated on the container label

3. Assisting the member with pouring or taking the medication

The aide will report to the RN supervisor any changes in the member's condition, including those which may be related to medications.

The provider agency, member and/or supervising registered nurse must immediately communicate any concerns regarding the member's medications, including the number or frequency in use, to the member's physician. The supervising registered nurse must report these concerns to the care coordinator within 24 hours. Within three business days of

verbally notifying the care coordinator, the provider must send a completed EDWP Notification Form to the care coordinator.

606.10 **Durable Medical Equipment (DME)**

A. For procedures relating to purchase, rental, repair, maintenance, and delivery of equipment and appliances, refer to the DMA Policies and Procedure Manual for Durable Medical Equipment.

B. Call the Provider Enrollment Unit at 1-800-766-4456 (toll-free) to request the DME service manual.

C. The provider must either assure provision of DME or make a referral to the care coordinator, as follows:

If the DME item is directly related to the service being provided under the EDWP (CCSP and SOURCE), and is reimbursable under the Medicaid program, the EDWP (CCSP and SOURCE) provider assists the member in obtaining the item through a vendor enrolled with the Division of Medical Assistance. If requested by the DME vendor, the provider assists the member in obtaining a prescription or certificate of Medical Necessity from the physician.

If the needed equipment is not directly related to the service being provided, the provider agency will alert the care coordinator, who will assist the member in obtaining the item(s) through a Medicare or Medicaid approved vendor.

~~D.~~ Within three business days of identifying the member's need for DME, the EDWP (CCSP and SOURCE) provider must send to the care coordinator a completed EDWP Notification Form.

606.11 **Non-Emergency Transportation Services (NET)**

For more detailed information, contact the NET broker serving the member's location. Refer to Appendix T of the EDWP (CCSP and SOURCE) General Manual for NET Brokers.

**NOTE: The Elderly and Disabled Waiver 1915 (c) does not include transportation in the rate for personal support or extended personal support services. NET is available to all Medicaid participants under the State Plan to provide transportation to medical appointments and for waiver services such as adult day health. A provider who allows an aide to make use of a member's or aide's car for transport needs to be sure the member's or aide's auto insurance assumes liability in case of an accident. Consider having the member or their family sign an agreement that discusses the assumption of liability in case of an accident. The provider should also carry adequate liability and**

**worker's comp insurance to cover any accidents. Any such transportation activities are at the risk of those who engage in them. Providers should consult their legal team to determine the extent of liability to which the agency may be exposed through such transportation activities, particularly if an aide assumes that this is part of their normal duties. Rev 4/2015**

606.12 **Emergency Information**

A. The provider must maintain written emergency information on each member. The emergency information must be easily accessible in the member's record and, at a minimum, include the following:

1. name and telephone number of the member's attending physician

2. member's hospital preference

3. names and phone numbers of member's representative and other emergency contacts

4. Known medication/pertinent medical information, including allergies

B. Provider staff members who deliver services must receive initial and ongoing training in dealing with medical emergencies. Provider staff must maintain current certification and/or training in basic first aid and cardiopulmonary resuscitation (CPR). Certification must be obtained through an approved, certified instructor.

**EXCEPTION**: ERS and HDM providers.

C. The clinical record must contain the member's written authorization for staff to seek emergency treatment, including transportation for treatment. **The provider must keep emergency information current by reviewing and updating it at least yearly and as needed. (See Appendix U of the** EDWP (CCSP and SOURCE) **General Manual).**

606.13 **Fees for Services**

1. A provider may not solicit or accept any contributions or gratuities from members or others for EDWP (CCSP and SOURCE) services rendered.

2. The care coordinator uses the Service Authorization Form (SAF) to indicate the amount of the cost share for each MAO member and the provider assigned to collect it.

**NOTE**: Members receiving Supplemental Security Income (SSI) are not required to pay toward the cost of their EDWP (CCSP and SOURCE) services.

3. **The** EDWP (CCSP and SOURCE) **Unit** determines the approved room and board rate for EDWP (CCSP and SOURCE) Alternative Living Services' members. **(Rev 7/2016)**

4. Providers may not charge EDWP (CCSP and SOURCE) members interest rates or late fees for EDWP (CCSP and SOURCE) services..

606.14 **Food and Nutrition**

Providers must deliver meals that meet the nutritional standards according to the specific program requirements for each service type (see Appendix O of the EDWP (CCSP and SOURCE) General Manual).

606.15 **Service Delivery Hours**

Providers rendering EDWP (CCSP and SOURCE) services in the member's home must use flexible scheduling to meet the individual member's needs and preferences for service. The provider's RN must be available to provider staff during hours that they deliver services. (See Section 601.1 M of the EDWP (CCSP and SOURCE) General Manual)

606.16 **Physician Certification**

The care coordinator orders services for members.

**A licensed physician, nurse practitioner or physician assistant must approve the member services listed on the Form 5588 (**EDWP (CCSP and SOURCE) **Level of Care and Placement Instrument) except in the following situations:**

**o The member experiences a change in condition that requires a new service, additional services (such as additional personal support service hours) or a change in the level of Adult Day Health services and the change occurs more than 60 days after the beginning date of the member's current length of stay (LOS) under a nursing home level of care (LOC). The physician's approval for new services or a change in the level of ADH services must be communicated through the physician's signature on the Physician Change in Services Letter (Appendix EE).**

**o The care coordinator adds other** EDWP (CCSP and SOURCE) **services within 60 days of the beginning date of the current LOS under a nursing home LOC. (Rev. 7/2015)**

Skilled and therapy service providers (ADH, SNS and HDS) require medical orders for specific medical procedures provided by agency staff. Physician orders for therapy services must include the specific procedures and modalities used and the amount, frequency, and duration.

**EXCEPTION:** Home Delivered Service providers must follow appropriate regulations regarding the Medical Plan of Treatment. Refer to the Department of Community Health's Policies and Procedures for Home Health Services.

**NOTE:** The care coordinator may add HDM, RC and Medical Social Services at any time

606.17 **Supervision of Services by a Registered Nurse (RN)**

Registered Nurse (RN) supervision is the provision of medical oversight to ensure that the provider serves the member effectively and safely in the community. Medical oversight includes assessing and monitoring the member's condition and implementing/arranging interventions to prevent or delay unnecessary and more costly institutional placement. A RN must supervise all EDWP (CCSP and SOURCE) services.

The registered nurse may assign certain tasks to unlicensed assistive personnel. The registered nurse will utilize the "RN Assignment Decision Tree," generated by the Georgia Board of Nursing, to assist the registered nurse in making appropriate decisions regarding whether to assign a task to an unlicensed person. The RN Assignment Decision Tree assists the registered nurse in evaluating the client care tasks on an individual client basis; it guides the nurse in assigning only those tasks that can be safely performed by trained unlicensed assistive personnel. (Refer to Appendix Z of the EDWP (CCSP and SOURCE) General Manual).

**EXCEPTION:** HDM and ERS providers

NOTE:
Refer to the specific service manual for additional staffing and supervision requirements, exceptions, or substitutions. Providers not following the required supervision policies will face adverse action, up to and including possible termination from the EDWP (CCSP and SOURCE).

A. The major tasks of the Registered Nurse include, but are not limited to:

1. Assessing and evaluating the member's needs, current status, environment, and changes during each supervisory visit or more often if indicated by member's condition

2. Reviewing the Level of Care and Placement Instrument

3. Conducting supervisory visits and re-evaluations of member care at the required frequency (refer to service-specific manual) or more often if medically necessary

**NOTE: Nursing staff are prohibited from administering medications to members or providing any other member care while conducting supervisory visits for all services except skilled nursing. For skilled nursing, the private home care provider's RN can perform a nursing visit and update the care plan as part of the same visit. Rev 4/2019**

4. Developing, coordinating, and revising member care plan. Communicating all revisions to appropriate staff.

**5.** Preparing progress/clinical notes, reviewing progress note entries of all staff, **reviewing and co-signing documentation of all LPN supervisory visits** and instructing staff on charting protocol. **The RN must indicate his/her review of notes and LPN supervisory visits, as well as the follow-up and resolution of problems, by signing and dating the documentation of all of the above. (Rev. 12/10)**

6. Conducting and maintaining ongoing communication with other service providers, the physician, care coordinator, and other relevant parties of changes in the member's medical condition or any change in member status that requires follow-up and/or additional services. The RN/provider must obtain the care coordinator's prior approval for changes in the member's service except in emergency cases.

7. Counseling and educating the member/representative, caregiver(s), and staff in meeting the member's medical and related needs.

8. Other duties assigned by the provider agency such as quality assurance activities and/or planning, scheduling and conducting in-service training sessions, etc.

9. In addition to the tasks listed above, the **Home Delivered Service RN** reviews the Medical Plan of Treatment (MPOT) and obtains the physician's dated signature a minimum of every sixty-two calendar days.

B. Nursing supervision of EDWP (CCSP and SOURCE) services must comply with the following guidelines:

1. The RN supervisor must document, sign and date supervisory visits/notes/contacts (Appendix B, Member Service Record/EVV daily/monthly aide record) and label them as such. Names and titles must be legible. **Staff may use initials if their signatures are on file**

**at the provider agency.** The supervisory RN signature must be an original, not a rubber stamp. (Rev. 7/21, 10/22)

**EXCEPTION**: An electronic signature and computer-generated signature, requiring the supervisory RNs' access codes to generate, are permitted.

2. The provider RN supervisor must conduct a face-to-face supervisory visit with the member to cover every period of service provided. If the member is not present, the visit is not considered a supervisory visit.

C. **Documentation of each RN or LPN supervisory visit must include the following:**

1. An evaluation of the member's health status and needs, noting changes in medical condition, medications, etc.

2. An evaluation of the quality of care being rendered, including member's statement of the level of satisfaction with services received

3. Results of the care being rendered

4. Planned interventions and follow-up for any problems identified

5. Any needed revisions to the member's care plan

6. The nurse's signature and date of the visit (see note below).

7. The date of the previous supervisory visit. (Rev. 4/12)

NOTE: A checklist does not replace narrative documentation, but can be used in addition to support narrative.

**NOTE: The RN or LPN who makes the supervisory visit must sign and date the documentation of the visit. If the supervisory visit was made by an LPN, the supervising RN must review and co-sign the documentation of the LPN's visit within 10 days unless otherwise stated in the provider manual for the particular service. (Rev. 12/10; 10/14).**

606.18 **Member Care Plan**

The Member's Care Plan (see Appendix K of the EDWP (CCSP and SOURCE) General Manual) reflects the provider agency's plan to deliver the services agreed upon by the provider agency, the member/member's

representative and the care coordinator based on the comprehensive care plan.

Individuals who participate in the EDWP (CCSP/SOURCE) Services Program have been determined to be at risk for nursing facility placement. Therefore, after the initial evaluation, the provider RN must review the care plan and revise, **sign and date** it as part of each supervisory visit, or as often as the member's condition requires. The provider RN communicates all revisions to the care plan to appropriate staff. The member care plan must be re-written at least once per year.

NOTE:Home Delivered Meals and Emergency Response Services do not require a member care plan.

A. The written member care plan must identify the following:

1. specific physical, mental, and social health problems of the member.

2. specific approaches that will be taken to address the member's health needs/problems

3. persons or agencies responsible for providing services to the member

4. instructions for timely discharge or referral, if appropriate

5. any other appropriate items

B. Guidelines for Preparation of Care Plan

1. The provider RN initiates member care plans within 72 hours of the provider's initial evaluation of the member. The provider RN maintains current member care plans, including any changes in effective dates of coverage. The provider RN reviews the member care plans during each supervisory visit or more often if required by the member's condition

2. The provider RN will develop the member care plan and coordinate care with input from the provider staff involved in the member's care. Provider staff must immediately bring to the attention of the provider RN any concerns about significant changes in the member's status.

3. Before a provider implements changes in frequency and type of service, the provider must discuss these care plan revisions with the care coordinator. The care coordinator must review and approve changes in services.

4. The member care plan must indicate approaches necessary to achieve identified goals (e.g., nutrition education, methods of care coordination, etc.).

NOTE: A copy of the recommended member care plan format is included in Appendix K of the EDWP (CCSP and SOURCE) General Manual. A provider may use a different format as long as it includes all elements listed on the form provided.

606.19 **Progress/Clinical Notes**

A member's clinical record must contain written progress notes, or clinical notes, which reflect the member's progress toward the goals and objectives identified in the member care plan. The RN supervising the member's care will prepare progress notes; however, any staff rendering care to the member may make notations in the clinical record. The notations may be recorded on the service form that reflects the date of service and must describe significant events/reactions/situations and follow-up which affect the member's care. All entries must be signed and dated at the time of occurrence. **The provider RN must review, sign and date all entries made by non-licensed staff.** Progress notes must be kept readily available for review by supervising personnel. The provider RN must train non-licensed staff on how, when, and where to keep progress notes. At a minimum, the provider RN must include progress note entries in the supervisory visit documentation, in accordance with the minimum frequency requirements of the specific EDWP (CCSP and SOURCE) service being delivered. (Refer to service-specific manuals).

606.20 **EDWP Notification Form**

A. Service providers and care coordinators are expected to be proactive on behalf of the EDWP (CCSP and SOURCE) member and maintain active dialogue within the care team.

The provider and care coordinator use the EDWP Notification Form (Appendix I of the EDWP (CCSP and SOURCE) General Manual) to maintain an ongoing, documented dialog concerning:

- Beginning date of services (**When rebrokering from one agency to another, collaborative communication is needed by all parties involved to ensure that there is a smooth transition, no loss of care for the member and no issues with double billing by both parties.)**
- Reason(s) for delay in starting services
- Acceptance or rejection of member referral following the initial evaluation

- Provider's evaluation that the member is inappropriate for EDWP (CCSP and SOURCE) services
- Member address change
- Changes in member's situation or environment (including social supports)
- Changes in the member's physical or mental condition/status
- Recommendations for changes to the care plan, including changes in services that increase or decrease the total cost of services.

NOTE:

If visit(s) is (are) shortened or omitted due to a member's absence, the provider may submit a completed EDWP Notification Form on the last working day of that month. Use the EDWP Notification Form to notify Case Management of emergency frequency changes that occur and need adjustments made to the PA. Examples- Pssx care cut short and Pss units need added to the PA on Gammis. ADH full day cut short and ADH partial day needs added.

- Concerns regarding the number and frequency of member's self-administered medications
- Provider identification of member's need for durable medical equipment
- Member discharge
- Problems with cost share collection

If any of the above occurs, the provider must telephone the care coordinator within 24 hours and will submit the completed EDWP Notification Form to the care coordinator within three business days of the change or action.

The procedure for notification is as follows:

1. Notification Regarding New Members:

   Refer to Section 605.2 of the EDWP (CCSP and SOURCE) General Manual

2. Notification Regarding Changes in Services:

Service providers must contact the care coordinator either before providing the service or the next business day. The provider must request all changes in service by completing the EDWP Notification Form and forwarding it to the care coordinator.

**The provider must obtain approval from the care coordinator <u>prior</u> to rendering a new service.**

Within three business days after receiving the EDWP Notification Form, the care coordinator will initial, date, and return the EDWP Notification Form to the provider, approving or denying the change in service.

If changes in the comprehensive care plan are approved, the care coordinator will revise the comprehensive care plan to reflect the changes and forward a copy to the provider(s). The provider RN will revise the member care plan to reflect the changes in the member's care.

<u>Non-Emergency Service</u> - If the provider and/or provider RN determines that the member needs a change in service, the provider must obtain approval from the care coordinator **before** initiating a change in service. The provider must telephone the care coordinator on the first business day following the determination that a member needs a change in service and must follow up with a completed EDWP Notification Form within three (3) business days.

<u>Emergency Visit</u> - If the provider and/or provider RN determines an emergency visit is required, the provider must immediately call the care coordinator and follow up with a EDWP Notification Form within three (3) business days. Examples of emergency situations include, but are not limited to:

- loss of caregiver support
- need for urgent care
- need for immediate attention due to compromised safety or health.

<u>Exceeding the Authorized Cost</u> - If a needed change in service (emergency or non-emergency) would cause the cost of care to exceed the amount authorized on the Service Authorization Form (SAF), the provider RN must obtain payment authorization in accordance with <u>Chapter 800 of the</u> EDWP (CCSP and SOURCE) <u>General Manual.</u>

1. Change in Address

a. If a member moves to another address within the same Planning and Service Area, OR moves to another Planning and Service Area in which the current provider is approved to render services

The provider must:

- telephone the care coordinator, within 24 hours of learning about the member's move
- send a completed EDWP Notification Form to the care coordinator within 3 business days advising of the address change
- transfer member records to the office serving the member's new address, if applicable

b. Member moves to another Planning and Service Area in which the current provider is not approved for service

The provider must:

- telephone the care coordinator, within 24 hours of learning of the address change
- send a completed EDWP Notification Form to the care coordinator, within 3 business days
- send a discharge EDWP Notification Form and a statement summarizing the services provided to the member, the reason for the member's move, and any special concerns to the care coordinator

B. Other Changes that Affect the Plan/Delivery of Care

- The provider will send a completed EDWP Notification Form to the care coordinator, within 3 business days
- The provider will telephone the care coordinator within 24 hours of learning of the change in the member's status (e.g., physical or social health status, informal support system, environmental/community status, etc.).
- The provider sends a completed EDWP Notification Form to the care coordinator within three business days. (Performance of the online incident report is required for ER, Hospitalization or Death)

C. Nursing Facility Placement

- The provider will telephone the care coordinator and follow up with a completed EDWP Notification Form to the care coordinator within three business days of learning that the member has been admitted to a nursing facility.

- **If a nursing facility discharges a member who needs** EDWP (CCSP and SOURCE) **services reinstated, the nurse care coordinator must complete a face to face review of the member within 48 hours of having received notice of the discharge, to assess the need for services not currently included on Form 5588 (**EDWP (CCSP and SOURCE) **Level of Care and Placement Instrument). If new services are indicated, the nurse care coordinator must document the new services on the EDWP Modified Assessment Form (Appendix QQ of this manual) and submit a request for approval to the member's physician on the Physician Change in Services Letter (Appendix EE). See Section 605.1 E of this manual for more information on the modified assessment. (Rev. 7/2015, 7/2019)**

- Providers who render services to members without a current EDWP (CCSP and SOURCE) Level of Care and Placement Instrument will not receive Medicaid reimbursement.

## 606.21 Potential Medical Assistance Only (PMAO) Members

**PMAO members** have incomes which exceed the current Supplemental Security Income (SSI) level. PMAO Members, screened by care coordinators and providers to determine their potential eligibility for EDWP (CCSP and SOURCE) Medicaid benefits, may be required to pay toward the cost of their EDWP (CCSP and SOURCE) services (cost share).

A. Brokering PMAO Members - PMAO members, who do not yet possess current Medicaid member numbers, are determined eligible for Medicaid services by the Division of Family and Children Services (DFCS). Care coordinators will broker services for Potentially Medical Assistance Only (PMAO) members with providers. If the member is PMAO:

1. During assessment, the care coordinator must inform the member of the possible requirement to pay a portion of the cost of services (cost share), and must discuss the Medicaid eligibility process with the member/representative.

2. Both the care coordinator and the service provider must reinforce the member's cost share responsibility by clearly informing the member that if cost share is not paid, the member is at risk of losing EDWP (CCSP and SOURCE) services.

3. The care coordinator must include in the referral packet sent to the provider a copy of the PMAO Financial worksheet indicating estimated cost share.

4. Once the care coordinator receives a EDWP Notification Form verifying that the PMAO member has begun receiving service, the care coordinator must advise the member to apply for Medicaid benefits through the local County DFCS, and will assist the member in arranging transportation to DFCS if necessary.

5. Within two weeks of referring the member to DFCS, the care coordinator must contact the County DFCS to determine the Medicaid application date and/or if the member has been interviewed.

6. The care coordinator must make a good faith effort to ensure that the member is proceeding with the Medicaid eligibility process. If the care coordinator determines that the member is having difficulty with the process, a case conference is scheduled with the member and DFCS to define areas where assistance is needed.

7. Within 45 days of the Medicaid application date, the care coordinator must contact DFCS to ascertain the member's eligibility status. If DFCS has not yet determined the member's Medicaid eligibility, the care coordinator will contact DFCS at least every two weeks until eligibility is established.

B. Accepting a PMAO member - When the provider accepts a referral for a PMAO member, the care coordinator must give the member a **written** estimate of the cost share amount **prior** to the delivery of services.

   The provider must inform the member in writing that the member is responsible for the total cost of all services rendered if DFCS later determines that the member is ineligible for Medicaid, or if the member fails to proceed with the Medicaid application.

C. Cost Share Collection -The provider must have written policies clearly describing cost share billing/collection and refund policies and procedures. For PMAO members, the provider may either:

   1. collect only the estimated cost share from the member. If this method is chosen, services to the member must be delivered before collecting cost share. The provider must bill the member for cost share at least monthly. The provider is not required to wait until the end of the month before collecting cost share, but may collect cost share as service is provided until the provider has collected the entire cost share.

**EXCEPTION:** ALS providers may collect cost share at the beginning of the service month.

**or**

2. collect the entire cost of service from the member until DFCS establishes Medicaid eligibility

Prior to delivering service, the provider must furnish the member written notice as to which of the above collection methods will be used.

D. Reconciliation of the Member's Account - Within 30 calendar days of receipt of the SAF(s) showing the actual cost share, the provider must return any excess cost share collected, or bill the member for any remaining cost share due the provider. A member determined ineligible for Medicaid is responsible for the entire cost of services delivered.

E. Reimbursement from Medicaid - The provider may not submit claims for Medicaid reimbursement until DFCS assigns the member a Medicaid member number. Within three business days of the receipt of the EDWP (CCSP/SOURCE) Communicator (CCC), Form 5590, from DFCS, the care coordinator must generate Service Authorization Forms showing the member's Medicaid member number and actual cost share. (Refer to Chapter 700 of the EDWP (CCSP and SOURCE) General Manual).

F. Member MAO Eligibility - Once eligibility is established and the actual cost share is determined, the PMAO member becomes MAO eligible.

NOTE:

In situations where a member's cost share is reduced after the member has paid, the care coordinator will adjust the SAF to enable the provider to bill Medicaid for the difference. The provider's cost share policy will state if the overpayment shall be credited or refunded.

## 606.22 **Medical Assistance Only (MAO) Members**

A Medical Assistance Only (MAO) member is one who receives Medicaid benefits but who receives no cash assistance such as Supplemental Security Income (SSI). MAO members may be required to pay toward the cost of EDWP (CCSP and SOURCE) services (cost share).

A. Cost Share Collection

1. The EDWP (CCSP and SOURCE) provider must furnish the member a written statement of the amount of cost share, if any, each month cost share is due.

The monthly statement will include:

ii. The date of the statement
iii. The amount due,
iv. The date payment is due
v. The statement that, "If the bill is not paid within 30 calendar days, discharge from the agency will be effective the 46th calendar day from the date of this statement".

2. Providers will bill for cost share at least monthly.

(See Section 606.13 A2 of the EDWP (CCSP and SOURCE) General Manual).

B. Members Failing to Pay Cost Shares

The provider may discharge a member from service for failure to pay cost share after the provider has given appropriate written notice on the monthly statement (see Section 606.22 A1of the EDWP (CCSP and SOURCE) General Manual).

The care coordinator and provider will advise members and/or member's representatives that providers may discharge members who fail to pay cost share.

If the member does not pay cost share by the 31st day, as indicated on the monthly statement, the provider will notify the care coordinator that services will be discontinued on the 46th day from the date of the statement.

Within three business days, the provider will submit a EDWP Notification Form and a copy of the cost share bill to the care coordinator (see Section 606.13 of the EDWP (CCSP and SOURCE) General Manual).

If the Care Coordinator attempts to broker the service with another provider, the Care Coordinator will inform the potential/subsequent provider of the member's failure to pay the required cost share to the current provider(s).

Care coordinators will frequently discuss cost share with members but will not engage in collection activities.

Providers who have difficulty collecting cost share will discuss the problem with the care coordinator as soon as it occurs.

## 607 **Staffing**

### 607.1 **General**

A. Staff Qualifications –The provider must employ a sufficient number of qualified and experienced staff members who are appropriately skilled and available to render services in their approved service areas in accordance with currently accepted standards of medical practice (refer to the service-specific manuals for program requirements related to staffing). Providers are required to screen each potential employee for competency.

Personnel providing EDWP (CCSP and SOURCE) services must:

- be qualified by education, training and/or experience to perform the tasks assigned
- fulfill all training requirements
- undergo criteria-based job performance evaluations of their job performance at least annually, including evaluation by members at least annually.
- be supervised by appropriately credentialed staff who are licensed and accountable for quality service and outcomes

B. Registered Nurse (RN) Supervision and Credentials - All EDWP (CCSP and SOURCE) services (except ERS and HDM) require that a licensed RN supervise the services delivered to EDWP (CCSP and SOURCE) members. Refer to the service-specific manuals for information regarding other required licenses.

C. Licensure – Providers maintain evidence of current licensure for all staff members in occupations requiring Georgia licenses or permits

D. Designated Professional Staff - A licensed professional, designated to provide professional supervision and oversight, will be available to staff at all times that services are being rendered to members.

E. Designated Management Staff - The provider must designate a responsible staff person to act as manager in the administrator/manager's absence.

F. **NOTE:** All provider staff members responsible for documentation of member records must be identified by name and discipline and include a sample of the staff member's signature and initials. This legend must be on file with provider agency and available at the agency place of business.

## 607.2 Volunteers

Providers may use volunteers to provide EDWP (CCSP and SOURCE) services, provided they meet the same qualifications required of paid staff. The provider is responsible for the supervision and performance of any volunteer who provides direct member service for the provider agency.

## 607.3 Personnel Policies

A. The provider must have written personnel policies and procedures.

B. The provider must establish and maintain current personnel records for all staff and volunteers. Each personnel record must include the following, at a minimum:

1. criteria-based job description, signed and dated by the employee
2. criteria-based performance evaluation
3. job application and/or resume
4. proof of current Georgia licensure, if applicable
5. documentation of knowledge of agency's policies related to Member Protection Assurances
6. documentation of all training completed
7. proof of satisfactory physical examinations and tuberculosis screening, as required- See 1406 Chapter 1400 Policies and Procedures for EDWP Personal Support/CD PSS/SFC Policy Manual.
8. signed and dated copy of the code of ethics.
9. evidence of a satisfactory criminal history background check determination (Georgia Applicant Processing Service (GAPS)/(Fieldprint))

C. Code of Ethics - All providers must have an ethics policy which is signed and dated by all persons under the provider's direction. The ethics policy, at a minimum, must prohibit employees, volunteers or contracted individuals from:

1. using the member's car for personal reasons
2. consuming the member's food or beverage
3. using the member's telephone for personal calls
4. discussing political or religious beliefs, or personal problems with the member
5. accepting gifts or financial gratuities (tips) from the member or member's representative
6. lending money or other items to the member; borrowing money or other items from the member or member's representative
7. selling gifts, food, or other items to or for the member
8. purchasing any items for the member unless directed in member care plan
9. bringing other visitors (e.g., children, friends, relatives, pets, etc.) to the member's home
10. smoking in the member's home
11. reporting for duty under the influence of alcoholic beverages or illegal substances
12. sleeping in the member's home
13. remaining in the member's home after services have been rendered

## 607.4 **Personnel Under Contract**

All agreements with contracted personnel including those responsible for their own withholding taxes, must be in writing. Refer to Section 601.1 J of the EDWP (CCSP and SOURCE) General Manual.

A provider may delegate authority, but responsibility for performance of individuals under contract may not be delegated to another agency or organization.

607.5 **Staff Development and Training**

A. The EDWP (CCSP and SOURCE) provider is responsible for developing and implementing a continuing education program for all employees/staff members, subcontractors and volunteers of the agency. Continuing education will consist of orientation for all new employees/staff, subcontractor's and volunteers and ongoing staff development and training programs related to the responsibilities of each individual's position.

NOTE: Provider agencies licensed by the Healthcare Facility Regulations Division must comply with all rules and regulations related to certification and/or training in cardiopulmonary resuscitation, emergency first aid, and continuing education.

B. The provider must furnish all staff development and training opportunities related to the performance of their jobs. In addition, provider staff and volunteers, if applicable, must attend EDWP (CCSP and SOURCE) training sessions as requested or required.

C. Providers must develop an ongoing in-service training plan and schedule for staff, subcontracted individuals, and volunteers. For all EDWP (CCSP and SOURCE) services except ERS and HDM, the plan must include, at a minimum, the following topics:

- orientation to the agency
- EDWP (CCSP and SOURCE) overview including program policies and procedures
- sensitivity to the needs and rights of older individuals
- re-certification and/or training in techniques of first aid and cardiopulmonary resuscitation (CPR)
- member rights/Elder Abuse Reporting Act/Advance Directives
- Personnel Code of Ethics
- Business Ethics
- infection control procedures (see Appendix Q of the EDWP (CCSP and SOURCE) General Manual)
- fire safety and accident prevention and safety

- confidentiality of member information
- medication management
- disaster planning/emergency procedures
- caring for members with Alzheimer's and related illnesses.
- Incident reporting and investigation requirements as outlined in Section 601.6

The provider must establish and maintain records to document the implementation of the training plan including, the name(s) and credentials of the trainer(s), training date, content, length of time and persons attending for each training.

For ERS and HDM providers, in-service training must include orientation to the agency, EDWP (CCSP and SOURCE) policies and procedures, and other service related training as required.

For Case Management providers, a certification curriculum provided by DCH is required. The testing will include online module performance. Topics will include waiver eligibility and program options, quality management requirements, case management roles and responsibilities and person-centered planning. Existing case management will have 6 months to complete the required certification and new hires must complete training within 60 days from the hire date. DCH also requires attendance by Lead Case Management at quarterly "Train the Trainer" meetings. (rev 10/2019)

D. All administrative and non-direct member care staff will demonstrate awareness and working knowledge of the topics listed in section 607.5C of the EDWP (CCSP and SOURCE) General Manual. In addition, all administrative and non-direct member care staff will receive training in:

- Business Ethics
- Financial Planning
- Medicaid Waivers
- Medicaid and Medicare Benefits

E. The EDWP (CCSP and SOURCE) provider will establish and maintain records that document the orientation and on-going staff development and training of each individual. The records will, at a minimum, include:

- the topic presented

- the name(s) and credentials of the trainer(s)
- the training date,
- the length of time of the training
- an outline or description of the content of the training
- the name of each individual who attended the training

F. ERS and HDM providers will include an orientation to the agency, EDWP (CCSP and SOURCE) policies and procedures, and other service related training as required for the orientation and staff development and training for their employees/staff, subcontractor's and volunteers.

## 608. **Environmental Safety Procedures**

### 608.1 **Disaster Preparedness**

The provider must establish and maintain written policies and procedures for members and staff to follow in the event of a disaster, to include procedures to see that care is provided during emergency situations (e.g., flood, fire, bomb threat, etc.) that may impede the provider's ability to reach members' homes.(Refer to *Rules and Regulations for Disaster Preparedness Plans, Chapter 290-5-45*). Procedures for disasters occurring at a EDWP (CCSP and SOURCE) facility must also be included.

A. Triage Levels

The provider establishes and maintains policies and procedures for assuring that a system of contingency plans for emergencies or disasters is in place. These plans will assure back-up care when usual care is unavailable and the lack of immediate care would pose a serious threat to the health, safety, and welfare of the member.

These policies and procedures should provide uninterrupted service according to the priority levels identified by the care coordinator for each member enrolled in the CCSP AND SOURCE. These policies and procedures include:

- Delivery of member service(s).
- Staff assignment and responsibilities.
- Names and phone numbers of the EDWP (CCSP and SOURCE) Unit, Area Agency on Aging, care coordination staff., and if applicable, the

Healthcare Facility Regulations Division and Long Term Care Ombudsman.

- Notification to care coordination, attending physicians, and responsible parties.
- Availability of members' records.

Emergencies include, but are not limited to, the following:

- Inclement weather (heavy rains, snow storm, etc.).
- Natural disasters (flood, tornado, hurricane, ice storms, etc.).
- Major industrial or community disaster (power outage, fire, explosion, roadblocks).
- Agency employee illness or severe staffing shortage affecting significant number of employees.
- Damage, destruction or fire at the agency's location.
- Remote areas where transportation would be limited.
- Suspected abuse, neglect and/or exploitation.

Communication with care coordination is an essential component to this process. Using the EDWP Notification Form, the provider will notify the care coordinator if he is not in agreement with the assigned Triage level. Assigned Triage levels will be documented in the comment section of the Comprehensive Care plan. Care coordinators will use the following to assign Triage levels.

**Level One members:**

- Require only minimal amount of care
- Require less complex treatments and/or observation and/or instruction
- Provide self-care, ADLs, or have a willing and able-bodied caregiver
- Do not exhibit any unusual behavioral problems

**Level Two members:**

- Require an average amount of care
- No longer experiencing acute symptoms

- Require periodic treatments and/or observation and/or instruction
- Require some assistance with ADLs, require help for limited periods, or have willing and capable caregivers
- Exhibit some psychological or social problems

**Level Three members:**

- Require an above average amount of care
- Require daily treatment and/or observation and/or instruction
- Have willing caregivers whose capabilities are limited
- Require assistance with ADLs
- Ambulate with the assistance of two people
- Exhibit disorientation or confusion

**Level Four members:**

- Require a maximum amount of care and have no caregivers in the home
- Exhibit acute symptoms
- Are confined to bed
- Require complete care
- Require treatment and/or procedures necessary to sustain life

B. Staff Training and Drills

• The provider must assure that all staff members are provided ongoing training in disaster preparedness. The training program must include drills so that employees are able to promptly and correctly carry out their assigned roles in case of a disaster.

• Disaster drills must be conducted at least annually and must be documented as to date, time, staff/member participation, problems, and action taken to prevent problems from recurring.

C. Posting of Instructions

- The provider posts emergency instructions and evacuation routes in a prominent place in each room of the facility and orients all members to these routes.

608.2 **Evacuation Procedures**

Evacuation drills must be **conducted at least every other month** in all EDWP (CCSP and SOURCE) facilities and must be documented. A designated place for members and staff to meet outside the facility following evacuation must be described in the written disaster procedures. One or more staff members must be assigned to make sure everyone is out of the building.

608.3 **Smoking Control**

If RC, ADH, and ALS providers permit smoking in a facility providing EDWP (CCSP and SOURCE) services, the provider must designate a separate and distinct smoking area. All smoking is confined to the designated area.

## 609. Program Evaluation

609.1 **General**

The Georgia Departments of Human Services and Community Health monitor program administration and perform utilization reviews of member services and care. Providers will develop a written continuous quality improvement plan that addresses how the agency determines the effectiveness of services, identifies areas that need improvement, and implements programs to improve services and quality of care.

609.2 **Program Evaluation and Customer Satisfaction**

A. Providers must establish and adhere to policies for program evaluation and conduct comprehensive reviews of their programs at least once a year. Provider agency administrative and program staff, members, and members' representatives participate in the review.

The provider agency will determine who will conduct self-evaluation reviews and will establish written policies and procedures for conducting them. At a minimum, the comprehensive program evaluation consists of a review of the agency's administrative policies and procedures, members' clinical records (available to authorized staff only), and members' satisfaction with services.

1. Policy and Administrative Review: The provider reviews policies and procedures at least annually and revises them as needed. The provider indicates in policy how changes in agency policies and procedures are communicated to all staff.

2. Clinical Record Review: The provider will monitor and review a 25% random sample or a minimum of 50 records (both active and closed clinical records), whichever is less, to:

    - assure that staff follow established policies and procedures in providing services
    - determine the adequacy of member care plans
    - determine the appropriateness of staff decisions regarding the particular care ordered for members.

    The review must include a summary of the program's effectiveness and a plan and time frame to correct deficiencies. The provider must maintain review results in the administrative files and keep them available for review when requested.

3. Member Satisfaction: The agency must conduct quality improvement activities which include collection, measurement and evaluation of member satisfaction with the services provided by the agency. The member satisfaction review must include direct communication with members. The provider agency's quality improvement activities must include:

    - publication of a local or toll-free telephone number for a designated staff person responsible for addressing quality improvement issues, member complaints, and conducting ongoing member satisfaction activities. The contact telephone number must be distributed to all EDWP (CCSP and SOURCE) members and/or member representatives
    - routine assessments of member satisfaction during supervisory visits. For frequency, refer to the requirement for supervision indicated in each service-specific manual.
    - collection and analysis of feedback regarding service staff reliability, responsiveness, competency, empathy, and courtesy
    - specific time frames for reporting, investigating and resolving service complaints
    - specific activities for addressing results of quality improvement activities.

B. The provider maintains a written report describing the findings of the evaluation and any corrective action taken. The provider must document follow-up to assure the issues have been resolved.

## 609.3 **Program and Administrative Monitoring (Rev 7/2016, 10/2016)**

The EDWP (CCSP and SOURCE) Unit uses results of monitoring by various entities to determine provider compliance with EDWP (CCSP and SOURCE) requirements.

A. Following policy set forth in Georgia's Elderly and Disabled 1915(c) Home and Community-Based Services Waiver, program specialists from the EDWP (CCSP and SOURCE) Unit/Waiver Quality Unit at DCH perform unannounced program integrity site visits on 25% of all active EDWP (CCSP and SOURCE) providers during each state fiscal year. Site visits are made on Alternative Living Services (ALS) Family and Group model homes, Personal Support Services (PSS) agencies and Adult Day Health (ADH) facilities. The compliance site visit involves completion of a monitoring tool that surveys the provider's compliance with EDWP (CCSP and SOURCE) program policy, supervision of the member and adherence to the member's care plan. A customer satisfaction survey is administered to at least one EDWP (CCSP and SOURCE) member during each site visit. Results of these visits can identify deficiencies that require corrective action from the provider.

B. The DCH Program Integrity Section in the Office of Inspector General conducts utilization reviews and audits.

C. The Healthcare Facility Regulations Division of DCH issues permits and licenses for adult day care facilities, personal care homes, private home care providers and home health agencies. In addition, the HFRD investigates complaints and conducts inspections to determine ongoing compliance with licensure requirements.

## 609.4 **Utilization Review**

A. The DCH performs periodic Utilization Reviews of EDWP (CCSP and SOURCE) member services to assure the medical necessity for continued care and the effectiveness of the care being rendered. Each provider is reviewed as frequently as deemed appropriate or necessary, with on-site reviews or audits sometimes conducted with no prior notice.

B. During each review visit, the DCH examines member records and conducts in-home or on-site individual member assessments.

1. The DCH examines member records to assure that they contain the following:

    - a current Level of Care and Placement Instrument that is signed, dated, certified, and initialed

- physicians' orders if applicable
- provider care plans
- documentation of services provided, their frequency, and appropriateness of service revisions
- documentation of supervisory visits.

2. The DCH conducts on-site assessments of members to determine if the member's condition warrants continuation of the current level of services rendered by all providers. The assessments determine whether:
   - additional needs exist
   - care provided is adequate
   - services have been effective
   - alternative methods of care should be considered

C. Alliant Health Solutions routinely provides the EDWP (CCSP and SOURCE) Unit with copies of Utilization Review reports. EDWP (CCSP and SOURCE) Unit staff members review each report and the provider's written response to all deficiencies cited in the report.

D. Upon completion of the on-site visit, the DCH forwards to the provider a written report of the Utilization Review findings. The provider must submit a corrective plan of action to the DCH within fifteen (15) calendar days of the date of the utilization review report. **The provider's failure to comply with the request for a corrective plan of action may result in adverse action, including suspension of referrals or termination from the program.**

E. When Utilization Review reports include recommendations for changes in member services, the DCH will mail the report to the provider five business days prior to mailing the member letter(s). The member has the right to appeal any adverse action recommendations made by the DMA. Adverse actions imposed by DMA include:

1. reducing service(s)
2. terminating service(s)
3. determining service is inappropriate

- If the member appeals by filing for a hearing within ten calendar days of the date of the member letter, the member may continue to receive services until the Administrative Law Judge (ALJ) makes a decision. Providers must consult with the care coordinator to confirm that the member has requested a hearing within ten calendar days and wishes to remain in service. The DCH will reimburse the provider for services rendered during the hearing process if the member's request for hearing was filed within the ten calendar day limit.

- If the member does not file for a hearing within ten calendar days of the adverse action letter, the DCH's recommendation becomes effective at the end of the ten calendar days as stated in the utilization review report and the DMA notice to the member. However, the member has the right to request a hearing within 30 calendar days from the date of the member's letter. (See Appendix M of the EDWP (CCSP and SOURCE) General Manual).

## PART II - CHAPTER 700

## ELIGIBILITY CONDITIONS

701. **General**

The DMA reimburses enrolled providers for EDWP (CCSP and SOURCE) services provided to eligible persons only. Eligible persons are those who:

1. have been determined Medicaid eligible or potentially Medicaid eligible
2. have been assessed appropriate for the EDWP (Community Care/SOURCE Services Programs) by the care coordinator
3. are certified for a level of care appropriate for placement in an intermediate care facility
4. are in need of service(s) which can be provided by the EDWP (CCSP AND SOURCE) at less cost than the Medicaid cost of nursing facility care

NOTE: Rev 4/2021

A member may **NOT** participate in more than one Medicaid waiver program/duplicative service programs at the same time. However, a provider may participate in more than one Medicaid waiver program.

Medicaid Waiver Programs include:

- EDWP (CCSP/SOURCE)
- Independent Care Waiver Program (ICWP)
- Comprehensive Supports Waiver (COMP formerly CHSS)
- New Options Waiver (NOW formerly MRWP)

Other Service Programs include:

- Georgia Pediatric Program (GAPP) / Medicaid State Plan

702. **Verification of Medicaid Eligibility**

Medicaid Eligible Members

The care coordinator must verify a member's Medicaid eligibility prior to brokering services with a provider. The provider verifies eligibility monthly thereafter by checking the member's Medicaid card at www.mmis.georgia.gov **. A copy of the Medicaid Card is included in Appendix BB.** If the member is

ineligible for Medicaid benefits, the DMA does not reimburse a provider for services rendered. Refer to Section II of the DCH Part I Policies and Procedures Manual's Billing Appendix for additional methods to check Medicaid eligibility.

PMAO Members

Care coordinators broker potentially medical assistance only (PMAO) members with providers. Providers may not bill Medicaid for services rendered to PMAO members until the care coordinator has issued SAFs reflecting the member's Medicaid member number.

In cases of lost or stolen Medicaid cards or other emergency situations, a provider may verify Medicaid eligibility for the current month by calling the Verification Unit at the Division at 1 (800) 766-4456.

To verify Medicaid eligibility for past months, a provider may request information in writing from:

Division of Medical Assistance
Medicaid Card Control Unit
P.O. Box 38435
Atlanta, Georgia 30334

The request must include the following information:

1. Member's name exactly as it appears on the Medicaid card
2. Member's Medicaid or Social Security number
3. Member's birth date
4. Dates for which the provider is requesting verification
5. Return address of provider agency

NOTE: Refer to Section 606.21 E of the EDWP (CCSP and SOURCE) General Manual.

## PART II - CHAPTER 800

## PAYMENT AUTHORIZATION

If the provider anticipates that the member's service costs will exceed the level of service(s) authorized, the provider must notify the care coordinator.

Close communication with the care coordinator is important in the prior approval / prepayment request process. The care coordinator consults with the provider to determine if a reassessment is needed when the member's need for services increases.

### 801. Prior Approval (Rev 7/2016)

If, prior to the beginning of the service month, the provider anticipates that the member's service costs will exceed the authorized cost:

- The provider must call the care coordinator and request approval to increase the level of services. If the care coordinator agrees, the increased level will be approved.
- Within three business days of the care coordinator's verbal approval, the provider will complete the EDWP Notification Form, attaching the physician's order or other relevant medical/social information, if applicable, and send it to the care coordinator.
- The care coordinator will then complete the DMA-80, if necessary, and submit it to the EDWP (CCSP and SOURCE) **Unit**. (See Appendix R of the EDWP (CCSP and SOURCE) General Manual)
- The EDWP (CCSP and SOURCE) Unit will send the approval to the care coordinator who will forward it to the provider.
- If the care coordinator does not approve the additional service level, additional services will not be authorized.

### 802. Prepayment Review

If an unforeseen emergency not anticipated at the beginning of the service month causes the level of a member’s services to exceed the level of services authorized, the provider may request a prepayment review. A prepayment review is appropriate only in an emergency situation.

- The provider must contact the care coordinator to advise that services have been provided at a higher level and that a EDWP Notification Form is forthcoming.

- If the care coordinator agrees that the higher service level is appropriate, the provider must send to the care coordinator the completed EDWP Notification Form and any attachments such as physician's orders and additional medical/social information, by the 15th day of the month following the month in which service(s) were rendered.

- The care coordinator will complete the DMA-80, (see Appendix R of the EDWP (CCSP and SOURCE) General Manual) if necessary, and submit it to the EDWP (CCSP and SOURCE) Unit for approval.

- The EDWP (CCSP and SOURCE) Unit will send the approval to the care coordinator who will forward it to the provider.

- If the care coordinator does not approve the higher service level, additional services will not be authorized, and the provider will not be reimbursed for the higher level of services.

803. **DMA-80s for PMAO Members**

Care coordinators may **not** submit DMA-80 requests for PMAO members who are in the eligibility determination process and do not yet have a Medicaid number. Once DFCS verifies the member's Medicaid eligibility, the care coordinator must complete the DMA-80s for retroactive reimbursement, attach a copy of the EDWP (CCSP/SOURCE) **Communicator** (CCC), and forward with a completed **Care Coordination Transmittal** to the EDWP (CCSP and SOURCE) Unit as a **prepayment review.**

NOTE:
If ERS installation is the sole reason for the cost of the member's service(s) exceeding the cost limit, the care coordinator is not required to submit a DMA-80 to the EDWP (CCSP and SOURCE) Unit. The care coordinator may approve the installation at the local level and the provider may proceed with installation immediately.

804. **Cost Share and the EDWP (CCSP and SOURCE) Cost Limit**

Cost share is the amount that a member pays towards the cost of waiver services.

To determine the amount billed to Medicaid, the care coordinator determines the total cost of services and deducts the cost share.

The care coordinator and the provider determine if the cost of the member's services are within the cost limit.

## PART II - CHAPTER 900

## SCOPE OF SERVICES

901. **Covered Services**

The DCH reimburses providers only for EDWP (CCSP and SOURCE) services:

A. rendered by approved enrolled providers who comply with the policies and procedures contained in the:

- DCH Part I Policies and Procedures Manual
- Part II Chapters 600 – 1000 Policies and Procedures for EDWP (CCSP/SOURCE) Services General Manual
- EDWP (CCSP and SOURCE) policies and procedures contained in service specific manuals.

B. supervised by staff as required in the appropriate service Policy and Procedure Manuals

C. ordered on the Comprehensive Care Plan by the EDWP (CCSP and SOURCE) EDWP (CCSP and SOURCE) care coordinator and reflected on the SAF

D. provided to persons who are Medicaid eligible at the time the services were rendered

E. provided to persons who are certified for a level of care appropriate for placement in an intermediate care facility

F. If an individual is enrolled in the EDWP (CCSP and SOURCE) waiver and is diagnosed with a terminal illness, he/she may elect to enroll in a hospice program. He/she may continue to receive waiver services that are not duplicative of hospice services.

An individual who is not enrolled in the EDWP (CCSP and SOURCE) and is receiving hospice services may be referred to the CCSP AND SOURCE. If the individual meets eligibility criteria for CCSP AND SOURCE, the individual may receive EDWP (CCSP and SOURCE) services that are not duplicative of hospice services. The hospice agency continues to assume full responsibility for the professional management of the individual's hospice care in accordance with the hospice Conditions of Participation

Waiver services that are not duplicative of hospice services are:

- Adult Day Health
- Home Delivered Meals

- Extended Personal Support (Respite)
- Alternative Living Services *
- Emergency Response Services
- Structured Family Caregiver * (Rev 7/2019, 1/2020)

***EXCEPTION ALS: An EDWP (CCSP and SOURCE) member receiving hospice services in a private home can choose/coordinate his/her own placement into a personal care home or accept hospice services after already residing in the ALS. The hospice agency does not coordinate the placement/services for the benefit of the agency. The hospice agency will continue to assume full responsibility for the professional management of the individual's hospice care in accordance with the hospice Conditions of Participation. (Rev. 7/2015, 1/2020)**

***EXCEPTION SFC: See Part II Chapter 1400 Policies and Procedures for** EDWP (CCSP and SOURCE) **Personal Support Services/Consumer Direction/Structured Family Caregiver 1407.6 (#4) and 1407.7 (#3)** (Rev. 1/2020)

Requests or claims for other waiver services while enrolled in a hospice program will be denied.

901. 1 **Waiver Residential Services**

An individual's home is where he or she resides. An individual may continue to receive residential services in a waiver program. When this occurs, the hospice agency assumes full responsibility for the professional management of the individual's **hospice** care in accordance with the hospice Conditions of Participation. When an individual elects hospice, the hospice agency and the waiver resident **must** communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy and is based on an assessment of the individual's need and unique living situation.

- Evidence of the coordinated plan of care must be in the clinical records of both providers. The facility and the hospice must communicate with each other when any changes are indicated to the plan of care and each provider must be aware of the other's responsibilities in implementing the plan of care.

- All **hospice services must** be provided directly by hospice employees and cannot be delegated. The hospice may involve the facility staff in assisting with the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely utilize the services of the patient's family/caregiver.

- The facility **must** offer the same service to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The hospice patient should not experience any lack of facility services or personal care because of his/her status as a hospice patient.

| **NOTE:** |
| --- |
| The provider RN will **not** provide supervision of care and services to the EDWP (CCSP and SOURCE) member who elects Hospice services in the ALS. |

902. **Non-Covered Services**

A. Supportive Living Services oriented to the mental health needs of the member.

B. Adult Day Care Services oriented to the social service needs of the member.

C. Medical rehabilitation services provided on an outpatient basis but not provided as part of the EDWP (CCSP and SOURCE) Comprehensive Care Plan.

D. While the member is in a treatment facility, institution or nursing facility, PSS, ADH, RC, HDS, SNS, and HDM services are not covered.

| NOTE: |
| --- |
| See Sections 1203.10 and 1253.12 of the Alternative Living Services manual and Section 1602.3 of the Emergency Response Services manual for the authorized time limits in these services. |

E. Services not authorized by the EDWP (CCSP and SOURCE) care coordinator.

F. Services not rendered in accordance with the provisions of all applicable Policy and Procedure manuals.

G. Refer to Chapter 700, Eligibility Conditions, and Chapter 1000, Basis for Reimbursement, of the EDWP (CCSP and SOURCE) General Manual for additional information that impacts the scope of services.

## PART II - CHAPTER 1000

## BASIS FOR REIMBURSEMENT

### 1001 Processing the Service Authorization Form (SAF), or Prior Authorization

Reimbursement is made to EDWP (CCSP and SOURCE) providers who have:

- completed the EDWP (CCSP and SOURCE) enrollment process
- been assigned a EDWP (CCSP and SOURCE) Medicaid provider number
- provided the services ordered on the Comprehensive Care Plan and authorized on the SAF/PA.

EDWP (CCSP and SOURCE) services must be rendered **before** providers submit claims for reimbursement.

NOTE:

Before filing claims providers must reconcile service units **actually provided** with service units authorized on the SAF/PA; **providers can only bill the Department for services provided**. If the provider or their billing agent over bills the Department, the provider must refund the overpayment to the Department. Failure to refund overpayment will result in recoupment and possible adverse action against the provider. See Section VIII-Adjustments in the DCH Billing Manual for instructions on refunding overpayments to the Department.

### 1002 Beginning Date of Reimbursement Rev. 01/2019

**1002.1** The provider can bill and be reimbursed for services only after the member's Medicaid eligibility has been approved and the member's nursing home level of care has been approved for a length of stay to cover the provider's dates of service, as documented by the receipt of a signed Level of Care and Placement Instrument (LOC form) from the member's case management agency. The *earliest* date the provider can be reimbursed under the length of stay on the LOC form is the *beginning date of the length of stay* indicated at the bottom of the form. The beginning date of the length of stay is the date of the in-home assessment for a new admission or the day following the expiration of the previous length of stay for an annual reassessment. All services must be authorized on the member's prior authorization for services (PA) on GAMMIS.

**1002.2** Case management providers can bill and be reimbursed from the date of the in-home assessment after all conditions in section 1002.1 above have been met.

**1002.3** Alternative Living Services (ALS) providers can bill and be reimbursed from the date of the in-home assessment or the date of admission, whichever is later, after all conditions in section 1002.1 above have been met.

**1002.4** Billing and reimbursement for all other services begins with the first date of the service, which can't be authorized by the case manager until on or after the date of the RN's signature at the bottom of the level of care and placement instrument. All conditions in section 1002.1 above must also be met before billing and reimbursement can begin.

## 1003 Relative Caregivers

**1003.1** Georgia Medicaid will not reimburse for personal care services or any waiver services when provided to recipients by legally responsible relatives, i.e., spouses, legal guardians or parents of minor children, when the services are those the persons are already legally obligated to provide.

Services provided by relatives, except as noted above, may be covered when the following criteria are met:

- The relative meets the qualifications for providers of care; Part II- Chapter 1400 Policies and Procedures for EDWP (CCSP and SOURCE) Personal Support Services/Consumer Direction/Structured Family Caregiver Section 1404.3 **Rev. 4/2023**

- The relative must meet all required training and qualifications before he/she assumes the role of paid caregiver for the member; Part II- Chapter 1400 Policies and Procedures for EDWP (CCSP and SOURCE) Personal Support Services/Consumer Direction/Structured Family Caregiver Section 1404.3 **Rev. 01/2013, 4/2023**

NOTE: See 1404.3 Part II- Chapter 1400 Policies and Procedures for EDWP (CCSP and SOURCE) Personal Support Services/Consumer Direction/Structured Family Caregiver manual for more information on Personal Support Aide qualifications. Rev. 04/2023

"Relative" is defined as a person who is related by blood **or legal adoption** within the third degree of consanguinity or by marriage. Third degree of consanguinity means mother, father, grandmother, grandfather, sister, brother, daughter, son, granddaughter, grandson, aunt, uncle, great aunt, great uncle, niece, nephew, grand-niece, grand-nephew, 1st cousins, 1st cousins, once removed, and 2nd cousins. **Rev 10/14**

**1003.2 In the case of self-directed care provided by a relative, all of the following criteria must be met:**

*****An agreement must be in place between the member, employee and or the provider before services are rendered;

*The member must pay the caregiver at a rate that does not exceed that which would otherwise be paid to a provider of a similar service;

*The service must not be an activity that the family would ordinarily perform or is responsible to perform.

See 1406 Part II-Chapter 1400 Policies and Procedures for the EDWP (CCSP and SOURCE) Personal Support Services/Consumer Direction/Structured Family Caregiver manual for CD PSS employee eligibility.

**Reimbursement for Consumer Directed Personal Support Services**

Reimbursement for wages in excess of 40 hours per week to a consumer directed PSS aide will automatically be paid at one and one/half times the normal hourly rate from the member's budget, in accordance with current federal law on overtime pay for personal support services, unless the employee has been exempted from overtime as a live-in caregiver. Rev. 01/2019

See Appendix S of the EDWP (CCSP and SOURCE) General Manual for current procedure codes and reimbursement rates.

## 1005 Duplication of Services

Waiver Programs include:

- Comprehensive Supports Waiver (COMP formerly CHSS)
- Elderly and Disabled Waiver Program (CCSP AND SOURCE)
- Independent Care Waiver Program (ICWP)
- New Options Waiver (NOW formerly MRWP)

Other Service Programs include:

- Georgia Pediatric Program (GAPP)

A member may receive more than one service within a single waiver program, but a member may not participate in more than one waiver program at any given time. Claims submitted for services rendered to the same member under more than one Waiver Program will be denied.

**Member Exclusions**

- Members who are at the time of application for enrollment or at the time of enrollment, domiciled or residing in an institution, including skilled nursing

facilities, hospital swing bed units, hospice, intermediate care facilities for the mentally ill, or correctional institutions

- Members who are enrolled in the Georgia Families program
- Children enrolled in the Medical Services Program administered by the Georgia Division of Public Health (Children's Medical Services)
- Members enrolled in the Service Options Using Resources In Community Environments (SOURCE) program
- Children in foster care or otherwise in the custody of the State
- Participants in some other waiver programs (BCC Waiver, Independent Care Waiver, Mental Retardation Waiver, Laurens County Waiver)
- Participants in the Recipient Lock –In program (GEXP, , SOURCE, PASSR, HMO, GAPP)
- Children enrolled in the Georgia Pediatric Program (GAPP)
- Members with retroactive eligibility only and members with presumptive eligibility
- Children with severe emotional disturbances whose care is coordinated under the TRIS or PRTF programs
- Children who are receiving services under Title V (CMS) funding

## 1006 Billing Tips

A. **Use a current DCH Billing Manual**. Manuals may be obtained from www.mmis.georgia.gov. Manuals may also be obtained by calling GAINWELL TECHNOLOGIES Provider Enrollment at 1-800-766-4456.

B. **Check the** EDWP (CCSP and SOURCE) **member's Medicaid eligibility each month**. The SAF authorizes service units but it is **NOT** proof of Medicaid eligibility. (See Section II, Billing Manual, Division of Medical Assistance, for methods of determining member eligibility).

C. **Do Not provide services without authorization** from the care coordinator.

D. **Prepare claims carefully and submit claims timely after the service has been provided**

To assure maximum use of EDWP (CCSP and SOURCE) service dollars, it is necessary to periodically "de-authorize" unused units of service from the system. This "de-authorization" removes unpaid units of service from the GAINWELL TECHNOLOGIES Prior Authorization file and updates the record to reflect the number of paid units only. Claims that are denied due to de-authorization must be re-authorized by the Care Coordinator.

E. **Timeliness -** Providers are allowed 180 days from the last day of the month of service to submit claims. If you are having difficulty getting a claim paid you must keep the claim timely by billing a minimum of every 3 months.

F. **Providers are encouraged <u>not</u> to bill more frequently than every two weeks**. Monthly billing is advised.

G. **Bill only for actual dates and units of service provided**.

H. **Keep copies of all documentation** such as Remittance Advices, and document all telephone contacts (name(s), agency, date and time of contact) made regarding billing.

I. **Carefully review each Remittance Advice** for accuracy and address problems timely.

J. Denied claims must be resubmitted when the problem has been corrected. GAINWELL TECHNOLOGIES does not maintain the denied claim on file.

K. Attend all training offered on EDWP (CCSP and SOURCE) Billing.

**L. The paper version of the CMS-1500 claim form has been revised. Please use the new version if submitting paper claims. Rev 4/2014**

## 1007 General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers (Rev 4/1/2014)

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e.,

rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid**.

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

**For the NEW CMS-1500 claim form:**
Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

**For claims entered via the web:**
Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

**For claims transmitted via EDI:**

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.
**Rev. 7/13, 4/14**

## 1008 Resolving Billing Problems

A. Carefully review the error code message (EOB) and recheck the information on the Remittance Advice (RA) against the information on the Service Authorization Form (SAF), correct any error and re-bill the claim.

B. Contact the GAINWELL TECHNOLOGIES Telephone Inquiry Unit for information updates on the claim you are billing. The GAINWELL TECHNOLOGIES system updates weekly.

C. If the SAF is not posted as a "PA Record" in the GAINWELL TECHNOLOGIES Enterprise Services (HPES) system, contact the applicable Case Management CCSP or Source agency assigned to that member. For all other billing issues, contact GAINWELL TECHNOLOGIES telephone inquiry.

D. For assistance with billing problems **unrelated** to 700 error codes, providers must complete the **Provider Inquiry Form** and mail, with a copy of the RA, to the address on the form. The problem will be researched.

E. Request an on-site visit by a GAINWELL TECHNOLOGIES Field Representative by calling GAINWELL TECHNOLOGIES Telephone Inquiry. See Appendix X of the EDWP (CCSP and SOURCE) General Manual for telephone numbers.

## 1009 Rounding Rules

To provide the most accurate and fair methodology for billing for services rendered. The state utilizes the following ***Rounding Rules*** as it relates to those services provided in 15-minute increments. Providers should review this table when determining how many units will be billed following rendering of services. Documentation with actual time spent rendering services will be reflected in the member's service notes.

**Units Number of Minutes 15 Minute Units**

1 unit: ≥ 8 minutes through 22 minutes

2 units: ≥ 23 minutes through 37 minutes

3 units: ≥ 38 minutes through 52 minutes

4 units: ≥ 53 minutes through 67 minutes

5 units: ≥ 68 minutes through 82 minutes

6 units: ≥ 83 minutes through 97 minutes

7 units: ≥ 98 minutes through 112 minutes

8 units: ≥ 113 minutes through 127 minutes

**Units Number of Minutes (1) One Hour Units**
1 unit ≥ 30 minutes through 60 minutes

All other services not billed in 15-minute increments are to be billed as indicated within the Reimbursement Rate Table Appendix S.

Appendix A - blank

**APPENDIX B -** EDWP (CCSP and SOURCE) **Expansion Application**

Submission Requirements/ Checklist for EDWP (CCSP and SOURCE) Expansion Request

Submit the below Application to Expand to ccsp.messages@dch.ga.gov

1. Signed and dated expansion application
2. Signed statement that the Applicant Organization assumes supervisory, administrative and professional responsibility for the operation of the services and assures the quality of the service.
3. Current state license from HFRD (adult day health providers, private home care providers and personal care homes only) **Revised 4/2016**
4. HFRD letter of county approval, PSS/X only. **Revised 10/2022**
5. Food service permit from health department (on-site food service providers)
6. Most recent inspection reports from the following agencies:

   ~Healthcare Facilities Regulation Division (HFRD)

   ~Fire Inspection (adult day health and personal care homes)

   ~Health Department (on-site food service providers)

   ~Utilization Review

   **All inspections must be clear of deficiencies.
7. Copy of supervising RN(s) Georgia license
8. If services will be contracted, copy of contract agreement(s)
9. Proof of $1,000,000 liability insurance coverage
10. PSS/PSSX/SN providers must submit proof of worker's compensation coverage
11. Medicaid Enrollment Application (if services will be provided out of a new office or applying for a new service)

***EDWP (CCSP/SOURCE) Services***
***Program* GENERAL**
**APPLICATION to EXPAND**
**SERVICE AREA**

Complete the expansion application to add a new service to your current location, add new counties to your current location/service or to add a new site location. If additional space is required to properly answer each question, label and attach the applicant organization's response.

1. Name of Applicant Organization (Legal and DBA):

   _____

2. Provider Enrollment Medicaid Number _____

   Fed Tax ID _____

3. Service you are expanding (e.g., PSS, SNS, SFC etc.)_____

   ATN numbers for new service addition or new site addition Source _____ CCSP _____

   Not needed for county expansion of existing site.

4. Mailing Address:

   _____

   _____

5. Street Address:

   _____

   _____

6. Business Telephone Number: (_____) _____

7. After-Hours Telephone Number: (_____)

8. FAX Number: (_____)

9. Business E-mail Address:_____

10. Administrative Contact Person:

    _____ (  )

    Name Title Telephone Number

    _____

    Location

11. Operational Contact Person:

    _____ (  )

    Name Title Telephone Number

    _____

12. **Current and Proposed Geographic Areas of Service:** Mark **"C"** for those counties being **currently s**erved. Mark **"P"** for those counties **proposed** to be served (up to 10).

***NOTE- ADH, ALS and Out of Home Respite Providers should check the one county in which the facility is located. Up to 10 counties may be requested for initial enrollment and for each expansion request***. *Submit the HFRD letter of county approval, PSS/X only.

☐ Statewide

**1 – Northwest GA**

_____Bartow
_____Catoosa
_____Chattooga
_____Dade
_____Fannin
_____Floyd
_____Gilmer
_____Gordon
_____Haralson
_____Murray
_____Paulding
_____Pickens
_____Polk
_____Walker
_____Whitfield

**2 –GA Mtns/ Legacy Link**

_____Banks
_____Dawson
_____Forsyth
_____Franklin
_____Habersham
_____Hall
_____Hart
_____Lumpkin
_____Rabun
_____Stephens
_____Towns
_____Union
_____White

**3 – Atlanta Regional**

_____Cherokee
_____Clayton
_____Cobb
_____DeKalb
_____Douglas
_____Fayette
_____Fulton
_____Gwinnett
_____Henry
_____Rockdale

**4 – Three Rivers**

_____ Butts
_____ Carroll
_____ Coweta
_____ Heard
_____ Lamar
_____ Meriwether
_____ Pike
_____ Spalding
_____Troup
_____Upson

**5 – Northeast Georgia**

_____Barrow
_____Clarke
_____Elbert
_____Greene
_____Jackson
_____Jasper
_____Madison
_____Morgan
_____Newton
_____Oconee
_____Oglethorpe
_____Walton

**6 – River Valley**

_____Chattahoochee
_____Clay
_____Crisp
_____Dooly
_____Harris
_____ Macon
_____ Marion
_____ Muscogee
_____Quitman
_____Randolph
_____Schley
_____Stewart
_____Sumter
_____Talbot
_____Taylor
_____Webster

**7 – Middle Georgia**

_____ Baldwin
_____Bibb
_____Crawford
_____Houston
_____Jones
_____Monroe
_____Peach
_____Pulaski
_____Putnam
_____Twiggs
_____Wilkinson

**8 – Central Savannah River**

_____Burke
_____Columbia
_____Glascock
_____Hancock
_____Jefferson
_____Jenkins
_____Lincoln
_____McDuffie
_____Richmond
_____Screven
_____Taliaferro
_____Warren
_____Washington
_____Wilkes

**9 – Heart of GA/Altamaha**

_____Appling
_____Bleckley
_____Candler
_____Dodge
_____Emanuel
_____Evans
_____Jeff Davis
_____Johnson
_____Laurens
_____Montgomery
_____Tattnall
_____Telfair
_____Toombs
_____Treutlen
_____Wayne
_____Wheeler
_____Wilcox

**10 – Southwest Georgia**

_____Baker
_____Calhoun
_____Colquitt
_____Decatur
_____Dougherty
_____Early
_____Grady
_____ Lee
_____Miller
_____Mitchell
_____Seminole
_____Terrell
_____Thomas
_____Worth

**11 – Southern Georgia**

_____Atkinson
_____Bacon
_____Ben Hill
_____Berrien
_____Brantley
_____Brooks
_____Charlton
_____Clinch
_____Coffee
_____Cook
_____Echols
_____Irwin
_____Lanier
_____Lowndes
_____Pierce
_____Tift
_____Turner
_____Ware

**12 – Coastal**

_____Bryan
_____Bulloch
_____Camden
_____Chatham
_____Effingham
_____Glynn
_____Liberty
_____Long
_____McIntosh

13. List the Medicaid provider number and effective dates for all Medicaid services you currently provide:

| Medicaid Service | Medicaid Provider Number | Effective Dates |
|---|---|---|
| | | |
| | | |
| | | |

**Target Population:**

12. How many CCSP/SOURCE clients are currently receiving services from your agency? _____

13. Are you currently providing this service in the proposed area to non-CCSP/SOURCE clients?

Yes ___ No ____

**Supervision:**

14. Provide the name and telephone numbers of the person responsible for day-to-day operations and the Registered Nurse supervisor in each Planning Service Area (PSA).

| Planning and Service Area | Person Responsible for Day-to-Day Operations Location & Telephone Number | Person Responsible for Registered Nurse Supervision Location & Telephone |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Administration and Clinical Records:**

15. Please provide the location and mailing address for the expanded area office:

Location _____

Mailing Address _____

Telephone Number _____

FAX Number _____

Contact Person _____

I hereby certify that my application for EDWP (CCSP and SOURCE) Expansion of Service is complete and contains all required materials in accordance with submission requirements established by the EDWP (CCSP and SOURCE) Unit at the GA Department of Community Health / Division of Medical Assistance.

**I understand that my application will be returned to me if it is not complete and that this could delay any consideration and/or approval to expand service area(s).**

_____
Signature of person legally authorized to act for the Applicant Organization

_____
Date

## APPENDIX C

## REFERRAL SYSTEM FOR USE WITH MULTIPLE EDWP (CCSP and SOURCE) PROVIDERS OF THE SAME SERVICE.

A. Client is able to choose

Where more than one EDWP (CCSP and SOURCE) provider offers the same major service within a given geographic area, a choice of these providers is presented to the client. The client or client representative indicates the preferred provider.

Factors affecting the client's choice are:

1. Physician's recommendation for service

If the client's physician specifies a preference for a particular EDWP (CCSP and SOURCE) provider to render services to the client, the client will be informed of the physician's recommendation, and whether or not the particular services needed are provided by the recommended provider. The client makes the final choice regarding the service provider.

2. Availability of services

If the client is in need of immediate (emergency) services and the EDWP (CCSP and SOURCE) provider chosen by the client is unable to render the immediate service, an alternate provider may be utilized.

If the EDWP (CCSP and SOURCE) provider chosen does not provide the comprehensive services needed (i.e., O.T.) the client may be referred to an alternate provider.

NOTE: Care coordinator/Lead Agency notifies the EDWP (CCSP and SOURCE) Unit when a EDWP (CCSP and SOURCE) provider does not offer a required service.

B. Client is unable to choose

If, for any reason (unfamiliarity with service providers, confused mental state, etc.), a client is unable to choose from among multiple providers of the same service, the EDWP (CCSP and SOURCE) care coordinator will help the client make an informed choice.

**APPENDIX D**

**INFORMATION ABOUT ADVANCE DIRECTIVES**

## WHAT ARE ADVANCE DIRECTIVES?

Advance Directives are documents that state an individual's choices about medical treatment or name someone to make choices about medical treatments for the individual if the individual is unable to make those decisions. Advance Directives are written before the onset of serious illness. The Patient Self-Determination Act requires all programs that provide home health care or personal care services and that participate in Medicaid and Medicare programs to have written policies and procedures on Advance Directives. The State of Georgia has two forms of Advance Directives: the Living Will and the Durable Power of Attorney for Health Care.

## WHAT IS A LIVING WILL?

A Living Will is one type of an Advance Directive. A Living Will is a document that is used only when a person has a terminal condition. It instructs the physician regarding decisions to withhold or withdraw certain medical procedures which could be used to prolong life. A Living Will deals with how an individual wishes to be treated when that individual is dying. The Living Will allows an individual to die naturally, without death being artificially prolonged by various medical procedures.

## WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

A Durable Power of Attorney for Health Care is another form of Advance Directives. This document allows one to designate a person or persons to make decisions regarding health care when the individual is unable to do so.

## AM I REQUIRED TO HAVE ADVANCE DIRECTIVES?

No. No one is required to have Advance Directives. Each individual has the right to choose whether or not to have Advance Directives.

Rev.
10/01/03

## WHAT ARE MY RIGHTS?

Each individual has the right to refuse any medical or surgical treatment or services that the individual does not wish to receive. Georgia law allows individuals to sign Advance Directives so that the individual's wishes will be followed even if the individual becomes unable to communicate those wishes to the health care provider.

## CAN I BE REFUSED ADMISSION TO THE EDWP (CCSP/SOURCE) SERVICE PROGRAM IF I DO NOT HAVE AN ADVANCE DIRECTIVE?

No. Federal law prohibits programs from refusing to admit a client because the client does not have an Advance Directive. However, individuals will be asked if they do have an advance directive and those answers will be documented.

## WHERE CAN I GET MORE INFORMATION ABOUT ADVANCE DIRECTIVES?

This information sheet is one way of providing clients with information about Advance Directives. If you would like more information about Advance Directives, you may contact the Division of Aging Services at (404) 657-5319 or an attorney.

## ADVANCE DIRECTIVE CHECKLIST

Please read the following three statements. After reading the statements, please write your initials at the end of **each** statement.

1. I have been given written materials on my rights to accept or refuse medical treatment and/or services and on my rights to formulate Advance Directives.

   _____(Client's initials)

2. I understand that I am not required to have an Advance Directive in order to receive services or medical treatment from

   _____
   (EDWP Provider)

   _____(Client's initials)

3. I desire that the terms of any Advance Directive that I execute will be followed by

   _____
   (EDWP Provider)

   _____(Client's initials)

Please read the following statements. After reading the statements, please check **ONE** of the following statements:

1. _____ I have executed an Advance Directive and will provide a copy to the EDWP (CCSP and SOURCE) provider agency providing services. I understand that the staff of:

   _____

   (EDWP (CCSP and SOURCE) Provider) will not be able to follow the terms of my Advance Directive until I provide a copy of it to the staff.

2. _____ I have not executed an Advance Directive and do not wish to discuss Advance Directives at this time.

3. _____ I have not executed an Advance Directive but would like to obtain additional information about Advance Directives.

_____ _____
Client's Signature Date

_____ _____
Witness' Signature Date

**APPENDIX E (CCSP, Form 5588) or APPENDIX F (SOURCE) – Revised 4/1/2015, 7/1/2019**

**Instructions**
**EDWP (CCSP and SOURCE) Level of Care and Placement Instrument**

## LEVEL OF CARE

*Purpose:* The Level of Care (LOC) page summarizes the client's physical, mental, social, and environmental status to help determine the client's appropriateness for the EDWP (CCSP and SOURCE) or other services. In addition, the LOC page represents the physician's order for all waivered services provided by CCSP AND SOURCE.

*Who Completes Form:* Initial assessments are completed by the RN care coordinator. Subsequent reassessments are completed by the RN or LPN. However, the LOC is always certified by the RN care coordinator. The client's physician, nurse practitioner or physician assistant participates in all assessments and reassessments by completing designated sections of the LOC page and signing the form.

*When the Form is Completed:*
The RN care coordinator completes the LOC page at initial assessments and reassessments.

*Instructions:*

**SECTION I A. IDENTIFYING INFORMATION**
Client Information in Section I is completed from information obtained from referral SOURCE or individual (patient) being referred.

1. Enter complete name, address & telephone number, including area code, of care coordination team.

2. Enter client's last name, first name, and middle initial, in that order, exactly as it appears on the Medicaid, Medicare, or social security card.

3. Enter home address of client, including street number, name of street, apartment number (if applicable), or rural route and box number, town, state and zip code.

4. Enter client's area code and telephone number.

5. Enter client's county of residence.

6. Enter planning and service area (PSA) number where client resides.

7. Enter client's Medicaid number exactly as it appears on the Medicaid card.

**NOTE:** Potential Medical Assistance Only (PMAO) applicants do not have a current Medicaid number. For PMAO applicants, please leave this item blank.

8. Enter client's nine-digit social security number.

9. Enter client's mother's maiden name.

10, 11, 12. Enter client's sex ("M" or "F"), age, and date of birth (month/day/year).

13. Enter client's race as follows:
A = Asian/Pacific Islander H = Hispanic W = White
B = Black NA = Native American

1. Enter client's marital status as follows:
S = Single M = Married W = Widowed
D = Divorced SP = Separated

2. Check (✓) appropriate type of recommendation:
1. Initial: First referral to EDWP (CCSP and SOURCE) or re-entry into EDWP (CCSP and SOURCE) after termination
2. Reassessment: Clients requiring annual recertification or reassessment because of change in status.

3. Enter referral SOURCE by name and title (if applicable), or agency and type as follows:
MD = Doctor S = Self HHA = Home health agency
NF = Nursing facility FM = Family PCH = Personal Care Home
HOSP = Hospital ADH = Adult Day Health APS= Adult Protective Services
O = Other (Identify fully) DFCS = Division of Family & Children Services

17, 18. Client signs and dates in spaces provided. If client is unable to sign, spouse, parent, other relative, or legal/authorized representative may sign and note relationship to client after signature.

**NOTE:** This signature gives client's physician permission to release information to care coordinator regarding level of care determination.

**SECTION I B. PHYSICIAN'S EXAMINATION REPORT AND DOCUMENTATION**
Section B is completed and signed by licensed medical person completing medical report.

19. The licensed physician/nurse practitioner/physician assistant enters client's primary, secondary, and other (if applicable) diagnoses. CCRN may pre fill Line 19 based on client self-report when physical impairments and/or medication(s) indications support the self-reported diagnosis. In situations where the CCRN completes the primary diagnosis; a cover letter to the physician which clarifies the nurses completion of Line 19 must accompany the assessment documents.

* The primary diagnosis should support EDWP (CCSP and SOURCE) eligibility.

**NOTE:** After the physician/ nurse practitioner returns signed LOC page, care coordination team enters the ICD codes. Enter ICD codes for "primary diagnosis", "secondary diagnosis" or "third diagnosis" in the appropriate box. Care coordination teams secure codes from ICD code book, local

hospitals or client's physician. **Beginning October 2013, please enter the ICD codes in both ICD-9 and ICD-10 formats in preparation for the implementation of ICD-10 in October 2015. Rev 10/14**

20. The physician/nurse practitioner (RNP)/physician assistant (PA) checks appropriate box to indicate if client is free of communicable diseases.

21. List all medications, including over-the-counter (OTC) medications and state dosage, how the medications are dispensed, frequency, and reason for medication. Attach additional sheets if necessary and reference.

22. List all diagnostic and treatment procedures the client is receiving.

23. List all waivered services ordered by care coordination team.

    **NOTE:** Waivered services ordered by care coordination and approved by the physician/ nurse practitioner/physician assistant are considered physician's orders for EDWP (CCSP and SOURCE) waivered services.

24. Enter appropriate diet for client. If "other" is checked (√), please specify type. Completion of this item is important as this information may serve as the service order for home delivered meals. (Nutrition Screening Initiative (NSI), Appendix 100, is to be completed in conjunction with the LOC page, MDS-HC and CCP.)

25. Enter number of hours out of bed per day if client is not bedfast. Check (√) intake if client can take fluids orally. Check (√) output if client's bladder function is normal without catheter. Check (√) all appropriate boxes.

26. Check (√) appropriate box to indicate client's overall condition.

27. Check (√) appropriate box to indicate client's restorative potential.

28. Check (√) *all* appropriate boxes to indicate client's mental and behavioral status. Document on additional sheet any behavior that indicates need for a psychological or psychiatric evaluation.

29. Check (√) appropriate box to indicate if client has decubiti. If "Yes" is checked and surgery did occur, indicate date of surgery.

30. Check (√) appropriate box.

31. Check (√) appropriate box.

32. If applicable, enter number of treatment or therapy sessions per week that client receives or needs.

33. Enter appropriate numbers in boxes provided to indicate level of impairment or assistance needed.

NOTE: Information on the MDS-HC must match the LOC form.

34. Care coordination team or the admitting/attending physician/nurse practitioner/physician assistant indicates whether client's condition could or could not be managed by provision of EDWP (CCSP/SOURCE) or Home Health Services by checking (√) appropriate box.

**NOTE:** If physician/nurse practitioner/physician assistant indicates that client's condition cannot be managed by provision of EDWP (CCSP/SOURCE) and/or Home Health Services, the physician may complete and sign a DMA-6

35. Care coordination team or the admitting/attending physician/nurse practitioner/physician assistant certifies that client requires level of care provided by an intermediate care facility.

36. Admitting/attending physician (or RNP or PA) certifies that CCP, plan of care addresses patient's needs for EDWP (CCSP/SOURCE). If client's needs cannot be addressed in EDWP (CCSP and SOURCE) and nursing facility placement is recommended, the physician may complete and sign a DMA-6.

37. This space is provided for signature of admitting/attending physician/ nurse practitioner/ physician assistant indicating his certification that client needs can or cannot be met in a community setting. **Only a licensed physician (MD or DO), nurse practitioner or physician assistant may sign the LOC page.**

**NOTE: MD, DO, RNP or PA must sign form 5588**. Physician/nurse practitioner/PA's signature must be original. Signature stamps are <u>not</u> acceptable. Electronic signatures are acceptable when Medicaid criteria for electronic signatures is met. See Policies and Procedures for Medicaid/PeachCare for Kids Part I – Definitions and Part I/Section 106 (R). UR will recover payments made to the provider if there is no physician/RNP/PA signature. "Faxed" copies of LOC page are acceptable**. (Rev 1/2018)**

38, 39, 40, 41, 42. Enter admitting/attending physician's name, address, date of signature, licensure number, and telephone number, including area code, in spaces provided. If nurse practitioner or physician assistant is completing the document, he or she will provide information relative to his/her license and contact information. LOC cover letter will reference instructions for RNP and PA.

**NOTE:** The date the physician signs the form is the service order for EDWP (CCSP and SOURCE) services to begin. UR will recover money from the provider if date is not recorded.

**43, 44, 45. REGISTERED NURSE (RN) USE ONLY**

43. The registered nurse checks (√) the appropriate box regarding Nursing Facility Level of Care (LOC). When RN denies a level of care, the nurse signs the form after the "No" item in this space. The RN does <u>not</u> use the customized "Approved" or "Denied" stamp.

44. LOS (Length of Stay) - Indicate time frame for certification**. LOS cannot exceed 365 days. If the level of care has been certified by Alliant Health Solutions (AHS), use the date of AHS's approval as the beginning date of the length of stay.**

45. **The registered nurse who is certifying the level of care must sign in this space and indicate their title (R.N.) and date of signature. The length of stay is calculated from the date shown in Number 44. The RN must complete a recertification of the level of care prior to expiration of the length of stay. (Rev 1/2018)**

*Distribution*: The original is filed in the case record. Attach a copy with the CCC to DFCS at initial assessment and reassessment. Include a copy with the provider referral packet.

***Physicians please fill in highlighted areas, specifically items 19, 20 and your signature on line 37. Thank you***

**PLEASE RETURN THIS PAGE (LOC) TO OUR AGENCY: ALL OTHER DOCUMENTATION MAY BE RETAINED FOR YOUR PATIENT FILE.**

Georgia Department of Community Health

# COMMUNITY CARE SERVICES PROGRAM LEVEL OF CARE AND PLACEMENT INSTRUMENT

Section 1 - A. Identifying Information

| 1. CCSP ASSESSMENT TEAM NAME AND ADDRESS | 2. Patient's Name (Last, First, Middle Initial) | Client ID |
|---|---|---|
| | 3. Home Address: | |
| | 4. Telephone Number | 5. County: / 6. PSA 01 |

| 7. Medicaid Number | 8. Social Security Number | 9. Mother's Maiden Name: |
|---|---|---|

| 10. Sex | 11. Age | 12. Birthday | 13. Race | 14. Marital Status | 15. Type of recommendation ☐ Initial Assessment ☐ Reassessment |
|---|---|---|---|---|---|
| | | | | | |

16. Referral Source _____

This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance and the Department of Human Services with necessary information including medical data.

17. Signed _____ 18. Date _____

(Patient, Spouse, Parent or other Relative or Legal Representative)

## B. Physician's Examination Report, Recommendation and Nursing Care Needed

**19. Diagnosis on Admission to Community Care** (Hospital transfer record may be attached)

1. Primary _____ 2. Secondary _____ 3. Other _____

| ICD 10 CODE | ICD 10 CODE | ICD 10 CODE |
|---|---|---|
| | | |

***20 Is Patient free of communicable disease?*** ☐ Yes ☐ No

21. Medications (including OTC) ☐ see attached sheet for listing

| Name | Dosage | Route | Frequency |
|---|---|---|---|
| | | | |

22. Diagnostic and Treatment Procedures

| Type/Frequency |
|---|
| |

23. COMMUNITY CARE SERVICES ORDERED: _____

| 24. Diet | 25. Hours Out of Bed Per Day _____ | 26. Overall Condition | 27. Restorative Potential | 28. Mental and Behavioral Status | | |
|---|---|---|---|---|---|---|
| ☐ Regular | ☐ Intake | ☐ Improving | ☐ Good | ☐ Agitated | ☐ Noisy | ☐ Dependent |
| ☐ Diabetic | ☐ Output | ☐ Stable | ☐ Fair | ☐ Confused | ☐ Nonresponsive | ☐ Independent |
| ☐ Formula | ☐ Catheter Care | ☐ Fluctuating | ☐ Poor | ☐ Cooperative | ☐ Vacillating | ☐ Anxious |
| ☐ Low Sodium | ☐ Colostomy Care | ☐ Deteriorating | ☐ Questionable | ☐ Depressed | ☐ Violent | ☐ Well Adjusted |
| ☐ Tube Feeding | ☐ Sterile Dressings | ☐ Critical | ☐ None | ☐ Forgetful | ☐ Wanders | ☐ Disoriented |
| ☐ Other | ☐ Suctioning | ☐ Terminal | | ☐ Alert | ☐ Withdrawn | ☐ Inappropriate Reaction |
| | ☐ IV | | | | | |
| | ☐ Bedfast | | | | | |

| 29. Decubiti | 30. Bowel | 31. Bladder |
|---|---|---|
| ☐ Yes | ☐ Continent | ☐ Continent |
| ☐ No | ☐ Occas. Incontinent | ☐ Occas. Incontinent |
| ☐ Infected | ☐ Incontinent | ☐ Incontinent |
| ☐ On Admission | ☐ Colostomy | ☐ Catheter |
| ☐ Surgery Date | | |

32. Indicate Frequency per Week

| Physical Therapy | Occupational Therapy | Remote Therapy | Reality Orientation | Speech Therapy | Bowel/Bladder Retrain | Activities Program |
|---|---|---|---|---|---|---|
| | | | | | | |

33. Record Appropriate

**Legend**

1. Severe
2. Moderate
3. Mild
4. None

**IMPAIRMENT**

| Sight | Hearing | Speech | Limited Motion | Paralysis |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

1. Dependent
2. Needs Assistance
3. Independent
4. Not Applicable

**ACTIVITIES OF DAILY LIVING**

| Eats | Wheel Chair | Transfers | Bath | Ambulation | Dressing |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

34. This patient's condition ☐ could ☐ could not be managed by provision of ☐ Community Care or ☐ Home Health Services

35. I certify that this patient ☐ requires ☐ does not require the intermediate level of care provided by a nursing facility.

36. I certify that the attached plan of care addresses the client's needs for Community Care.

37. Physician's Signature _____

38. Physician's Name (Print) _____

39. Physician's Address _____

| 40. Date signed by Physician | 41. Physician's License No. | 42. Physician's Phone/Fax / FAX: |
|---|---|---|
| | | |

**ASSESSMENT TEAM USE ONLY**

43. Nursing Facility Level of Care ☐ Yes ☐ No 44. L.O.S._____365 DAYS Certified_____thru _____

45. Signed by person certifying LOC: _____ Title:_____Date Signed: _____

# APPENDIX F – LEVEL OF CARE
# Minimum Data Set for Home Care – Version 9 (MDS-HC v.9)
# (InterRAI Home Care v. 2.0)
# Revised Sept 2016
**(See next page.)**

| 1. EDWP (CCSP and SOURCE) - interRAI MDS HC Assessment |
|---|
| **Client:** |
| **Review Date:** |
| **InterRAI Assessment** |
| **MDS Assessment Type:** |
| **A. Identification Information** |
| **A.1. NAME** |
| **A1a. First name** |
| **A1b. Middle Initial** |
| **A1c. Last name (surname/family name)** |
| **A1d. Jr./Sr.** |
| **A.2. GENDER** |
| **Gender** |
| **A.3. BIRTHDATE** |
| **Birthdate (month, day, year)** |
| **A.4. MARITAL STATUS** |
| **Marital Status** |
| **A.5. NATIONAL NUMERIC IDENTIFIER [EXAMPLE - USA]** |
| **A5a. Social Security Number** |
| **A5b. Medicare number (or comparable railroad insurance number)** |
| **A5c. Medicaid number [Note: "+" if pending, "N" if not Medicaid recipient]** |
| **A.6. FACILITY / AGENCY PROVIDER NUMBER [EXAMPLE - USA]** |
| **Facility / Agency Provider Number** |
| **A.7. CURRENT PAYMENT SOURCES [EXAMPLE - USA]** |
| **Current Payment Sources [Note: Billing Office to indicate]** |
| **A.8. REASON FOR ASSESSMENT** |
| **Reason for Assessment** |
| **A.9. ASSESSMENT REFERENCE DATE** |

| |
|---|
| **Assessment Reference Date = 3 Calendar Days prior to Assessment Date** |
| **Assessment Reference Date (month, day, year)** |
| **A.10. PERSON'S EXPRESSED GOALS OF CARE** |
| **Enter primary goal** |
| **A.11. POSTAL / ZIP CODE OF USUAL LIVING ARRANGEMENT [EXAMPLE - USA]** |
| **Postal / Zip Code of Usual Living Arrangement** |
| **A.12. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT** |
| **Residential / Living Status at Time of Assessment** |
| **A.13. LIVING ARRANGEMENT** |
| **A13a. Lives** |
| **A13b. As compared to 90 DAYS AGO (or since last assessment), person now lives with someone new - e.g., moved in with another person, other moved in** |
| **A13c. Person or relative feels that the person would be better off living elsewhere** |
| **A.14. TIME SINCE LAST HOSPITAL STAY** |
| **Time since last hospital stay - Code for most recent instance in LAST 90 DAYS** |
| **Identification Information Notes** |
| **B. Intake and Initial History** |
| **B.1. DATE CASE OPENED (this agency)** |
| **Date Case Opened (this agency) (month, day, year)** |
| **B.2. ETHNICITY AND RACE [EXAMPLE - USA]** |
| **B2a. Ethnicity - Hispanic or Latino** |
| **Race** |
| **B.3. PRIMARY LANGUAGE [EXAMPLE - USA]** |
| **Primary Language** |
| **B.4. RESIDENTIAL HISTORY OVER LAST 5 YEARS - Code for all settings person lived in during 5 years prior to date case opened.** |
| **B4a. Long-term care facility - e.g., nursing home** |
| **B4b. Board and care home, assisted living** |
| **B4c. Mental health residence - e.g., psychiatric group home** |
| **B4d. Psychiatric hospital or unit** |

| |
|---|
| **B4e. Setting for persons with intellectual disability** |
| **Intake and Initial History Notes** |
| **C. Cognition** |
| **C.1. COGNITIVE SKILLS FOR DAILY DECISION MAKING** |
| **Making decisions regarding tasks of daily life - e.g., when to get up or have meals, which clothes to wear or activities to do** |
| **C.2. MEMORY / RECALL ABILITY - Code for recall of what was learned or known.** |
| **C2a. Short-term memory OK - Seems / appears to recall after 5 minutes** |
| **C2b. Procedural memory OK - Can perform all or almost all steps in a multitask sequence without cues** |
| **C2c. Situational memory OK - Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room)** |
| **C.3. PERIODIC DISORDERED THINKING OR AWARENESS - Note: Accurate assessment requires conversation with staff, family, or others who have direct knowledge of the person's behavior over this time.** |
| **C3a. Easily distracted - e.g., episodes of difficulty paying attention; gets sidetracked** |
| **C3b. Episodes of disorganized speech - e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought** |
| **C3c. Mental function varies over the course of the day - e.g., sometimes better, sometimes worse** |
| **C.4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING** |
| **Acute change in mental status from person's usual functioning - e.g., restlessness, lethargy, difficult to arouse, altered environmental perception** |
| **C.5. CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)** |
| **Change in decision making as compared to 90 days ago (or since last assessment)** |
| **Cognition Notes** |
| **D. Communication and Vision** |
| **D.1. MAKING SELF UNDERSTOOD (Expression)** |
| **Expressing information content - both verbal and nonverbal** |
| **D.2. ABILITY TO UNDERSTAND OTHERS (Comprehension)** |
| **Understanding verbal information content (however able; with hearing appliance normally used)** |
| **D.3. HEARING** |
| **Ability to hear (with hearing appliance normally used)** |
| **D.4. VISION** |
| **Ability to see in adequate light (with glasses or with other visual appliance normally used)** |

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| **Communication and Vision Notes** |
| **E. Mood and Behavior** |
| **E.1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD - Code for indicators observed in last 3 days, irrespective of assumed cause** |
| **E1a. Made negative statements - e.g., "Nothing matters"; "Would rather be dead"; "What's the use"; "Regret having lived so long"; "Let me die"** |
| **E1b. Persistent anger with self or others - e.g., easily annoyed, anger at care received** |
| **E1c. Expressions, including non-verbal, of what appear to be unrealistic fears - e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations** |
| **E1d. Repetitive health complaints - e.g., persistently seeks medical attention, incessant concern with body functions** |
| **E1e. Repetitive anxious complaints / concerns (non-health related) - e.g., persistently seeks attention / reassurance regarding schedules, meals, laundry, clothing, relationships** |
| **E1f. Sad, pained, or worried facial expressions - e.g., furrowed brow, constant frowning** |
| **E1g. Crying, tearfulness** |
| **E1h. Recurrent statements that something terrible is about to happen - e.g., believes he or she is about to die, have a heart attack** |
| **E1i. Withdrawal from activities of interest - e.g., long-standing activities, being with family / friends** |
| **E1j. Reduced social interactions** |
| **E1k. Expressions, including non-verbal, of a lack of pleasure in life (anhedonia) - e.g., "I don't enjoy anything anymore"** |
| **E.2. SELF-REPORTED MOOD** |
| **E2a. In the last 3 days, how often have you felt a little interest or pleasure in things you normally enjoy?** |
| **E2b. In the last 3 days, how often have you felt anxious, restless, or uneasy?** |
| **E2c. In the last 3 days, how often have you felt sad, depressed, or hopeless?** |
| **Not being able to stop or control worrying?** |
| **E.3. BEHAVIOR SYMPTOMS** |
| **E3a. Wandering - Moved with no rational purpose, seemingly oblivious to needs or safety** |
| **E3b. Verbal abuse - e.g., others were threatened, screamed at, cursed at** |
| **E3c. Physical abuse - e.g., others were hit, shoved, scratched, sexually abused** |
| **E3d. Socially inappropriate or disruptive behavior - e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through other's belongings** |
| **E3e. Inappropriate public sexual behavior or public disrobing** |

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| **E3f. Resists care - e.g., taking medications / injections, ADL assistance, eating** |
| **Mood and Behavior Notes** |
| **F. Psychosocial Well-Being** |
| **F.1. SOCIAL RELATIONSHIPS** |
| **F1a. Participation in social activities of long-standing interest** |
| **F1b. Visit with a long-standing social relation or family member** |
| **F1c. Other interaction with long-standing social relation or family member - e.g., telephone, e-mail** |
| **F1d. Conflict or anger with family or friends** |
| **F1e. Fearful of a family member or close acquaintance** |
| **F1f. Neglected, abused, or mistreated** |
| **F.2. LONELY** |
| **Says or indicates that he / she feels lonely** |
| **F.3. CHANGE IN SOCIAL ACTIVITIES IN LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO)** |
| **Decline in level of participation in social, religious, occupational, or other preferred activities**<br><br>**IF THERE WAS A DECLINE, person distressed by this fact** |
| **F.4. LENGTH OF TIME ALONE DURING THE DAY (MORNING AND AFTERNOON)** |
| **Length of time alone during the day (morning and afternoon)** |
| **F.5. MAJOR LIFE STRESSORS IN LAST 90 DAYS** |
| **e.g., episode of severe personal illness; death or severe illness of close family member / friend; loss of home; major loss of income / assets; victim of a crime such as robbery or assault; loss of driving license / car** |
| **Psychosocial Well-Being Notes** |
| **G. Functional Status** |
| **G.1. IADL SELF-PERFORMANCE AND CAPACITY** |
| **G1a. PERFORMANCE - Meal preparation - How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)** |
| **CAPACITY - Meal preparation - How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)** |
| **UNMET NEED - Meal preparation - How meals are prepared (e.g.,<br>planning meals, assembling ingredients, cooking, setting out food and utensils)** |
| **G1b. PERFORMANCE - Ordinary housework - How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)** |

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| **CAPACITY - Ordinary housework - How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)** |
| **UNMET NEED - Ordinary Housework - How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)** |
| **G1c. PERFORMANCE - Managing finances - How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored** |
| **CAPACITY - Managing finances - How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored** |
| **UNMET NEED - Managing finances - How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored** |
| **G1d. PERFORMANCE - Managing medications - How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)** |
| **CAPACITY - Managing medications - How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)** |
| **UNMET NEED - Managing medications - How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)** |
| **G1e. PERFORMANCE - Phone Use - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)** |
| **CAPACITY - Phone Use - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)** |
| **UNMET NEED - Phone Use - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)** |
| **G1f. PERFORMANCE - Stairs - How full flight of stairs is managed (12-14 stairs)** |
| **CAPACITY - Stairs - How full flight of stairs is managed (12-14 stairs)** |
| **UNMET NEED - Stairs - How full flight of stairs is managed (12-14 stairs)** |
| **G1g. PERFORMANCE - Shopping - How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION** |
| **CAPACITY - Shopping - How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION** |
| **UNMET NEED - Shopping - How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION** |
| **G1h. PERFORMANCE - Transportation - How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)** |
| **CAPACITY - Transportation - How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)** |

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| **UNMET NEED - Transportation - How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)** |
| **G.2. ADL SELF-PERFORMANCE** |
| **G2a. Bathing - How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed; arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR** |
| **LEVEL OF IMPAIRMENT - Bathing - How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed; arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR** |
| **UNMET NEED - Bathing - How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed; arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR** |
| **G2b. Personal hygiene - How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS** |
| **LEVEL OF IMPAIRMENT - Personal hygiene - How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS** |
| **UNMET NEED - Personal hygiene - How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS** |
| **G2c. Dressing upper body - How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.** |
| **LEVEL OF IMPAIRMENT - Dressing upper body - How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc** |
| **UNMET NEED - Dressing upper body - How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.** |
| **G2d. Dressing lower body - How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.** |
| **LEVEL OF IMPAIRMENT - Dressing lower body - How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.** |
| **UNMET NEED - Dressing lower body - How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.** |
| **G2e. Walking - How walks between locations on same floor indoors** |
| **LEVEL OF IMPAIRMENT - Walking - How walks between locations on same floor indoors** |
| **UNMET NEED - Walking - How walks between locations on same floor indoors** |

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| **G2f. Locomotion - How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair** |
| **LEVEL OF IMPAIRMENT - Locomotion - How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair** |
| **UNMET NEED - Locomotion - How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair** |
| **G2g. Transfer toilet - How moves on and off toilet or commode** |
| **LEVEL OF IMPAIRMENT - Transfer toilet - How moves on and off toilet or commode** |
| **UNMET NEED - Transfer toilet - How moves on and off toilet or commode** |
| **G2h. Toilet use - How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET** |
| **LEVEL OF IMPAIRMENT - Toilet use - How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET** |
| **UNMET NEED - Toilet use - How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad,<br>manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET** |
| **G2i. Bed mobility - How moves to and from lying position, turns from side to side, and positions body while in bed** |
| **LEVEL OF IMPAIRMENT - Bed mobility - How moves to and from lying position, turns from side to side, and positions body while in bed** |
| **UNMET NEED - Bed mobility - How moves to and from lying position, turns from side to side, and positions body while in bed** |
| **G2j. Eating - How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)** |
| **LEVEL OF IMPAIRMENT - Eating - How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)** |
| **UNMET NEED - Eating - How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)** |
| **G.3. LOCOMOTION / WALKING** |
| **G3a. Primary mode of locomotion** |
| **G3b. Timed 4-meter (13-foot) walk - Enter time in seconds, up to 30 seconds (30: 30 or more seconds to walk 4 meters, 77: Stopped before test complete, 88: Refused to do the test, 99: Not tested - e.g., does not walk on own)** |

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| **G3c. Distance walked - Farthest distance walked at one time without sitting down in the LAST 3 DAYS (with support as needed)** |
| **G3d. Distance wheeled self - Farthest distance wheeled self at one time in the LAST 3 DAYS (includes independent use of motorized wheelchair)** |
| **G.4. ACTIVITY LEVEL** |
| **G4a. Total hours of exercise or physical activity in LAST 3 DAYS - e.g., walking** |
| **G4b. In the LAST 3 DAYS, number of days went out of the house or building in which he / she resides (no matter how short the period)** |
| **G.5. PHYSICAL FUNCTION IMPROVEMENT POTENTIAL** |
| **G5a. Person believes he / she is capable of improved performance in physical function** |
| **G5b. Care professional believes person is capable of improved performance in physical function** |
| **G.6. CHANGE IN ADL STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO** |
| **Change in ADL status as compared to 90 days ago, or since last assessment if less than 90 days ago** |
| **G.7. DRIVING** |
| **G7a. Drove car (vehicle) in the LAST 90 DAYS** |
| **G7b. If drove in LAST 90 DAYS, assessor is aware that someone has suggested that person limits OR stops driving** |
| **G.8. DL SELF-PERFORMANCE** |
| **LEVEL OF IMPAIRMENT - Laundry - How do laundry including sorting, carrying, loading, unloading, folding, and putting away** |
| **UNMET NEED - Laundry - How do laundry including sorting, carrying, loading, unloading, folding, and putting away** |
| **LEVEL OF IMPAIRMENT - Transfer - How transfer (from/to) between bed and wheelchair, walker, etc.** |
| **UNMET NEED - Transfer - How transfer (from/to) between bed and wheelchair, walker, etc.** |
| **LEVEL OF IMPAIRMENT - Routine Health - How follow the directions of physicians, nurses or therapists, as needed for routine health care** |
| **UNMET NEED - Routine Health - How follow the directions of physicians, nurses or therapists, as needed for routine health care** |
| **LEVEL OF IMPAIRMENT - Being Alone - How be left alone** |
| **UNMET NEED - Being Alone - How be left alone** |
| **LEVEL OF IMPAIRMENT - Special Health - How follow directions of physicians, nurses or therapists as needed for specialized health care** |
| **UNMET NEED - Special Health - How follow directions of physicians, nurses or therapists as needed for specialized health care** |

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| **Functional Status Notes** |
| **H. Continence** |
| **H.1. BLADDER CONTINENCE** |
| **Bladder continence** |
| **H.2. URINARY COLLECTION DEVICE (Exclude pads / briefs)** |
| **Urinary collection device (Exclude pads / briefs)** |
| **H.3. BOWEL CONTINENCE** |
| **Bowel continence** |
| **H.4. PADS OR BRIEFS WORN** |
| **Pads or briefs worn** |
| **Continence Notes** |
| **I. Disease Diagnoses** |
| **I.1. DISEASE DIAGNOSES - Musculoskeletal** |
| **I1a. Hip fracture during last 30 days (or since last assessment if less than 30 days)** |
| **I1b. Other fracture during last 30 days (or since last assessment if less than 30 days)** |
| **I. Neurological** |
| **I1c. Alzheimer's disease** |
| **I1d. Dementia other than Alzheimer's disease** |
| **I1e. Hemiplegia** |
| **I1f. Multiple sclerosis** |
| **I1g. Paraplegia** |
| **i1h. Parkinson's disease** |
| **I1i. Quadriplegia** |
| **I1j. Stroke / CVA** |
| **I. Cardiac or Pulmonary** |
| **I1k. Coronary heart disease** |
| **I1l. Chronic obstructive pulmonary disease** |
| **I1m. Congestive heart failure** |
| **I. Psychiatric** |

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| **I1n. Anxiety** |
| **I1o. Bipolar disorder** |
| **I1q. Depression** |
| **I1p. Schizophrenia** |
| **I. Infections** |
| **I1r. Pneumonia** |
| **I1s. Urinary tract infection in last 30 days** |
| **I. Other** |
| **I1t. Cancer** |
| **I1u. Diabetes mellitus** |
| **I.2. OTHER DISEASE DIAGNOSES** |
| **a. Other Disease Diagnoses** |
| **a. Disease Code** |
| **a. ICD Code** |
| **a. Add Another Other Disease Diagnoses** |
| |
| **Disease Diagnoses Notes** |
| **J. Health Conditions** |
| **J.1. FALLS** |
| **Falls** |
| **J.2. RECENT FALLS** |
| **Recent Falls**<br><br>**[Skip if last assessed more than 30 days ago or if this is first assessment]** |
| **J.3. PROBLEM FREQUENCY - Balance** |
| **J3a. Difficult or unable to move self to standing position unassisted** |
| **J3b. Difficult or unable to turn self around and face the opposite direction when standing** |
| **J3c. Dizziness** |
| **J3d. Unsteady gait** |
| **J. Cardiac or Pulmonary** |

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| **J3e. Chest pain** |
| **J3f. Difficulty clearing airway secretions** |
| **J. Psychiatric** |
| **J3g. Abnormal thought process - e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality** |
| **J3h. Delusions - Fixed false beliefs** |
| **J3i. Hallucinations - False sensory perceptions** |
| **J. Neurologica** |
| **J3j. Aphasia** |
| **J. GI Status** |
| **J3k. Acid reflux - Regurgitation of acid from stomach to throat** |
| **J3l. Constipation - No bowel movement in 3 days or difficult passage of hard stool** |
| **J3m. Diarrhea** |
| **J3n. Vomiting** |
| **J. Sleep Problems** |
| **J3o. Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep** |
| **J3p. Too much sleep - Excessive amount of sleep that interferes with person's normal functioning** |
| **J. Other** |
| **J3q. Aspiration** |
| **J3r. Fever** |
| **J3s. GI or GU bleeding** |
| **J3t. Hygiene - Unusually poor hygiene, unkempt, disheveled** |
| **J3u. Peripheral edema** |
| **J.4. DYSPNEA (Shortness of breath)** |
| **Dyspnea (Shortness of breath)** |
| **J.5. FATIGUE** |
| **Inability to complete normal daily activities - e.g., ADLs, IADLs** |
| **J.6. PAIN SYMPTOMS** |
| **J6a. Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other nonverbal signs suggesting pain)** |

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| **J6b. Intensity of highest level of pain present** |
| **J6c. Consistency of pain** |
| **J6d. Breakthrough pain - Times in LAST 3 DAYS when person experienced sudden, acute flare-ups of pain** |
| **J6e. Pain control - Adequacy of current therapeutic regimen to control pain (from person's point of view)** |
| **J.7. INSTABILITY OF CONDITIONS** |
| **J7a. Conditions/diseases make cognitive, ADL, mood, or behavior patterns unstable (fluctuating, precarious, or deteriorating)** |
| **J7b. Experiencing an acute episode, or a flare-up of a recurrent or chronic problem** |
| **J7c. End-stage disease, 6 or fewer months to live** |
| **J.8. SELF-REPORTED HEALTH** |
| **Ask: "In general, how would you rate your health?"** |
| **J.9. TOBACCO AND ALCOHOL** |
| **J9a. Smokes tobacco daily** |
| **J9b. Alcohol - Highest number of drinks in any "single sitting" in LAST 14 DAYS** |
| **Health Conditions Notes** |
| **K. Oral and Nutritional Status** |
| **K.1. HEIGHT AND WEIGHT [INCHES AND POUNDS - COUNTRY SPECIFIC]** |
| **K1a. Height (in.)** |
| **K1b. Weight (lb.)** |
| **K.2. NUTRITIONAL ISSUES** |
| **K2a. Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS** |
| **K2b. Dehydrated or BUN / Cre ratio > 25 [Ratio, country specific]** |
| **K2c. Fluid intake less than four 8 oz cups per day (or less than 1,000 cc per day)** |
| **K2d. Fluid output exceeds input** |
| **K.3. MODE OF NUTRITIONAL INTAKE** |
| **Mode of nutritional intake** |
| **K.4. DENTAL OR ORAL** |
| **K4a. Wears a denture (removable prosthesis)** |
| **K4b. Has broken, fragmented, loose, or otherwise non-intact natural teeth** |

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| **K4c. Reports having dry mouth** |
| **k4d. Reports difficulty chewing** |
| **Oral and Nutritional Status Notes** |
| **L. Skin Condition** |
| **L.1. MOST SEVERE PRESSURE ULCER** |
| **Most severe pressure ulcer** |
| **L.2. PRIOR PRESSURE ULCER** |
| **Prior pressure ulcer** |
| **L.3. PRESENCE OF SKIN ULCER OTHER THAN PRESSURE ULCER** |
| **Presence of skin ulcer other than pressure ulcer - e.g., venous ulcer, arterial ulcer, mixed venous-arterial ulcer, diabetic foot ulcer** |
| **L.4. MAJOR SKIN PROBLEMS** |
| **Major skin problems - e.g., lesions, 2nd or 3rd degree burns, healing surgical wounds** |
| **L.5. SKIN TEARS OR CUTS** |
| **Skin tears or cuts - Other than surgery** |
| **L.6. OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION** |
| **Other skin conditions or changes in skin condition - e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema** |
| **L.7. FOOT PROBLEMS** |
| **Foot problems - e.g., bunions, hammer toes, overlapping toes, structural problems, infections, ulcers** |
| **Skin Condition Notes** |
| **M. Medications** |
| **M.1. LIST OF ALL MEDICATIONS** |
| **List all active prescriptions, and any nonprescribed (over-the-counter) medications taken in the LAST 3 DAYS**<br><br>**[Note: Use computerized records if possible; hand enter only when absolutely necessary]**<br><br>**For each drug record:** |
| **Number of Medications (code 0 for none or 9 if more than 9)** |
| **M.2. ALLERGY TO ANY DRUG** |
| **Additional allergy to any food or environmental etc** |
| **M.3. ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN** |
| **Adherent with medications prescribed by physician** |

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| **Medications Notes** |
| **N. Treatments and Procedures** |
| **N.1. PREVENTION** |
| **N1a. Blood pressure measured in LAST YEAR** |
| **N1b. Colonoscopy test in LAST 5 YEARS** |
| **N1c. Dental exam in LAST YEAR** |
| **N1d. Eye exam in LAST YEAR** |
| **N1e. Hearing exam in LAST 2 YEARS** |
| **N1f. Influenza vaccine in LAST YEAR** |
| **N1g. Mammogram or breast exam in LAST 2 YEARS (for women)** |
| **N1h. Pneumovax vaccine in LAST 5 YEARS or after age 65** |
| **N.2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS - Treatments** |
| **N2a. Chemotherapy** |
| **N2b. Dialysis** |
| **N2c. Infection control - e.g., isolation, quarantine** |
| **N2d. IV medication** |
| **N2e. Oxygen therapy** |
| **N2f. Radiation** |
| **N2g. Suctioning** |
| **N2h. Tracheostomy care** |
| **N2i. Transfusion** |
| **N2j. Ventilator or respirator** |
| **N2k. Wound care** |
| **N. Programs** |
| **N2l. Scheduled toileting program** |
| **N2m. Palliative care program** |
| **N2n. Turning / repositioning program** |
| **N.3. FORMAL CARE - Days (A) and Total minutes (B) of care in last 7 days** |
| **N3a. (A) Home health aides - # of days** |

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| **(B) Home health aides - Total Minutes in Last Week** |
| **N3b. (A) Home nurse - # of days** |
| **(B) Home nurse - Total Minutes in Last Week** |
| **N3c. (A) Homemaking services - # of days** |
| **(B) Homemaking services - Total Minutes in Last Week** |
| **N3d. (A) Meals - # of days** |
| **N3e. (A) Physical therapy - # of days** |
| **(B) Physical therapy - Total Minutes in Last Week** |
| **N3f. (A) Occupational therapy - # of days** |
| **(B) Occupational therapy - Total Minutes in Last Week** |
| **N3g. (A) Speech-language pathology and audiology services - # of days** |
| **(B) Speech-language pathology and audiology services - Total Minutes in Last Week** |
| **N3h. (A) Psychological therapy (by any licensed mental health professional) - # of days** |
| **(B) Psychological therapy (by any licensed mental health professional) - Total Minutes in Last Week** |
| **N.4. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT** |
| **N4a. Inpatient acute hospital with overnight stay** |
| **N4b. Emergency room visit (not counting overnight stay)** |
| **N4c. Physician visit (or authorized assistant or practitioner)** |
| **N.5. PHYSICALLY RESTRAINED** |
| **Physically restrained - Limbs restrained, used bed rails, restrained to chair when sitting** |
| **Treatments and Procedures Notes** |
| **O. Responsibility** |
| **O.1. LEGAL GUARDIAN [EXAMPLE - USA]** |
| **Legal guardian** |
| **Responsibility Notes** |
| **P. Social Supports** |
| **P.1. TWO KEY INFORMAL HELPERS** |
| **P1a. Relationship to primary helper** |
| **P1a. Relationship to secondary helper** |

| |
|---|
| **P1b. Lives with primary helper** |
| **P1b. Lives with secondary helper** |
| **P. AREAS OF INFORMAL HELP DURING LAST 3 DAYS** |
| **P1c. Primary IADL help** |
| **P1c. Secondary IADL help** |
| **P1d. Primary ADL help** |
| **P1d. Secondary ADL help** |
| **P.2. INFORMAL HELPER STATUS** |
| **P2a. Informal helper(s) is unable to continue in caring activities - e.g., decline in health of helper makes it difficult to continue** |
| **P2b. Primary informal helper expresses feelings of distress, anger, or depression** |
| **P2c. Family or close friends report feeling overwhelmed by person's illness.** |
| **P.3. HOURS OF INFORMAL CARE AND ACTIVE MONITORING DURING LAST 3 DAYS** |
| **Hours of informal care and active monitoring during last 3 days - For instrumental and personal activities of daily living in the LAST 3 DAYS, indicate the total number of hours of help received from all family, friends, and neighbors** |
| **P.4. STRONG AND SUPPORTIVE RELATIONSHIP WITH FAMILY** |
| **Strong and supportive relationship with family** |
| **Social Supports Notes** |
| **Q. Environmental Assessment** |
| **Q.1. HOME ENVIRONMENT** |
| **Q1a. Disrepair of the home - e.g., hazardous clutter; inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor; leaking pipes** |
| **Q1b. Squalid condition - e.g., extremely dirty, infestation by rats or bugs** |
| **Q1c. Inadequate heating or cooling - e.g., too hot in summer, too cold in winter** |
| **Q1d. Lack of personal safety - e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street** |
| **Q1e. Limited access to home or rooms in home - e.g., difficulty entering or leaving home, unable to climb stairs, difficulty maneuvering within rooms, no railings although needed** |
| **Q.2. LIVES IN APARTMENT OR HOUSE RE-ENGINEERED ACCESSIBLE FOR PERSONS WITH DISABILITIES** |
| **Lives in apartment or house re-engineered accessible for persons with disabilities** |
| **Q.3. OUTSIDE ENVIRONMENT** |

| |
|---|
| **Q3a. Availability of emergency assistance - e.g., telephone, alarm response system** |
| **Q3b. Accessibility to grocery store without assistance.** |
| **Q3c. Availability of home delivery of groceries** |
| **Q.4. FINANCES** |
| **Because of limited funds, during the last 30 days made trade-offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heating or cooling; necessary health care** |
| **Environmental Assessment Notes:** |
| **R. Discharge Potential and Overall Status** |
| **R.1. ONE OR MORE CARE GOALS MET IN THE LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)** |
| **One or more care goals met in the last 90 days (or since last assessment if less than 90 days)** |
| **R.2. OVERALL SELF-SUFFICIENCY HAS CHANGED SIGNIFICANTLY AS COMPARED TO STATUS OF 90 DAYS AGO** |
| **Overall self-sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days)** |
| **R.3. NUMBER OF 10 ADL AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION** |
| **Number of 10 ADL areas in which person was Independent prior to deterioration** |
| **R.4. NUMBER OF 8 IADL PERFORMANCE AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION** |
| **Number of 8 IADL performance areas in which person was Independent prior to deterioration** |
| **R.5. TIME OF ONSET OF THE PRECIPITATING EVENT OR PROBLEM RELATED TO DETERIORATION** |
| **Time of onset of the precipitating Event or problem related to deterioration.** |
| **Discharge Potential and Overall Status Notes** |
| **S. Discharge** |
| **S.1. LAST DAY OF STAY** |
| **Last day of stay (month, day, year)** |
| **S.2. RESIDENTIAL / LIVING STATUS AFTER DISCHARGE** |
| **Residential / Living status after discharge** |
| **Discharge Notes** |

# Georgia Department of Community Health
# COMMUNITY CARE SERVICES PROGRAM



| Client Name | SSN | Medicaid # | Care Plan Type | Recommendation | Date | Next Care Plan |
|---|---|---|---|---|---|---|
| John Doe | 666-66-6666 | | | | 4/30/01 | |

| Needs | Goals | Comments |
|---|---|---|
| IADL Need | Assure Proper Hygiene | |
| ADL Need | | |

| Service | Provider | Phone | C | Freq | Units | Cost | Ordered | Begin | End | Payment |
|---|---|---|---|---|---|---|---|---|---|---|
| Community Care Services Program | | | ☐ | | 0 | | | | | Medicaid |



☑ Client Chose CCSP vs. Nursing Home Placement ☐ Client Signature on File

Care Coordinator _____ Signature Date

Collaborating Team Member _____ Signature Date

_____ Signature Date

**Instructions**
Community Care Services Program

## COMPREHENSIVE CARE PLAN (CCP)

*Purpose:* The CCP is used for the Initial Plan of Care. It is used again at the 30 day review, which takes place after the Initial Plan of Care, for subsequent comprehensive care plan reviews, and for reassessments.

**NOTE:** Clients must receive the first waivered service within 60 days of LOC determination which is date the RN signs LOC page in #42 or the assessment is void.

*Who Completes/When completed:* The care coordinator completes the CCP at initial assessment, 30-day review, comprehensive care plan review, and reassessment.

*Instructions:*

**NOTE:** Instructions for the CCP are numbered. These items correspond to CCP screen items in CHAT.

1. Enter name of client.

2. Enter Social Security number of client.

3. Enter Medicaid number of client. Leave this item blank if the client is a PMAO client who does not have a Medicaid number at this point.

4. Enter care plan type, i.e., Initial, 30 day, CCP Review or Reassessment.

5. Indicate care coordination team's recommendation for client. **NOTE:** If skilled waivered services ordered document in comments section that client meets homebound criteria.

**NOTE:** If nursing home placement is recommended, skip #7-22. Have client or representative sign signature page and complete #23 and #24.

6. Enter date CCP is completed.

7 Indicate date of next care plan review. If this is an initial assessment the next CCP Review will be due 30 days from the date services were brokered.

8. Problems/Needs: Record the problems/needs of the client as established at the assessment/30 day review/reassessment/care plan review visit. Document any deviation from normal functioning that requires different or additional health or social services. For

*non-CCSP service*, list the problem here.

9. Goals/Approach: Record the goals and/or objectives for the CCSP services ordered/provided. This is used as a basis for measurable evaluation of the client's condition at reassessment and follow-up. Approach describes the process followed to achieve goals set with client. For *non-CCSP service,* leave the "Goals/Approach" column blank.

10. Use the Comments section to explain why services were ordered, changed, discontinued, etc., or to add any specific information regarding any services being provided to client or to alert provider with specific instructions. Include discharge plan recommendations.

11. Service: Record all services including CCSP which the client currently receives. In the comment section, document services received in the past three months that are now terminated. The care coordinator uses the client's input to develop the care plan services.

12. Enter name of provider, including non-CCSP providers.

13. Enter the telephone number including area code of provider agency.

14. Indicate whether the CCSP provider was the client's choice or was selected from the rotation list. If the client chooses a provider, but the care coordinator does not broker service with the selected provider, document an explanation in case notes.

15. Enter the frequency of service to be provided. For non-CCSP services enter frequency of service if known.

16. Enter the units of service to be provided For non-CCSP services enter units of service if known.

17. Enter the estimated cost per month for the service to be provided. In the Cost column record the Medicaid rate. Calculate cost per month by multiplying rate per unit of service by number of units provided (for example: ALS $24.66 x 30 units per month = $739.80). Use current provider rates to determine cost per month. *If total cost of client services is expected to exceed cost cap consistently, client is not appropriate for CCSP.* For non-CCSP services leave estimated cost blank.

18. Enter the date the CCSP service is ordered/brokered.

19. Enter the date the CCSP service started as indicated on the initial Community Care Notification Form (CCNF). Leave blank at Initial, to be completed when the CCNF is received from the provider(s) or no later than the 30 day review.

20. Enter the date any service was terminated.

21. Enter the payment/fund source for CCSP and non-CCSP services if known. NOTE: This

includes Medicaid Home Health Services. Any deviation from the care plan is discussed and explained in Comments section.

22. Signature of care coordinator who completed this care plan.

23. Signature of collaborating team member and date signed needed at initial assessment and reassessment. This signature is not needed for CCP reviews and Interim CCPs.

24. Indicate date signed. Indicate whether or not client chooses CCSP or nursing home placement by checking (✓) the appropriate box. Have client or representative sign the signature page to indicate the choice.

25. Indicate if client or representative signed signature page by checking ( ) appropriate box.

26. Enter date client or representative signed signature page.

**NOTE**: Care coordinator who completes assessment/reassessment signs CCP at time of assessment. Collaboration team member signs prior to form being sent to physician for review and completion.

*Distribution:* Send LOC page, addendum to medication list (if applicable) and CCP to physician for review and completion. Upon return from physician, maintain original in client file and send copies to each provider providing services to the client and Level of Care page to DFCS if client is MAO or PMAO.

**<u>NOTE on instruction 23 (above)</u>: The signature of the collaborating team member is only required when the assessment is performed by an LPN or the service addition is made by a staff member other than an RN. (Rev 1/2015)**

**Enter the estimated cost per month for the service to be provided. In the Cost column record the Medicaid rate. Calculate cost per month by multiplying rate per unit of service by number of units provided (for example: ALS $50.00 x 30 units per month = $1500.00. Use current provider rates to determine cost per month.** ***If total cost of client services is expected to exceed cost cap consistently, client is not appropriate for CCSP AND SOURCE.*** **For non-** EDWP (CCSP and SOURCE)

**APPENDIX H**
**Georgia Department of Human Services**

**Alzheimer's Disclosure Form**

# General Information/Background

During the 1994 session of the Georgia General Assembly, Title 31 of the Official Code of Georgia Annotated was amended to include a new article (number 7), requiring facilities, programs, or entities advertising specialized care for persons with a probable diagnosis of Alzheimer's disease or related dementia to provide written disclosure of information related to staffing, training, activities, involvement with the family, and program costs, among others. The Act requires that this information be provided to any person seeking information concerning placement in or care, treatment, or therapeutic activities from the program.

# Which Organizations Must Complete This Form

Any program, facility, entity or any instrumentality of the state or political subdivision of the state other than those excluded by Code Section 31-8-181 (Disclosure of Treatment of Alzheimer's Disease or Alzheimer's Related Dementia) which advertises, markets, or offers to provide specialized care, treatment, or therapeutic activities for one or more persons with a probable diagnosis of Alzheimer's Disease or Alzheimer's-related dementia is required to complete this form. The Act does not apply to physicians or their employees. However, if a physician operates, manages, owns or controls a nursing home, personal care home, hospice, respite care service, adult day program or home health agency, the entity is still required to make the disclosure. Hospitals are exempt from the disclosure requirement. However, a hospital's nursing home, respite care service, adult day program, or home health agency is required to make the disclosure if it holds itself out as providing specialized care for persons with Alzheimer's Disease or Alzheimer's-related dementia.

# Instructions

Please complete this form in the spaces provided and provide copies of this form to any person seeking information concerning placement in or care, treatment, or therapeutic activities for persons with Alzheimer's Disease or Alzheimer's-related dementia. **Information requested must be completed on this form, unless otherwise indicated.** This form must be revised whenever significant changes occur.

Failure to provide disclosure as required shall be considered a violation of Part 2 of Article 15 of the Chapter 1 of Title 10, the Fair Business Practices Act of 1995, and could result in a civil penalty of up to a maximum of $2,000 per violation, per day. If the facility providing specialized care for persons with a probable diagnosis of Alzheimer's Disease fails to provide the Disclosure Form or the information contained within is inaccurate, contact:

The Administrator
Governor's Office of Consumer Affairs
2 Martin Luther King Jr., Drive, Suite 356
Atlanta, GA 30334
(404) 656-3790
Facsimile (404) 651-9018

**Name of Program, Facility, or Entity:**

**Address:** _____

_____

**Phone Number:** _____ **Date Completed** _____

**For further information regarding this program, contact** _____

**(specify phone number).** _____

**.....**

# Section 1: Philosophy and Mission

Describe the overall philosophy and mission which reflects the needs of people with Alzheimer's Disease or related dementias. (Useful information might include type of license, permit or accreditation, or name of monitoring agency).

_____

_____

_____

**.....**

# Section 2: Admission and Discharge Requirements

## Admission

Please attach a copy of the admission application form. If there is no form, please describe how the facility or program obtains information on physical status, mental status, functional ability, and medication profile of the person with dementia.

_____

_____

_____

What is the title of the staff member who performs the assessment for admission?

_____

## Discharge

Does the facility/program have written criteria related to discharge? Yes ____ No ____ (*If yes, attach copy).*

Are family members provided a copy of discharge criteria? Yes ____ No ____

Describe any circumstances under which a person can be discharged without notice: _____

_____

_____

_____

Is the family informed of discharge? Yes ____ No ____

**.....**

## Section 3: Defining Programs/Services

*If applicable,* describe how the facility or program develops care plans to meet individual needs of people with dementia. (Useful information might include whether a person needs assistance with activities of daily living (ADL's): activities that address level of functioning; level of supervision needed; frequency of care plan updates; involvement of families in care plan development; or the credentials of the staff person who develops the care plan).

What are the Alzheimer's specific qualifications of the person(s) that develops the individualized care plans?

Are families consulted in the preparation of individualized care plans? Yes ____ No ____

How often are clients re-evaluated: _____

## Section 4: Training/Staffing

Is training provided to new employees regarding Alzheimer's Disease and other dementias? Yes ____ No ____

Describe the training for your staff that enables them to provide the specialized programs and services your organization provides for persons with dementia. (Example: Music Therapy for persons with Alzheimer's Disease. *Attach copy of the training plan if available.* Useful information might include topics of training sessions: hours of initial training; frequency of in-service training; credentials of employee trainers.)

*Additional questions for nursing homes, personal care homes, adult day programs, and other programs where applicable:*

What is the program's ratio of staff to persons with dementia? _____

If applicable, how does this ratio differ from the program's ratio of staff to clients for non-dementia persons?

## Section 5: Description of the Physical Environment

Describe the physical environment of the facility, if applicable. (Useful information might include amount of privacy provided; enclosed outdoor area for walking; safety features of the building; frequency of fire or disaster drills; building modifications to create soothing atmosphere; visions' policy).

## Section 6: Frequency and Types of Activities

What special activities are planned for participants with dementia? (List activities in this space or attach a copy of activity calendar as a supplement if desired).

## Section 7: Family Support Programs

Describe any programs, services or activities provided to family members or friends or members of clients with dementia. (Useful information might include ways these programs complement your care/treatment/activities: support groups, information and referral; care plan conferences; social functions or other activities.)

## Section 8: Charge Structure

Specify the name and phone number of the staff person who can provide information regarding fees, AND attach a copy of any fees to the potential participant, family, or other decision maker (e.g., guardian). Include basic and any potential supplementary charges, including support services (e.g., occupational therapy, physical therapy, speech therapy, incontinence supplies, vision and hearing aids, dental, laundry, etc.).

How often is a copy of a list of incurred, itemized expenses provided to the client or their family? (Please specify)

When an increase in charges occurs, how much advance notice does the program/facility provide to clients and their families?

What is the policy regarding non-payment or late payment? Specify penalties, etc.

# Alzheimer's Disclosure Form

## Glossary of Terms

**Accreditation** - assurance by public or private agency that a facility, program, or entity meets standards which are separate from and in addition to any applicable state licensure requirements. Accreditation may include both 1) assurance that a facility, program, or entity meets standards of quality set forth by the accrediting agency (e.g., Joint Commission on Accreditation of Health Organizations {JCAHO} and 2) assurance that a facility, program, or entity meets standards necessary to qualify for the receipt of funds from the accrediting agency (e.g., the Division of Medical Assistance for Medicaid, Health Care Financing Administration (HCFA) for Medicare).

**Alzheimer's Disease -** A progressive neurodegenerative disease characterized by loss of function and death of nerve cells in several areas of the brain, leading to loss of cognitive function such as memory and language. The cause of this nerve cell death is unknown. Alzheimer's disease in the most common type of dementia.

**care plan -** a determination by a social worker or nurse of the problems and needs of the client based on information obtained during assessment and observations of individual functional capabilities. In addition, care plans include what service(s) are needed to meet client needs, set goals toward which to work, and indicate specific, expected changes in client capabilities at a specific future time as a result of services implemented.

**client -** in this document, the person with dementia who is receiving specialized Alzheimer's services.

**dementia -** the loss of intellectual functions (such as thinking, remembering, and reasoning) of sufficient severity to interfere with an individual's daily functioning. Dementia is not a disease itself, but rather a group of symptoms which may accompany certain diseases and conditions. Symptoms also include changes in personality, mood, and behavior. Dementia is irreversible when caused by disease and injury, but may be reversible when caused by drugs, alcohol, hormone or vitamin imbalances, or depression.

**resident -** in this document, a person with dementia who makes his/her home in a nursing home or personal care home.



**DHS**
**GEORGIA**
**DEPARTMENT OF**
**HUMAN RESOURCES**

Form 5534 (2-97)

# EDWP NOTIFICATION FORM

1. **Mark (X) indicate the reason for sending:** ***(CC to Provider*** ☐ **Provider to CC** ☐**)**
   ☐ **Initial** ☐ **Change** ☐ **Complaint/Concern** ☐ **Transfer** ☐ **Discharge** ☐ **Other**

2. **To:** **Date:**

3. **From:** **Telephone:**

4. **Client Name:** **(Source** ☐ **CCSP** ☐ **)** **Medicaid #:**

   ☐ **Mark if new address** **Client Address:**

   **City:** **Zip:** **County:** **Telephone:** ☐ **New Number**

5. **SERVICES:**
   ☐ **PSS** ☐ **PSSX** ☐ **CD PSS** ☐ **SFC**
   ☐ **ERS**
   ☐ **ALS**
   ☐ **ADH** ☐ HALF, ☐FULL ☐LEVEL I, ☐ LEVEL II
   ☐ **HDM**
   ☐ **SNS** ☐ RN, ☐ LPN
   ☐ **HDS**
   ☐ **OHR**
   **COMMENTS:**

6. **Date your RN/Staff completed initial evaluation with client:** ***(Must be RN for ALS, ADH and PSS/X)***
   ☐ **Services were accepted** ☐ **Services were not accepted – REASON:**

7. **Date services began:**

8. **Service Issues:** ***(Check all applicable below and clarify in #13)***

| | | | |
|---|---|---|---|
| **Request for service increase** | ☐ | **Request for service decrease** | ☐ |
| **Failure to pay cost share** | ☐ | **Client out of home** | ☐ |
| **Services initiated** | ☐ | **Client termination** | ☐ |
| **Requested provider change** | ☐ | **Health/Safety Issue** | ☐ |
| **Request for information** | ☐ | **Missed Visit(s)** | ☐ |
| **Admission to Rehab/NH** | ☐ | **Request for PA info/PA update** | ☐ |
| **Scheduled day surgery/no hospital admission** | ☐ | | |
| **Other** | ☐ | | |

(***scheduled hospital admits/overnight stay, ER visits or reports of falls require an online incident report-no form needed)***

9. **Discharge (briefly describe actions leading up to need for discharge process):**

10. **Date discharge (30-day) letter sent** **Actual discharge date** **Last day of service**

11. **Are services continuing through 30-day notice?** ☐ **Yes** ☐ **No**

12. **Initial or current services/frequency in the home/facility:**

13. **Complaint/Concern/Other (from #8)**

14. **Sender name or signature:** **Title:** **Date:** **Email:**

15. **Recipient name or signature:** **Title:** **Date:** **Email:**

16. **Recipient response:**

**Revised** 4/2021

**Instructions**
Elderly and Disabled Waiver Program

**Appendix I – EDWP Notification Form**

The EDWP Notification Form conveys information between the site and participating service providers. The form serves as documentation of interactions on behalf of individual EDWP members and may be initiated by either case management or service provider staff. The form confirms key exchanges (new admissions, service level changes, hospitalizations, etc.) but also should be used to identify issues that potentially jeopardize an EDWP member's ability to continue living in the community.

**Instructions:**
1. Indicate entity-initiating form (site or provider) with a check mark and provide explanation of reason for the communication.
2. Indicate the person/agency and date the form is being sent to.
3. Indicate the person/agency and phone number of the sender of the form.
4. Indicate the EDWP Member name and program served as well as Medicaid ID of the member. Provide Member address, county and phone info.
5. Indicate services delivered in the home by the provider sending the form or services of the provider the form is being sent to. Provide comments if applicable.
6. Service Provider to indicate dates of evaluation performed in the home and if services will be accepted or declined.
7. Provider to indicate date services began.
8. Indicate service issues, checking all that are applicable. Do not submit this form when performing the online incident system reporting.
9/10. Indicate date of discharge, last day of service, reason and date of notification being sent.
11. Indicate whether service will continue during the 30 day notice.
12. Indicate current service frequency presently received.
13. Indicate details regarding the complaint/concern or other from #8.
14. Indicate sender name, title, date and email information.
15. Indicate recipient name, title, date and email information.
16. Indicate recipient response as applicable.

**NOTE: The agency receiving the form must acknowledge receipt in writing with signature and date. Return the form to the agency which generated the form with three (3) business days.**

**APPENDIX J**

Last Update Date

DCH – Division of Medicaid
**Community Care Services Program**
**Service Authorization Form**

Print date:
Print time:

| | | |
|---|---|---|
| Case Manager: | | |
| Client Name: | SAF #: | Version |
| Medicaid #: | SSN: | |
| Date of Birth: | County: | |
| Services Begin Date: | Services End: | |
| SAF Month: | Reason: | |

| Provider ID | Procedure | Rate | Units | Amount | Net Amount |
|---|---|---|---|---|---|

Gross Total:

_____ **Client Liability** _____

**Net Total:**

_____ **Authorization and Approval** _____

| | |
|---|---|
| Case Manager: | Phone No: |

Authorizing Signature: _____ Date: _____/_____/_____

_____ Authorization and Approval _____

This service authorization has been Pended until
A DMA-80 number has been approved by the GA Department of Community Health's Medicaid Division

| | |
|---|---|
| Case Manager: | Phone #: |

# Appendix K
# Client Care Plan

1. Client Name: _____ 2. Medicaid #:_____ 3. Provider Agency: _____

4. Medicaid Diagnosis:_____ 5. Service Provider: ___ ADH ___ALS ___ PSS ___ RC ___HDS

6. Physician's Name:_____ 7. Effective Dates: _____ to _____

| 8. Problem | 9. Approach | 10. Goal | 11. Target Date | 12. Agency/Person(s) Providing Services | 13. Date |
|---|---|---|---|---|---|
| | | | | | |

14. Discharge Plans:

15. Provider R.N.: _____ 16. Date: _____
(Signature)

## INSTRUCTIONS FOR COMPLETING CLIENT CARE PLAN

1. **Client's Name:** Copy as appears on #2 of the Comprehensive Care Plan or #5 on the Client Assessment.

2. **Medicaid #:** Copy from #8 on the Comprehensive Care Plan or #9 on the Client Assessment.

| |
|---|
| Note: A potential MAO client will NOT have a Medicaid card. |

3. **Provider Agency:** Your agency's name.
4. **Medical Diagnosis:** Copy from Client Assessment Instrument.
5. **Service Provider:** Type of EDWP (CCSP and SOURCE) service you are providing to the client.
6. **Physician's Name:** Client's physician's name.

7. **Effective Dates: The care plan effective dates should not span more than one year. The Client Care Plan is be reviewed and revised as needed by the provider's R.N. during each supervisory visit. Rev. 10/2018**

8. **PROBLEM:** Refer to #11 on the Comprehensive Care Plan plus your own observations of the client's status.

9. **APPROACH:** Indicate how you intend to address the specific problem/need. (Example: if the ALS Client needs assistance with bathing, your "approach" might be to provide ALS personal care services).

10. **GOAL:** The goal should address the specific problem(s) that the client has. (Example: the goal for the ALS Client in the above example could be to "promote good personal hygiene").

11. **TARGET DATE:** If the APPROACH calls for a specific time frame, indicate that time frame here. (Example: if a client is non-compliant with medications and the provider is spending a specific period to time teaching the client how to competently self-administer medications, indicate the time frame).

12. **AGENCY/PERSONS(S) PROVIDING SERVICES:** Your agency name - if specific staff person, note name.

13. **DATE:** Refers to time frame for achieving GOALS (number 11. above). Example: for the ALS Client referred to above who is to receive assistance with bathing, the DATE would be "on-going" after the initial date was entered when the provider began giving service).

14. **Discharge Plans:** It is the provider's responsibility to plan with the client and/or the client's family what will occur if the client is no longer appropriate for service with the provider. Refer to Section 606.6 and 606.7 of the Policies and Procedures for EDWP (CCSP and SOURCE) for discharge planning information.

15. **Provider R.N. (signature):** The provider's R.N. signs every Client Care Plan to document the review frequency (i.e., every 60-62 calendar days or every 30 days depending on the service).

16. **Date:** The provider's R.N. dates every Client Care Plan.

Georgia Department of Community Health

Name of Individual/Consumer/Patient/Applicant

Date of Birth

IF AVAILABLE:

ID Number Used by Requesting Agency

ID Number Used by Releasing Agency

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize:

(Name of Person or Agency Requesting Information)

(Address)

to obtain from:

(Name of Person or Agency Holding the Information)

(Address)

the following type(s) of information from my records (and any specific portion thereof):

for the purpose of:

*I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for:* (PLEASE CHECK ONE)

☐ ninety (90) days unless I specify an earlier expiration date here: (Date)

☐ one (1) year.

☐ the period necessary to complete all transactions on matters related to services provided to me.

*I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.*

(Date)

(Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness)

(Title or Relationship to Individual)

(Signature of Parent or other legally Authorized Representative, where applicable)

(Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

(Date this authorization is revoked by Individual)

(Signature of Individual or legally authorized Representative)

## APPENDIX M

## UTILIZATION REVIEW/APPEAL PROCESS

| If Recommendation is<br>Decrease in Services | If Recommendation is<br>Discharge from Services |
|---|---|
| The Utilization Review (UR) analyst will visit the EDWP (CCSP/SOURCE) recipient in the home or ADH center (after chart review at agency) and recommend reduction in service. | The Utilization Review (UR) analyst will visit the EDWP (CCSP/SOURCE) recipient in the home or ADH center (after chart review at the agency) and recommend discontinuation of services. |
| The report, with recommendations, is received at DMA. DMA reviews UR worksheets and if it concurs with the recommendations regarding decreases in services, a letter is sent to the recipient with a copy to the DCH Legal Services Office and the local county Department of Family and Children Services. The letter notifies the recipient of DMA's intent to reduce services. The letter includes steps the recipient must take to obtain a hearing and specific instructions for the recipient to notify the care coordinator of the intent to appeal. | The report, with recommendations, is received at DMA. DMA reviews UR worksheets and if it concurs with the recommendations regarding discontinuation of services, a letter is sent to the recipient with a copy to the EDWP (CCSP and SOURCE) Unit, DCH Legal Services Office and county Department of Family and Children Services. The letter notifies the recipient of DMA's intent to discontinue services. It includes steps the recipient must take to obtain a hearing and specific instructions for the recipient to notify the care coordinator of the intent to appeal. |
| DFCS will assist the recipient if a hearing is requested (notify DHS Legal Services Office). | If an MAO recipient does not request a hearing within ten (10) calendar days of receipt of the letter, the care coordinator informs DFCS to terminate eligibility. |
| The DHS Legal Services Office will notify DMA if the recipient appeals and of the date and location of the hearing. | DFCS will assist the recipient if a hearing is requested (notify DHS Legal Services Office). |
| | The DHS Legal Services Office will notify DMA if the recipient appeals and of the date and location of the hearing. |

**APPENDIX N**

## Designating a Representative

EDWP (CCSP and SOURCE) clients have the option of designating a representative to assist, at the client's direction, in matters of health, well-being, and access to records, information, or notices regarding client care. Designating a representative is optional. If the client has a Durable Power of Attorney for Health Care currently in effect, the client should not designate a representative.

**Representative** is defined as a person who voluntarily, with the client's written authorization, may act upon the client's direction with regard to matters concerning the health and welfare of the client, including being able to access personal records contained in the client's file and receive information and notices pertaining to the client's overall care and condition. Neither the care coordinator nor a member of the provider's family, governing body, administration, or staff may serve as the representative for the client.

Designating a Representative

I, _____, authorize
(Client's Name)

_____ as my representative
(Representative's Name)

_____
(Representative's Address)

(_____)_____
(Representative's Telephone Number)

To act on my direction in matters of:

____ Health and Well-Being

____ Access to any records pertaining to me or my care

____ Receiving information and notices pertaining to my care and condition

Signed: _____ Date _____

☐ I choose not to designate a representative at this time

Signed _____ Date _____

EDWP (CCSP and SOURCE) **clients who have not designated a client representative, or do not have a legal guardian are subject to the following law concerning consent for medical treatment:**

**O.C.G.A. 31-9-1 Consent for Surgical or Medical Treatment**

**31-9-1. Short title**.

This chapter shall be known and may be cited as the Georgia Medical Consent Law. (Code 1933, ' 88-2901), enacted by Ga. L. 1971, p.438, '1.)

**31-9-2. Persons authorized to consent to surgical or medical treatment**.

(a) In addition to such other person as may be authorized and empowered, any one of the following persons is authorized and empowered to consent, either orally or otherwise, to any surgical or medical treatment or procedures not prohibited by law which may be suggested, recommended, prescribed, or directed by a duly licensed physician:

(1) Any adult, for himself, whether by living will or otherwise;

(1.1) Any person authorized to give such consent for the adult under a health care agency complying with Chapter 36 of Title 31, the Durable Power of Attorney for Health Care Act;

(2) In the absence or unavailability of a living spouse, any parent, whether an adult or a minor, for his minor child;

(3) Any married person, whether an adult or a minor, for himself and for his spouse;

(4) Any person temporarily standing in loco parentis, whether formally serving or not, for the minor under his care; and any guardian, for his ward;

(5) Any female, regardless of age or marital status, for herself when given in connection with pregnancy, or the prevention thereof, or childbirth;

(6) Upon the inability of any adult to consent for himself and in the absence of any person to consent with paragraph (2) through (5) of this subsection the following person in the following order of priority:

(A) Any adult child for his parents;

(B) Any parent for his adult child;

(C) Any adult for his brother or sister; or

(D) Any grandparent for his grandchild.

(b) Any person authorized and empowered to consent under subsection (a) of this Code section shall, after being informed of the provisions of this Code section, act in good faith to consent to surgical or medical treatment or procedures which the patient would have wanted had the patient understood the circumstances under which such treatment or procedures are provided.

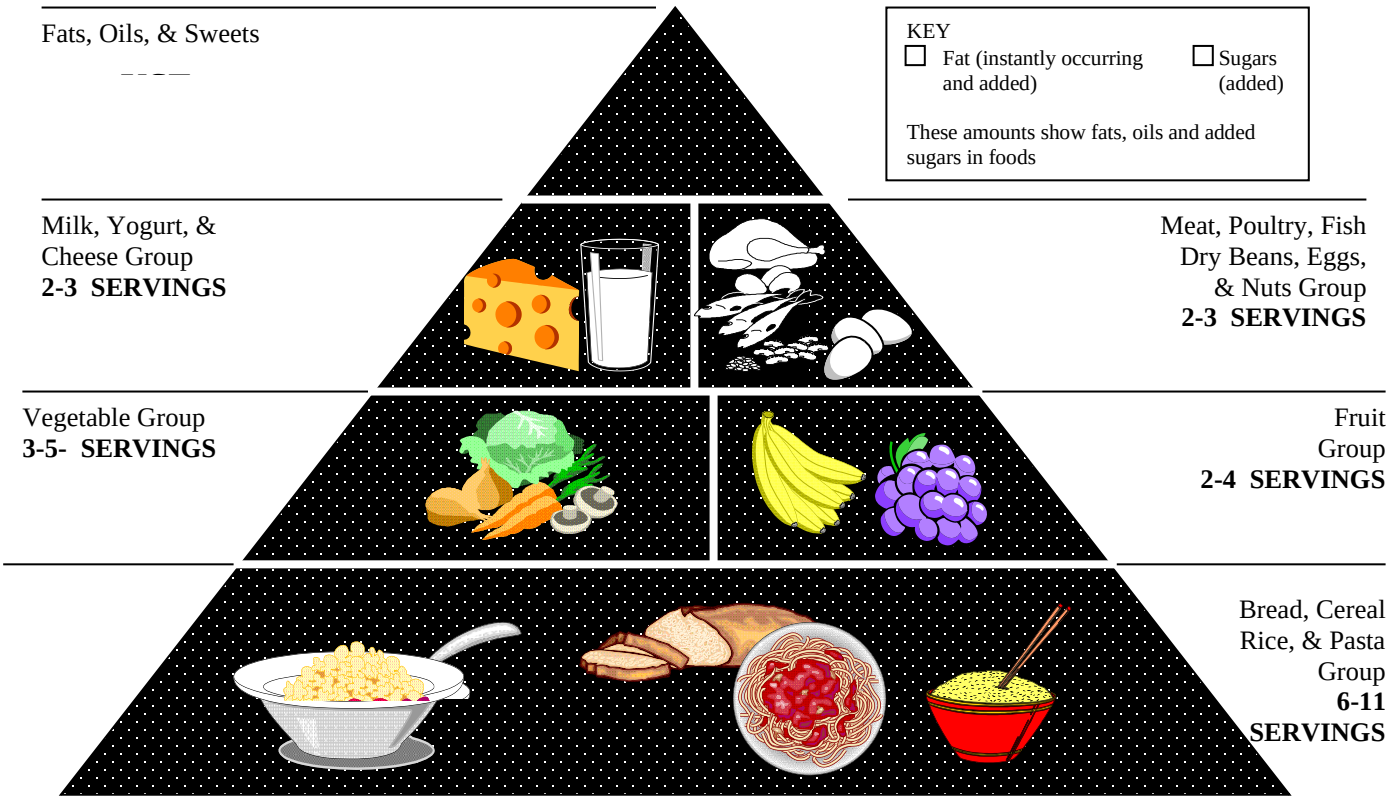
(c) For purposes of this Code section, inability of any adult to consent for himself shall mean a determination in the medical record by a licensed physician after the physician has personally examined the adult that the adult lacks sufficient understanding or capacity to make significant responsible decisions regarding this medical treatment or the ability to communicate by any means such decisions. (Code 1993, ' 88-2904, enacted by Ga. L. 1971, p. 438, ' 1; Ga. L. 1972, p. 688, ' 1; Ga. L. 1975, p. 704, ' 2; Ga. L. 1991, p. 335, ' 1.)

**31-9-3. Emergencies**

(a) As used in this Code section, the term emergency means a situation wherein (1) according to competent medical judgement the proposed surgical or medical treatment or procedures are reasonably necessary and (2) a person authorized to consent under Code Section 31-9-2 is not readily available, and any delay in treatment could reasonably be expected to jeopardize the life or health of the person affected or could reasonably result in disfigurement or impaired faculties.

(b) In addition to any instances in which a consent is excused or implied at law, a consent to surgical or medical treatment or procedures suggested, recommended, prescribed, or directed by a duly licensed physician will be implied where an emergency exists (Code 1933, ' 88-2905, enacted by Ga. L. 1971, p. 438, ' 1).

# APPENDIX O
# THE FOOD GUIDE PYRAMID




SOURCE: U.S. Department of Agriculture/U.S. Department of Health and Human Services

***What Counts as a Serving?***

With the Food Guide Pyramid, what counts as a "serving" may not always be a typical "helping" of what you eat. Here are some examples of servings:

**Bread, Cereal, Rice & Pasta** - 6-11 servings recommended
Examples of one serving:
- 1 slice of bread
- 1 oz. Of ready-to-eat cereal
- 1/2 cup of cooked cereal, rice, or pasta
- 3 or 4 small plain crackers

**Vegetables** - 3-5 servings recommended
Examples of one serving:
- 1 cup of raw leafy vegetables
- 1/2 cup of other vegetables, cooked or chopped raw
- 3/4 cup of vegetable juice

**Fruits** - 2-4 servings recommended
Examples of one serving:

- 1 medium apple, banana, or orange
- 1/2 cup of chopped, cooked, or canned fruit
- 3/4 cup of fruit juice

**Milk, Yogurt, and Cheese** - 2-3 servings recommended
Examples of one serving:
- 1 cup of milk or yogurt
- 1 1/2 oz. Of natural cheese
- 2 oz. of process cheese

**Meat, Poultry, Fish, Dry beans, Eggs and Nuts** - 2-3 servings recommended
Examples of one serving:
- 2-3 oz. of cooked lean met, poultry, or fish
- 1/2 cup of cooked dry beans, 1 egg, or 2 table-spoons of peanut butter = 1 oz. of lean meat

How Much Is an Ounce of Meat?

Here's a handy guide to determining how much meat, chicken, fish, or cheese weigh:
1 ounce is the size of a match box.
3 ounces are the size of a deck of cards.
8 ounces are the size of a paperback book.

Nutrition Education

# The Food Guide Pyramid-Putting the Dietary Guidelines Into Action

Learning to eat right is now made simpler with the new Food Guide Pyramid by the U.S. Department of Agriculture (USDA). The Pyramid is a graphic description of what registered dietitians and other nutrition experts have been advising for year:
Build your diet on a base of grains, vegetables, and fruits. Add moderate quantities of lean meat (poultry, fish, eggs, legumes) and dairy products, and limit the intake of fats and sweets.

The Food Guide Pyramid illustrates how to turn the Dietary Guidelines for Americans (issued by USDHHS/USDA in 1990) into real food choices.

The Dietary Guidelines-and their relationship to the Food Guide Pyramid--are as follows:

■ **Eat a variety of foods.** The body needs more than 40 different nutrients for good health, and since no single food can supply all these nutrients, variety is crucial. Variety can be assured by choosing foods each day form the five major groups shown in the Pyramid: (1) Breads, Cereals, Rice & Pasta (6-11 servings); (2) Vegetables (3-5 servings); (3) Fruits (2-4 servings); (4) Milk, Yogurt & cheese (2-3 servings); (5) Meat, Poultry, Fish, Dry Beans, Eggs & Nuts (2-3 servings) and (6) Fats, Oils and Sweets (use sparingly).

■ **Maintain healthy weight.** Being overweight or underweight increases the risk of developing heart problems, so it is important to consume the right amount of calories each day. The number of calories needed for ideal weight (which varies according to height, frame, age, and activity) will generally determine how many servings in the Pyramid are needed.

■ **Choose a diet low in fat, saturated fat, and cholesterol.** As shown in the Pyramid, fats and oils should be used sparingly, since diets high in fat are associated with obesity, certain types of cancer, and heart disease. A diet low in fat also makes it easier to include a variety of foods, because fat contains more than twice the calories of an equal amount of carbohydrates or protein.

■ **Choose a diet with plenty of vegetables, fruits, and grain products.** Vegetables, fruits, and grains provide the complex carbohydrates, vitamins, minerals, and dietary fiber needed for good health. Also, they are generally low in fat. To obtain the different kinds of fiber contained in these foods, it is best to eat a variety.

■ **Use sugars only in moderation.** Sugars, and many foods containing large amounts of sugars, supply calories but are limited in nutrients. Thus, they should be used in moderation by most healthy people and sparingly by those with low calorie needs. Sugars, as well as foods that contain starch (which breaks down into sugars), can also contribute to tooth decay. The longer foods containing sugars or starches remain in the mouth before teeth are brushed, the greater the risk for tooth decay. Some examples of foods that contain starches are milk, fruits, some vegetables, breads, and cereals.

■ **Use salt and sodium only in moderation.** Table salt contains sodium and chloride, which are essential to good health. However, most Americans eat more than they need. Much of the sodium in people's diets comes from salt they add while cooking and at the table. Sodium is also added during food processing and manufacturing.

■ **If you drink alcoholic beverages, do so in moderation.** Alcoholic beverages contain calories but little or no nutrients. Consumption of alcohol is linked with many health problems, causes many accidents, and can lead to addiction. Therefore, alcohol consumption is not recommended.

Adapted from *At the Center*, National Center for Nutrition and Dietetics, Chicago, IL, Summer 12992

Rev. 10/09, 01/10

**APPENDIX P**

# **POTENTIAL** EDWP (CCSP and SOURCE) **MAO FINANCIAL WORKSHEET**

Client's Name _____ Date of Birth _____

| Section I. | INCOME | AMOUNT |
|---|---|---|
| | Social Security | $_____ |
| | VA Benefits | $_____ |
| | Retirement/Pension | $_____ |
| | Interest/Dividends | $_____ |
| | Other (specify) | $_____ |
| | TOTAL INCOME | $_____ |

NOTE: If monthly income exceeds the Medicaid Cap, stop here and refer client to DFCS for information about a Medicaid Qualifying Trust.

Section II. RESOURCES

| | ESTIMATED VALUE |
|---|---|
| Cash | $_____ |
| Checking Account | $_____ |
| Savings Account | $_____ |
| Credit Union Account | $_____ |
| Certificate of Deposit or IRA $_____ | |
| Stocks or Bonds | $_____ |
| Patient Fund Account (held by nursing home) | $_____ |
| House or property other than home-place that is not producing income | $_____ |
| Face Value of Life Insurance Policies | $_____ |
| Burial Contract | $_____ |
| Other (specify) | $_____ |
| TOTAL RESOURCES | $_____ |
| Subtract Individual or Spousal Impoverishment Resource Limit | _____ |

**NOTE:** Use the Spousal Impoverishment Resource Limit when one spouse is in EDWP (CCSP and SOURCE) and the other is not in CCSP AND SOURCE, nursing home or other institutional living arrangement.

List any resource(including home place) where ownership has been transferred in the last 60 months:

_____

_____

_____

**Section III. Statement of Intent: Cost Responsibility**

I have applied for services through the EDWP (CCSP/SOURCE) Services Program. I am aware that I am responsible for the cost of services under the EDWP (CCSP/SOURCE) Services Program until the Department of Family and Children services determines my eligibility for Medicaid and cost share

amount. I understand that I must apply for EDWP (CCSP and SOURCE) Medicaid benefits through the county Department of Family and Children Services (DFCS). If DFCS determines that I have to pay a cost share, I will pay the monthly cost share to the appropriate provider(s). While waiting for DFCS to determine my cost share amount, I agree to pay the appropriate provider(s) the full cost of services or the ESTIMATED cost share indicated on the line below, whichever the provider chooses.

$_____
ESTIMATED COST SHARE: Based on the information provided by the client/representative, this is an estimate of the client cost share. This estimated cost share was discussed with the client/representative. They agree to apply for EDWP (CCSP and SOURCE) Medicaid at DFCS, and understand the DFCS will determine Medicaid eligibility and exact cost share amount.

ALL THE INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____ _____
(Client / Client Representative's signature) (Date)

This form is not an application for Medicaid benefits. The care coordinator will advise you when to apply for Medicaid.

_____ _____
Care Coordinator (Date)

**Rev. 02/07**

## INSTRUCTIONS

EDWP (CCSP/SOURCE) Services Program

**POTENTIAL** EDWP (CCSP and SOURCE) **MEDICAL ASSISTANCE ONLY (MAO) FINANCIAL WORKSHEET**

*Purpose:* The Financial Worksheet is completed at the initial assessment of MAO or PMAO clients and when a change in income or resources may affect eligibility for the CCSP AND SOURCE.

*Who Completes/When Completed:* The RN completes at the initial assessment. The care coordinator completes thereafter when income or resources change.

*Instructions:*

Section I. Income--record total income reported by client.

Section II. Resources--record client's statement of all resources based on current market value and total.

Section III. Statement of Intent:- Cost share Responsibility -- Explain cost share responsibility to client and include information that DFCS determines the cost share amount. Give client written information about Medicaid and DFCS. Indicate the estimated cost share and discuss with client.

*Distribution:* Send a copy of this form to DFCS with the CCC and LOC. File the original in the client's case record.

## APPENDIX Q

## INFECTION CONTROL PROCEDURES

The EDWP (CCSP and SOURCE) provider staff must observe the following procedures in the provision of services to prevent exposure to infectious disease. These procedures are universal precautions to prevent the spread of infectious diseases.

**All blood and body fluids visible with blood are to be treated as potentially infectious.** Wash hands and other skin surfaces immediately and thoroughly if soiled with blood or body fluids, and **change gloves after contact with each client.** Wash hands before and after giving care to clients.

A. Wear latex gloves when:

1. Touching blood/body fluids, mucous membranes, or non-intact skin.

2. Handling items or surfaces soiled with blood/body fluids visible with blood.

3. Performing venipuncture and other vascular access procedures.

4. Cleaning and decontaminating spills of blood/body fluids.

5. Although no diseases are known to be spread by direct skin contact with feces or other body fluids, gloves should be worn when having contact with feces and any body fluids as a basic hygiene measure.

B. Standard housekeeping cleaning procedures to be used.

1. For spills of blood and body fluids, wipe up spill with soap and water and then disinfect area with a commonly used germicide or freshly prepared 1:10 bleach solution (1 part bleach to 10 parts water).

2. All soiled linen should be bagged at the location where it was used; it should not be sorted or rinsed in client-care areas. Linen soiled with blood or body fluids should be placed and transported in bags that prevent leakage.

3. Linens and personal clothing items laundered should be washed using routine laundering procedures.

4. Dish washing using routine cleaning procedures effectively destroys pathogenic (disease causing) organisms. Dishes of clients with hepatitis B or AIDS do not need to be separated from the rest of the facility clients. Do not share unwashed utensils or use common drinking glasses with any client.

C. Environmental procedures to be used:

1. Use a gown or apron during procedures that are likely to generate splashes of blood or other body fluids. Universal precautions also recommend the use of masks/eye wear during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of the mucous membrane of the mouth and nose/eyes.

2. Dispose of secretions directly into the toilet. An individual toilet for a client is not required, but is recommended if the person has diarrhea.

3. Care should be taken to prevent injuries caused by needles and other sharp instruments or devices.

4. To prevent needle stick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, and other sharp items should be placed in puncture-resistant containers for disposal. The puncture-resistant containers should be located as close as practical to the use area.

5. Direct mouth-to-mouth contact is not recommended. It is recommended that mouthpieces, ventilation bags or other ventilation devices be kept in areas where the need is predictable. However, if such devices are not available an employee should not hesitate to provide CPR (Cardiopulmonary Resuscitation) procedures.

**APPENDIX R**

# PRIOR AUTHORIZATION REQUEST
# DMA-80 (6/87)

**PRIOR AUTHORIZATION REQUEST***

**GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE**
**ATLANTA, GEORGIA 30334**

FOR DMA USE ONLY

*Include This Number On All Claim Forms* →

PRIOR AUTHORIZATION NO. 386740

| 1. Recipient Name (Last, First, Init.) | | | | 2. Medicaid ID No. |
|---|---|---|---|---|
| 3. Birthdate | 4. Sex | 5. Address | Nursing Home ☐ Yes ☐ No | 6. Telephone (Area Code/Number) |

| 7. Prescribing Physician/Practitioner Name And Address | | 10. Provider Of Service(s) Name And Address | |
|---|---|---|---|
| 8. Medicaid Provider Number | 9. Telephone (Area Code/Number) | 11. Medicaid Provider Number | 12. Telephone (Area Code/Number) |

☐ HOME HEALTH ☐ PODIATRIST ☐ OPTOMETRIST ☐ PHYSICIAN ☐ PSYCHOLOGIST ☐ DME/OP ☐ DDS ☐ PHARMACY

| 13. Authorization Period: From ___ Through ___ | 14. Description Of Service(s) Requested | DEPT. USE ONLY 15. Rec. Type | 16. Ctgy Of Svc. |
|---|---|---|---|
| | | | |

| 17. Primary Diagnosis Requiring Service(s) | 18. ICD-9-CM |
|---|---|
| 19. Justification And Circumstances For Required Service(s) (Use separate page if necessary) | |

STATEMENT OF SERVICE(S)

| LINE NO. 20 | 21. Description Of Procedures, Drugs, Equipment Or Other Services | 22. Procedure/ Drug Code | 23. Requested Or Estimated Price Per Unit | 24. Bill Units | 25. Months or Units Of Service | 26 Units Per Claim Max. | Min | 27. Max. Units Per Month |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |

28. PROVIDER'S SIGNATURE _____ 29. DATE SUBMITTED ___

| 30. REQUEST: ☐ APPROVED ☐ DENIED ☐ PENDING/ADDITIONAL INFORMATION ☐ APPROVED AS AMENDED | 31. DMA SIGNATURE | 32. DATE APPROVED |
|---|---|---|
| 33. Explanation to Provider | | |

*Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program.

DMA-80 (6-87) COPIES: WHITE: DMA; PINK: SERVICING PROVIDER; GREEN: RECIPIENT'S FILE; YELLOW: REQUESTING PROVIDER

## APPENDIX S

## REIMBURSEMENT RATES FOR CCSP AND SOURCE

| Description | National Code | Description | Modifier | Rate |
|---|---|---|---|---|
| Home Delivered Services; Nursing Visit | T1030 | Nursing care, in home, by registered nurse | TD | Provider Specific (–Fifty-first unit of service) |
| Home Delivered Services; Physical Therapy | S9131 | Physical therapy, in home, per diem | | Provider Specific Fifty-first unit of service |
| Home Delivered Services; Speech Therapy | S9128 | Speech therapy, in the home, per diem | | Provider Specific fifty first unit of service |
| Home Delivered Services; Occupational Therapy | S9129 | Occupational therapy, in the home, per diem | | Provider Specific Fifty-first unit of service |
| Home Delivered Services; Medical Social Services | S9127 | Social work visit, in the home, per diem | | Provider Specific Fifty-first unit of service) |
| Home Delivered Services; Home Health Aide | T1021 | Home health aide or certified nurse assistant, per visit | | Provider Specific Fifty-first unit of service) |
| Adult Day Health Level I Full Day | S5102 | Day care services, adult, per diem | | $55.62 per day minimum 5 hours (eff 7/2018)<br>$61.18 (eff 4/2023)<br>$61.49 (eff 10/2023) |
| Adult day Health Level I Partial Day | S5101 | Day care services, adult, per half day | | $33.37 per day minimum 3 hours (eff 7/2018)<br>$36.71(eff 4/2023)<br>$36.89 (eff 10/2023) |
| Adult Day Health; Physical Therapy | S9131 | Physical therapy in the home, per diem; services delivered under an outpatient physical therapy plan of care | GP | $44.15 per visit<br>$48.57 (eff 4/2023)<br>$48.81 (eff 10/2023) |
| Adult Day Health; Speech Therapy | S9128 | Speech therapy, in the home, per diem; services delivered under an outpatient speech therapy plan of care | GN | $44.15 per visit<br>$48.57 (eff 4/2023)<br>$48.81 (eff 10/2023) |
| Adult Day Health; Occupational Therapy | S9129 | Occupational therapy, in the home, per diem; services delivered under an outpatient occupational therapy plan | GO | $44.15 per visit<br>$48.57 (eff 4/2023)<br>$48.81 (eff 10/2023) |
| Adult Day Health Level II Full Day | S5102 | Day care Services, adult, per diem: intermediate level of care | TF | $69.53 per day (eff 7/2018)<br>$76.48 (eff 4/2023)<br>$76.86 (eff 10/2023) |
| Adult Day Health Level II Partial Day | S5101 | Day care services, adult, per half day; intermediate level of care | TF | $41.73 per day (eff 7/2018)<br>$45.90 (eff 4/2023)<br>$46.13 (eff 10/2023) |

| Description | National Code | Description | Modifier | Rate |
|---|---|---|---|---|
| Alternative Living Services - Group Model | T1020 | Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant); Group Setting | HQ | $50.00 per day (eff 7/2018)<br>$55.00 (eff 4/2023)<br>$55.28 (eff 10/2023) |
| Alternative Living Services – Family Model | T1020 | Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant); Individualized service provided to more than patient in same setting | TT | $50.00 per day (payment to the individual family model home must be no less than $25.00/$27.50 per day) (eff 7/2018)<br>$55.00 (eff 4/2023)<br>$55.28 (eff 10/2023) |
| Structured Family Caregiver | T1020 | Personal care services, per diem, paid to a third party to benefit the EDWP (CCSP and SOURCE) or SOURCE member who is being cared for by a live-in family caregiver. | UK | $90.20 per day. Stipend payment to the live-in family caregiver must by at least $54.12 per day. (eff 7/2019)<br>$59.53 of $99.22 (eff 4/2023)<br>$99.72 (eff 10/2023) |
| Out of Home Respite (12 hours) | S5151 | Unskilled respite care, not hospice, per diem; intermediate level of care | TF | $42.57 per night minimum 12 hours<br>$46.83 (eff 4/2023)<br>$47.06 (eff 10/2023) |
| Out of Home Respite (hourly) | S5150 | Unskilled respite care, not hospice, per 15 minutes | | $3.00 per unit, 32 units (8 hours) maximum, 12 units minimum (3 hours)<br>$3.30 (eff 4/2023)<br>$3.32 (eff 10/2023) |
| Personal Support Service | T1019 | Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) | | $5.07 per 15 minute unit (not to exceed 10 units, or 2.5 hours)<br>(eff 11/2017)<br>$5.58 (eff 4/2023)<br>$5.61 (eff 10/2023) |

| Description | National Code | Description | Modifier | Rate |
|---|---|---|---|---|
| Extended Personal Support | T1019 | Personal care services. Per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) intermediate level of care | TF | $4.51 per 15 minute unit for a minimum of 12 units, or 3 hours) (eff 11/2017)<br><br>$4.96 (eff 4/2023)<br>$4.98 (eff 10/2023) |
| Consumer Direction | T1019 | Personal care services for PSS clients who are eligible and choose to participate in Consumer-Directed Care. Not for an inpatient or resident of a hospital, nursing facility, or ICF/MR | UC | $4.80 for 15 minutes, or $19.20 per hour (This service is billed at $1 per unit.)<br>$5.28 (eff 4/2023)<br>$5.31 (eff 10/2023) |
| Fiscal Intermediary | T2040 | Financial Management Services for members participating in the Consumer Directed Option for Personal Support Services | UC | $80.00 per unit for a maximum of one (1) unit per calendar month<br>$88.00 (eff 4/2023)<br>$88.44 (eff 10/2023) |
| Emergency Response Monitoring (Monthly) | S5161 | Emergency response system; service fee, per month (excludes installation and testing) | | $36.69 per month (eff 11/2017)<br>$40.36 (eff 4/2023)<br>$40.56 (eff 10/2023) |
| Emergency Response Monitoring (Weekly) | T2025 | Emergency response system; waiver services; not otherwise specified (NOS) | U9 | $9.17 per week (eff 11/2017)<br>$10.09 (eff 4/2023)<br>$10.14 (eff 10/2023) |
| Emergency Response Installment | S5160 | Emergency response system; installation and testing | | Up to $110.10 for one installment (eff 11/2017)<br>$121.11 (eff 4/2023)<br>$121.72 (eff 10/2023) |
| Home Delivered Meals | S5170 | Home Delivered Meals | | $6.74 per meal (eff 11/2017/1/2022)<br>$7.41 (eff 4/2023)<br>$7.45 (eff 10/2023) |
| Skilled Nursing<br><br>Services RN CCSP<br>Services RN SOURCE | <br><br>S9123<br>T1030 | Nursing care, in the home, by registered nurse, per diem | | $65.00 per visit<br>$71.50 (eff 4/2023)<br>$71.86 (eff 10/2023) |
| Skilled Nursing<br><br>Services LPN CCSP<br>Services LPN SOURCE | <br><br>S9124<br>T1031 | Nursing care, in home, by licensed practical nurse, per diem | | $50.00 per visit<br>$55.00 (eff 4/2023)<br>$55.28 (eff 10/2023) |

| Description | National Code | Description | Modifier | Rate |
|---|---|---|---|---|
| Care Coordination Services | T2022 | Care coordination services for a EDWP (CCSP and SOURCE) member, payable at one unit per member per unit | | $175 per unit, max of 1 unit per member per month (eff 11/2017)<br>$192.50 (eff 4/2023)<br>$193.46 (eff 10/2023) |
| Enhanced Care Coordination Services | T2022 | Enhanced care coordination services for a EDWP (CCSP and SOURCE) member, payable at one unit per member per unit | SE | $192.27 per unit, max of 1 unit per member per month (eff 7/2018)<br>$211.50 (eff 4/2023)<br>$212.56 (eff 10/2023) |

**APPENDIX T**
**Non-Emergency Medical**
**Transportation**

Non-Emergency Medical Transportation (NEMT) services are defined as medically necessary transportation for any eligible Medicaid member and companion, if required, who have no other means of transportation available to any Medicaid-reimbursable service for the purposes of receiving treatment, medical evaluation, obtaining prescription drugs or medical equipment.

**How do I get NEMT services?**

If you are a qualifying Medicaid recipient and have no other means of transportation for your medical care or services covered by Medicaid, you may contact a transportation broker for transport to and from your appointment. The member must contact the Broker to request NEMT services at least three (3) business days prior to a non-urgent, scheduled appointment. The three (3) day advance scheduling includes the day of the call but not the day of the appointment. Advance scheduling will be mandatory for all NEMT services except urgent care and follow-up appointments when the timeframe does not allow advance scheduling. Urgent care or same day reservations may require verification from your direct provider of service confirming you must be seen that day. Each broker has a toll-free telephone number to schedule transportation services, and available weekdays (Monday-Friday) from 7 a.m. to 6 p.m.

All counties in Georgia are grouped into five regions for NEMT services. A NEMT Broker covers each region. If you need NEMT services, **you must contact the NEMT Broker serving the county you live in** to ask for Non-Emergency Medical Transportation. Contact Southeastrans for Atlanta and North Regions and ModivCare, formerly LogistiCare, for Central, East and Southwest See the chart below to determine which broker serves your county and call the broker's telephone number for that region.

**What if I have problems with a NEMT provider or broker?**

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. If you have a question, comment, or complaint about a NEMT provider or broker that has not been resolved with the broker, you may contact the Georgia Department of Community Health, NEMT unit.

NEMT REGIONS & COUNTIES
SERVED *(updated 7 1 23)*

| Region | NEMT Broker & Phone Number | Counties Served |
|---|---|---|
| North | **Verida**<br>***(formerly Southeastrans)***<br><br>*Toll free*<br>1-866-388-9844<br><br>*Local*<br>678-510-4555 | Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield |
| Atlanta | **Southeastrans**<br>***(formerly Southeastrans***) 404-209-4000<br><br>*Note: For Georgia Families 360°*<br><br>1-866-991-6701 | Fulton, DeKalb and Gwinnett |
| Central | **ModivCare**<br>***(formerly LogistiCare)***<br><br>*Toll free*<br>1-888-224-7981 | Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson |
| East | **ModivCare**<br>***(formerly LogistiCare)***<br><br>Toll free<br>1-888-224-7988<br><br>*Note: For Crisis Stabilization Units and Psychiatric Residential Treatment Facilities*<br><br>1-800-486-7642 Ext. 461 or 436 | Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes |
| Southwest | **ModivCare**<br>***(formerly LogistiCare)***<br><br>Toll free<br>1-888-224-7985 | Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth |

**APPENDIX U**
**CLIENT EMERGENCY INFORMATION FORM**

Client's Name: _____

Medicaid Number: _____

Home Address _____

Home Telephone _____

Emergency transportation for treatment: ----------
Advance Directive Information: _____

_____

_____

_____

| Medical Information | |
|---|---|
| Physician's Name: | |
| Physician's Telephone: | |
| Client's Hospital Preference: | |
| Known Medication Allergies/Pertinent Medical Information: | |
| | |
| | |
| | |

_____

Client Representative or Family Members/Emergency Contacts:

1. Name: _____ Telephone: (_____) _____

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Relationship: _____ Review Date: _____

Date: _____

2. Name: _____ Telephone: (_____) _____

Rev. 10/01/03

Relationship: _____ Review Date: _____

Date: _____

# Appendix V – AAA Service Areas

https://www.georgiaadrc.com/site/363/contact_us.aspx

| *Planning & Service Area (Region #)* | *Area Agency on Aging Address/ Phone / E-Mail* |
|---|---|
| **Atlanta Region (3)**<br><br>Cherokee<br>Clayton<br>Cobb<br>DeKalb<br>Douglas<br>Fayette<br>Fulton<br>Gwinnett<br>Henry<br>Rockdale | **Atlanta Regional AAA**<br><br>229 Peachtree Street, NE, Suite 100<br>Atlanta , GA 30303<br>(404) 463-3100<br>Fax: (404) 463-3264<br>Aging Connection: 1-866-552-4464 or<br>(404) 463-3333<br>info@empowerline.org<br><br>Division of Developmental Disabilities<br>Linda Blackwell<br>(404) 617-1303<br>linda.blackwell@dbhdd.ga.gov<br><br>Disability Link<br>1901 Montreal Rd., Suite 102<br>Tucker, GA 30084<br>Phone:(404) 687-8890 |
| **Central Savannah River Area (8)**<br><br>Burke<br>Columbia<br>Glascock<br>Hancock<br>Jefferson<br>Jenkins<br>Lincoln<br>McDuffie<br>Richmond<br>Screven<br>Taliaferro<br>Warren<br>Washington<br>Wilkes | **Central Savannah River AAA**<br><br>3626 Walton Way Ext.Suite 300<br>Augusta, GA 30909<br>(706) 210-2000 Aging Program<br>Fax: (706) 210-2006<br>Aging Connection:1-888-922-4464<br><br>Division of Developmental Disabilities<br>Lee Walker<br>(706) 564-8178<br>Lee.Walker@dbhdd.ga.gov<br><br>Walton Options for Independent Living<br>948 Walton Way<br>Augusta GA 30901<br>Phone: (706) 261-0201 |

| *Planning & Service Area (Region #)* | *Area Agency on Aging Address/ Phone / E-Mail* |
|---|---|
| **Coastal Georgia (12)**<br><br>Bryan<br>Bulloch<br>Camden<br>Chatham<br>Effingham<br>Glynn<br>Liberty<br>Long<br>McIntosh | **Coastal Georgia AAA**<br>1181 Coastal Drive, SW<br>Darien, GA 31305<br><br>Phone: (912) 437-0852<br>Fax: (912) 437-0313<br>Information Link: 1-800-580-6860<br><br>Division of Developmental Disabilities<br>Sharon Williamson<br>(912) 346-4194<br>Sharon.Williamson@dbhdd.ga.gov<br><br>Living Independence for Everyone (LIFE)<br>5105 Paulsen Street, Suite 143-B<br>Savannah, GA 31405<br>Phone: (912) 231-3606 |
| **Georgia Mountains (2)**<br>(The Legacy Link AAA)<br>Banks<br>Dawson<br>Forsyth<br>Franklin<br>Habersham<br>Hall<br>Hart<br>Lumpkin<br>Rabun<br>Stephens<br>Towns<br>Union<br>White | **Legacy Link AAA**<br>P. O. Box 1480<br>Oakwood, GA 30566<br>(770) 538-2650<br>Fax: (770) 538-2660<br><br>Intake Screening: 1-855-266-4283<br><br>Physical Address:<br>4080 Mundy Mill Road,<br>Oakwood, GA 30566<br><br>Division of Developmental Disabilities<br>Linda Blackwell<br>(404) 617-1303<br>linda.blackwell@dbhdd.ga.gov<br><br>Disability Resource Center<br>170 Scoggins Dr.,<br>Demorest, GA 30535<br>Phone: (706) 778-5355 |

| *Planning & Service Area (Region #)* | *Area Agency on Aging Address/ Phone / E-Mail* |
|---|---|
| **Heart of Georgia Altamaha (9)**<br><br>Appling<br>Bleckley<br>Candler<br>Dodge<br>Emanuel<br>Evans<br>Jeff Davis<br>Johnson<br>Laurens<br>Montgomery<br>Tattnall<br>Telfair<br>Toombs<br>Treutlen<br>Wayne<br>Wheeler<br>Wilcox | **Heart of Georgia Altamaha AAA**<br>331 West Parker Street<br>Baxley , GA 31513-0674<br>(912) 367-3648<br>Fax: (912) 367-3640 or (912) 367-3707<br>Toll Free: 1-888-367-9913<br><br>Division of Developmental Disabilities<br>Sharon Williamson<br>(912) 346-4194<br><br>Sharon.Williamson@dbhdd.ga.gov |
| **Middle Georgia (7)**<br><br>Baldwin<br>Bibb<br>Crawford<br>Houston<br>Jones<br>Monroe<br>Peach<br>Pulaski<br>Putnam<br>Twiggs<br>Wilkinson | **Middle Georgia AAA**<br>175 Emery Highway, Suite C<br>Macon, GA 31217-3679<br>(478) 751-6466<br>Fax: (478) 752-3243<br>Toll free: 1-888-548-1456<br><br>Division of Developmental Disabilities<br>Lee Walker<br>(706) 564-8178<br>Lee.Walker@dbhdd.ga.gov<br><br>Disability Connections<br>170 College Street<br>Macon GA 31201<br>Phone:(706) 845-4828 |
| **Northeast Georgia (5)**<br><br>Barrow<br>Clarke<br>Elbert<br>Greene<br>Jackson<br>Jasper<br>Madison<br>Morgan<br>Newton<br>Oconee<br>Oglethorpe<br>Walton | **Northeast Georgia AAA**<br>305 Research Drive<br>Athens, GA 30610<br>(706) 369-5650<br>Fax: (706) 425-3370<br>Toll free: 1-800-474-7540<br><br>Division of Developmental Disabilities<br>Lee Walker<br>(706) 564-8178<br>Lee.Walker@dbhdd.ga.gov<br>Multiple Choices<br>145 Barrington Drive<br>Athens, GA 30605 Phone: (706) 850-4025 |

| *Planning & Service Area (Region #)* | *Area Agency on Aging Address/ Phone / E-Mail* |
|---|---|
| **Northwest Georgia (1)**<br><br>Bartow<br>Catoosa<br>Chattooga<br>Dade<br>Fannin<br>Floyd<br>Gilmer<br>Gordon<br>Haralson<br>Murray<br>Paulding<br>Pickens<br>Polk<br>Walker<br>Whitfield | **Northwest Georgia AAA**<br>P.O. Box 1798<br>Rome, GA 30162-1798<br>Toll Free: 1-800-759-2963<br>Screening Fax: (706) 802-5508<br><br>Physical Address:<br>1 Jackson Hill Dr. 30161<br><br>Division of Developmental Disabilities<br>Linda Blackwell<br>(404) 617-1303<br>linda.blackwell@dbhdd.ga.gov<br><br>Northwest Georgia Center for Independent Living<br><br>527 Broad St, Suite 101<br>Rome, GA 30161<br><br>Phone: (706) 314-0008<br>Fax: (706) 314-0011 |
| **River Valley (6)**<br><br>Chattahoochee<br>Clay<br>Crisp<br>Dooly<br>Harris<br>Macon<br>Marion<br>Muscogee<br>Quitman<br>Randolph<br>Schley<br>Stewart<br>Sumter<br>Talbot<br>Taylor<br>Webster | **River Valley Regional Commission & AAA**<br>710 Front Ave., Suite A<br>P.O. Box 1908<br>Columbus, GA 31901<br>(706) 256-2900<br>Fax: (706) 256-2940<br>ADRC: (706) 256-2900<br><br>Division of Developmental Disabilities<br>Natalie Prater<br>(706) 392-1441<br>Natalie.Prater@dbhdd.ga.gov<br><br>Access2Independence<br><br>1315 Delaney Ave.,Suite 201<br>Columbus GA 31901<br>Phone: (706) 405-3807 |

| *Planning & Service Area (Region #)* | *Area Agency on Aging Address/ Phone / E-Mail* |
|---|---|
| **Southern Georgia (11)**<br><br>Atkinson<br>Bacon<br>Ben Hill<br>Berrien<br>Brantley<br>Brooks<br>Charlton<br>Clinch<br>Coffee<br>Cook<br>Echols<br>Irwin<br>Lanier<br>Lowndes<br>Pierce<br>Tift<br>Turner<br>Ware | **Southern Georgia AAA**<br>1725 South Georgia Parkway, West<br>Waycross , GA 31503-8958<br>(912) 285-6097<br>Fax: (912) 285-6126<br>Toll Free: 1-888-732-4464<br><br>Division of Developmental Disabilities<br>Sharon Williamson<br>(912) 346-4194<br>Sharon.Williamson@dbhdd.ga.gov |
| **Southwest Georgia (10)**<br><br>Baker<br>Calhoun<br>Colquitt<br>Decatur<br>Dougherty<br>Early<br>Grady<br>Lee<br>Miller<br>Mitchell<br>Seminole<br>Terrell<br>Thomas<br>Worth | **SOWEGA AAA**<br>335 West Society Avenue<br>Albany , GA 31701-1933<br>(229) 432-1124<br>Fax: (229) 483-0995<br>Toll free: 1-800-282-6612<br><br>Division of Developmental Disabilities<br>Natalie Prater<br>(706) 392-1441<br>Natalie.Prater@dbhdd.ga.gov<br><br>Bainbridge Advocacy Individual Network(BAIN)<br>316 W. Shotwell St.,<br>Bainbridge GA 39819<br>Phone: (229) 493-0110 |
| **Three Rivers (4)**<br><br>Butts<br>Carroll<br>Coweta<br>Heard<br>Lamar<br>Meriwether<br>Pike<br>Spalding<br>Troup<br>Upson | **Three Rivers AAA**<br>P.O. Box 1600<br>Franklin , GA 30217-1600<br>(678) 552-2838<br>Fax: (706) 675-9210 or (770) 854-5402<br>Toll Free: 1-866-854-5652<br><br>Physical Address: 13273 Hwy. 34 East<br><br>Division of Developmental Disabilities<br>Natalie Prater<br>(706) 392-1441<br>Natalie.Prater@dbhdd.ga.gov |

## APPENDIX W

## SUPPLEMENT TO PART II, CHAPTERS 600-1000, SECTION 602.1-602.3 RELATED TO CORRECTIVE ACTION

Roles and Responsibilities

Care Coordination Agency:

- Receives complaint
- Records on complaint log
- Note: CC Agency may refer the issue to DCH for their action.
- Discusses with provider; requests written plan of correction within 10 days; documents contact with provider
- Reports to HFR (Personal Care Home or Home Health Section) if complaint is of regulatory nature
- Reviews plan of correction; determines if acceptable
  Refers to DCH if not acceptable
- Documents if issue resolved, including date of resolution
  Refers to DCH is not resolved
- Coordinates with DCH regarding complaint log as applicable
- Tracks complaint logs to determine if providers have repeated complaints on complaint log; recommends to DCH suspension of client referrals
- Refers immediately EDWP (CCSP and SOURCE) Unit if complaint places client's health, safety and/or welfare at risk or in immediate jeopardy

Department of Community Health:

- Requests a meeting with provider to discuss issues/concerns/complaints; makes provider aware of seriousness of complaints and documents meeting as a verbal warning of need to correct issue
  - Additional complaints will result in written warning from DCH; if acceptable plan of correction is not submitted and/or if issue is not resolved, DCH may suspend client referrals
- Re complaint logs each month; determines if trends/patterns are occurring

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- Tracks complaint logs to determine if providers have received repeated complaints on complaint log; repeated unresolved complaints indicate need to suspend client referrals
- Monitors for complaints that places client's health, safety, and/or welfare at risk or in immediate jeopardy

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4/1/20

- If adverse action other than suspension of client referrals is indicated, requests supporting documentation (i.e., policies, procedures, incident reports, etc.) from Care Coordination Agency.
- Instructs care coordination to re-broker services immediately if the health, safety, and/or welfare of clients is at risk or in immediate jeopardy and/or if allegations of abuse, neglect, and/or exploitation have been reported.

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4/1/20

- Refers appropriate complaints for investigation and resolution
- Notifies AAA and coordination Agency of resolution

Provider Agency:

- Discusses complaint with Care Coordination Agency
- Submits written plan of correction to address issues
- Submits documentation to indicate issue has been resolved
- Maintains communication with Care Coordination Agency
- Submits requested information to the EDWP (CCSP and SOURCE) Unit at DCH
- Maintains compliance with EDWP (CCSP and SOURCE) and all other regulatory agencies
- Notifies care coordination of all serious and unusual events and incidents and action taken to prevent further occurrences of such events

**APPENDIX X**

# GAINWELL TECHNOLOGIES

## Member and Provider Correspondence

(Including claims submission)
GAINWELL TECHNOLOGIES
P.O. Box 105200
Tucker, GA 30085-5200

## Provider Inquiry Numbers:

800-766-4456 (Toll free)

The web contact address is
www.mmis.georgia.gov

## Electronic Data Interchange (EDI)

1-877-261-8785

- Asynchronous
- Web portal
- Physical media
- Network Data Mover (NDM)
- Systems Network Architecture (SNA)
- Transmission Control Protocol/
- Internet Protocol (TCP/IP)

## Retroactive Eligibility Claims, Out of State Claims

P.O. Box 105208
Atlanta, GA 30348

## Miscellaneous Non-claims documents and Business Reply mail

P.O. Box 105209
Atlanta, GA 30348

## Appendix Y

AAA Consult Form

**Memorandum**

To: DCH (EDWP) Elderly and Disabled Waiver Program

From: _____,

AAA Director Planning and Service Area

Re: CCSP Pre-Enrollment Provider Consultation

Date:_____

---

Provider/Applicant Name: _____

Has consulted with this Planning and Service Area. The following issues were discussed:

- ☐ Current Market for _____ service in this PSA
- ☐ Referral Process
- ☐ Funding Network Meetings
- ☐ Other (explain):

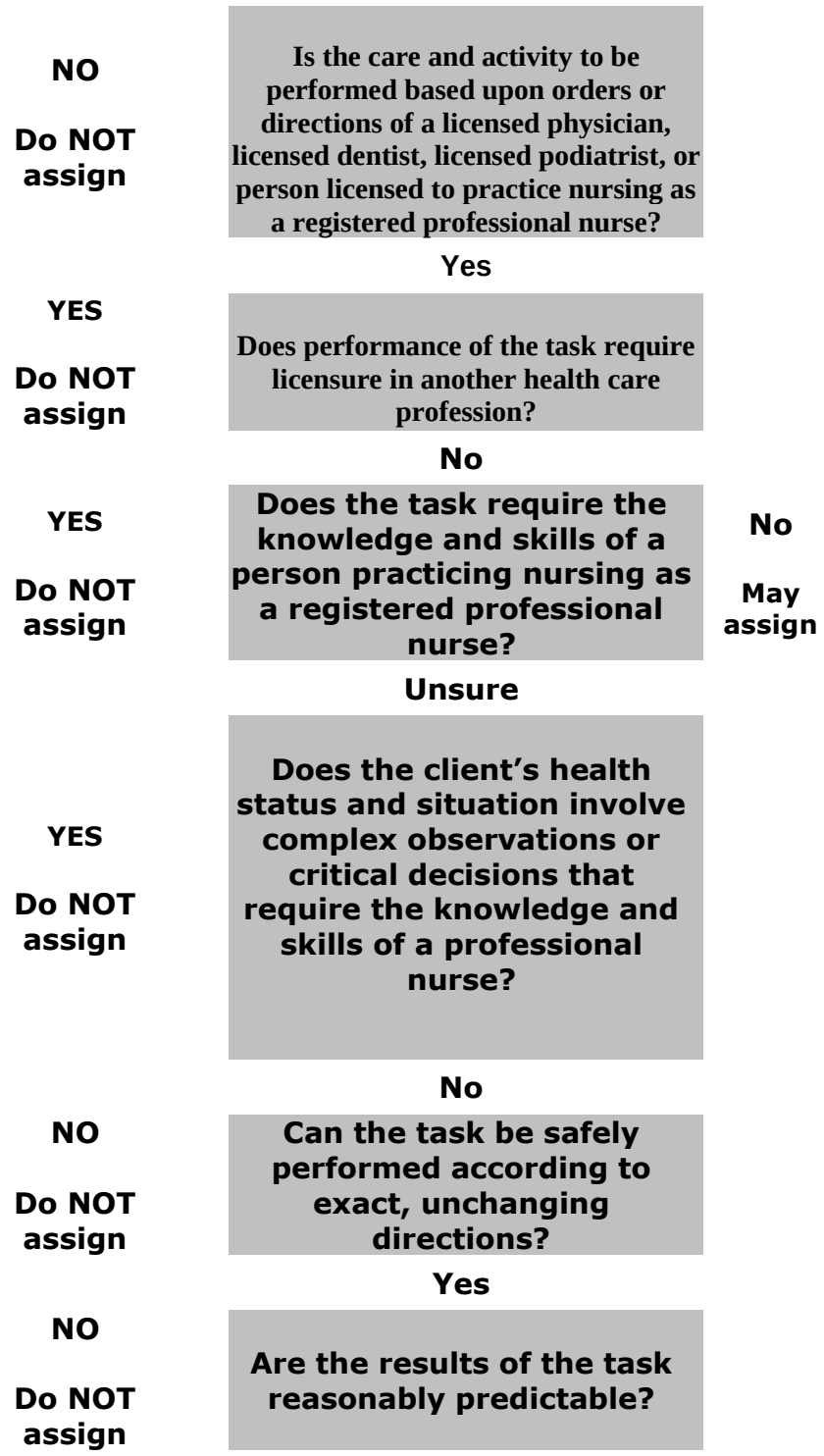
For existing provider agencies requesting expansion of service area, please attach the agency's complaint history (Rev 10/12, 1/20)

Rev.
1/01, 12/10, 1/20

*Note: Refer to Appendix V for a list of counties service by each Area Agency on Aging.*

**APPENDIX Z**

**RN ASSIGNMENT DECISION TREE**
**Assignment to Unlicensed Assistive Personnel (UAP)**



**Yes**

**NO**

**Do NOT assign to that UAP**

**Has the RN verified that the UAP has the knowledge and skills necessary to accept assignment?**

**Yes**

**May assign**

# Appendix AA
# Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the three CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The three licensed CMOs:

| | | |
|---|---|---|
| Amerigroup Community Care<br>1-800-454-3730<br>www.amerigroup.com | Peach State Health Plan<br>866-874-0633<br>www.pshpgeorgia.com | CareSource<br>1-855-202-1058<br>www.caresource.com |

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

| Included Populations | Excluded Populations |
|---|---|
| Parent/Caretaker with Children | Aged, Blind and Disabled |
| Transitional Medicaid | Nursing home |
| Pregnant Women (Right from the Start Medicaid – RSM) | Long-term care (Waivers, SOURCE) |
| Children (Right from the Start Medicaid – RSM) | Federally Recognized Indian Tribe |
| Children (newborn) | Georgia Pediatric Program (GAPP) |
| Women Eligible Due to Breast and Cervical Cancer | Hospice |
| PeachCare for Kids® | Children's Medical Services program |
| Parent/Caretaker with Children | Medicare Eligible |
| Children under 19 | Supplemental Security Income (SSI) Medicaid |
| Women's Health Medicaid (WHM) | Medically Needy |
| Refugees | Recipients enrolled under group health plans |
| Planning for Healthy Babies® | Individuals enrolled in a Community Based Alternatives for Youths (CBAY) |
| Resource Mothers Outreach | |

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All three CMOs are State-wide.**

The Department of Community Health has contracted with three CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

**Included Categories of Eligibility (COE):**

| COE | DESCRIPTION |
|---|---|
| 104 | LIM – Adult |
| 105 | LIM – Child |
| 118 | LIM – 1st Yr Trans Med Ast Adult |
| 119 | LIM – 1st Yr Trans Med Ast Child |
| 122 | CS Adult 4 Month Extended |
| 123 | CS Child 4 Month Extended |
| 135 | Newborn Child |
| 170 | RSM Pregnant Women |
| 171 | RSM Child |
| 180 | P4HB Inter Pregnancy Care |
| 181 | P4HB Family Planning Only |
| 182 | P4HB ROMC - LIM |
| 183 | P4HB ROMC - ABD |
| 194 | RSM Expansion Pregnant Women |
| 195 | RSM Expansion Child < 1 Yr |
| 196 | RSM Expn Child w/DOB < = 10/1/83 |
| 197 | RSM Preg Women Income < 185 FPL |
| 245 | Women's Health Medicaid |
| 471 | RSM Child |
| 506 | Refugee (DMP) – Adult |
| 507 | Refugee (DMP) – Child |
| 508 | Post Ref Extended Med – Adult |
| 509 | Post Ref Extended Med – Child |
| 510 | Refugee MAO – Adult |
| 511 | Refugee MAO – Child |
| 571 | Refugee RSM - Child |

| | |
|---|---|
| 595 | Refugee RSM Exp. Child < 1 |
| 596 | Refugee RSM Exp Child DOB </= 10/01/83 |
| 790 | Peachcare < 150% FPL |
| 791 | Peachcare 150 – 200% FPL |
| 792 | Peachcare 201 – 235% FPL |
| 793 | Peachcare > 235% FPL |
| 835 | Newborn |
| 836 | Newborn (DFACS) |
| 871 | RSM (DHACS) |
| 876 | RSM Pregnant Women (DHACS) |
| 894 | RSM Exp Pregnant Women (DHACS) |
| 895 | RSM Exp Child < 1 (DHACS) |
| 897 | RSM Pregnant Women Income > 185% FPL (DHACS) |
| 898 | RSM Child < 1 Mother has Aid = 897 (DHACS) |
| 918 | LIM Adult |
| 919 | LIM Child |
| 920 | Refugee Adult |
| 921 | Refugee Child |

**Excluded Categories of Eligibility (COE):**

| COE | DESCRIPTION |
|---|---|
| 124 | Standard Filing Unit – Adult |
| 125 | Standard Filing Unit – Child |
| 131 | Child Welfare Foster Care |
| 132 | State Funded Adoption Assistance |
| 147 | Family Medically Needy Spend down |
| 148 | Pregnant Women Medical Needy Spend down |
| 172 | RSM 150% Expansion |
| 180 | Interconceptional Waiver |
| 210 | Nursing Home – Aged |
| 211 | Nursing Home – Blind |
| 212 | Nursing Home – Disabled |
| 215 | 30 Day Hospital – Aged |
| 216 | 30 Day Hospital – Blind |
| 217 | 30 Day Hospital – Disabled |
| 218 | Protected Med/1972 Cola - Aged |
| 219 | Protected Med/1972 Cola – Blind |
| 220 | Protected Med/1972 Cola - Disabled |
| 221 | Disabled Widower 1984 Cola - Aged |
| 222 | Disabled Widower 1984 Cola – Blind |
| 223 | Disabled Widower 1984 Cola – Disabled |
| 224 | Pickle - Aged |
| 225 | Pickle – Blind |
| 226 | Pickle – Disabled |
| 227 | Disabled Adult Child - Aged |

| | |
|---|---|
| 227 | Disabled Adult Child - Aged |
| 229 | Disabled Adult Child – Disabled |
| 230 | Disabled Widower Age 50-59 – Aged |
| 231 | Disabled Widower Age 50-59 – Blind |
| 232 | Disabled Widower Age 50-59 – Disabled |
| 233 | Widower Age 60-64 – Aged |
| 234 | Widower Age 60-64 – Blind |
| 235 | Widower Age 60-64 – Disabled |
| 236 | 3 Mo. Prior Medicaid – Aged |
| 237 | 3 Mo. Prior Medicaid – Blind |
| 238 | 3 Mo. Prior Medicaid – Disabled |
| 239 | Abd Med. Needy Defacto – Aged |
| 240 | Abd Med. Needy Defacto – Blind |
| 241 | Abd Med. Needy Defacto – Disabled |
| 242 | Abd Med Spend down – Aged |
| 243 | Abd Med Spend down – Blind |
| 244 | Abd Med Spend down – Disabled |
| 246 | Ticket to Work |
| 247 | Disabled Child – 1996 |
| 250 | Deeming Waiver |
| 251 | Independent Waiver |
| 252 | Mental Retardation Waiver |
| 253 | Laurens Co. Waiver |
| 254 | HIV Waiver |
| 255 | Cystic Fibrosis Waiver |
| 259 | Community Care Waiver |
| 280 | Hospice – Aged |
| 281 | Hospice – Blind |
| 282 | Hospice – Disabled |
| 283 | LTC Med. Needy Defacto – Aged |
| 284 | LTC Med. Needy Defacto –Blind |
| 285 | LTC Med. Needy Defacto – Disabled |
| 286 | LTC Med. Needy Spend down – Aged |
| 287 | LTC Med. Needy Spend down – Blind |
| 288 | LTC Med. Needy Spend down – Disabled |
| 289 | Institutional Hospice – Aged |
| 290 | Institutional Hospice – Blind |
| 291 | Institutional Hospice – Disabled |
| 301 | SSI – Aged |
| 302 | SSI – Blind |
| 303 | SSI – Disabled |
| 304 | SSI Appeal – Aged |
| 305 | SSI Appeal – Blind |
| 306 | SSI Appeal – Disabled |
| 307 | SSI Work Continuance – Aged |
| 309 | SSI Work Continuance – Disabled |

| | |
|---|---|
| 308 | SSI Work Continuance – Blind |
| 315 | SSI Zebley Child |
| 321 | SSI E02 Month – Aged |
| 322 | SSI E02 Month – Blind |
| 323 | SSI E02 Month – Disabled |
| 387 | SSI Trans. Medicaid – Aged |
| 388 | SSI Trans. Medicaid – Blind |
| 389 | SSI Trans. Medicaid – Disabled |
| 410 | Nursing Home – Aged |
| 411 | Nursing Home – Blind |
| 412 | Nursing Home – Disabled |
| 424 | Pickle – Aged |
| 425 | Pickle – Blind |
| 426 | Pickle – Disabled |
| 427 | Disabled Adult Child – Aged |
| 428 | Disabled Adult Child – Blind |
| 429 | Disabled Adult Child – Disabled |
| 445 | N07 Child |
| 446 | Widower – Aged |
| 447 | Widower – Blind |
| 448 | Widower – Disabled |
| 460 | Qualified Medicare Beneficiary |
| 466 | Spec. Low Inc. Medicare Beneficiary |
| 575 | Refugee Med. Needy Spend down |
| 660 | Qualified Medicare Beneficiary |
| 661 | Spec. Low Income Medicare Beneficiary |
| 662 | Q11 Beneficiary |
| 663 | Q12 Beneficiary |
| 664 | Qua. Working Disabled Individual |
| 815 | Aged Inmate |
| 817 | Disabled Inmate |
| 870 | Emergency Alien – Adult |
| 873 | Emergency Alien – Child |
| 874 | Pregnant Adult Inmate |
| 915 | Aged MAO |
| 916 | Blind MAO |
| 917 | Disabled MAO |
| 983 | Aged Medically Needy |
| 984 | Blind Medically Needy |
| 985 | Disabled Medically Needy |

**HEALTH CARE PROVIDERS**
For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.
Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| 800-454-3730<br>(general information)<br>www.amerigroup.com | 1-855-202-1058<br>www.careSource.com/GeorgiaMedicaid | 866-874-0633 (general information)<br>866-874-0633 (claims)<br>800-704-1483 (medical management)<br>www.pshpgeorgia.com |

**Registering immunizations with GRITS:**
If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.
**Important tips for the provider to know/do when a member comes in:**
Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact GAINWELL TECHNOLOGIES at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.
**Use of the Medicaid Management Information System (MMIS) web portal:**

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. GAINWELL TECHNOLOGIES will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.
**Participating in a Georgia Families' health plan:**
Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.
**Billing the health plans for services provided:**
For members who are in Georgia Families, you should file claims with the member's health plan.
**If a claim is submitted to GAINWELL TECHNOLOGIES in error:**
GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.
**Credentialing**
Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.
Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia

Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- •Saves time
- •Increases efficiency
- •Eliminates duplication of data needed for multiple CMOs
- •Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

**Assignment of separate provider numbers by all of the health plans:**

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

**Billing the health plans for services provided:**

For members who are in Georgia Families, you should file claims with the member's health plan.

**If a claim is submitted to GAINWELL TECHNOLOGIES in error:**

GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

**Receiving payment:**

Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

**Health plans payment of clean claims:**
Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated.<br><br>Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday.<br><br>Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday.<br><br>**Dental:** Checks are mailed weekly on Thursday for **clean** claims.<br><br>**Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th)<br><br>**Pharmacy**: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day) | CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated.<br><br>Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays. | Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday.<br><br>For further information, please refer to the Peach State website, or the Peach State provider manual. |

**How often can a patient change his/her PCP?**

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| Anytime | Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as:<br>• Member requests to be assigned to a family member's PCP<br>• PCP does not provide the | Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate |

| | | |
|---|---|---|
| | covered services a member seeks due to moral or religious objections<br>• PCP moves, retires, etc. | PCP change. |

**Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:**

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| Next business day | PCP selections are updated in CareSource's systems daily. | PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month. |

**PHARMACY**

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| 800-454-3730<br>https://providers.amerigroup.com/pages/ga-2012.aspx | 844-441-8024<br>https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod | 866-874-0633<br>www.pshpgeorgia.com |

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

**The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:**

| Health Plan | PBM | BIN # | PCN # | GROUP # | Helpdesk |
|---|---|---|---|---|---|
| **Amerigroup Community Care** | IngenioRx | 020107 | HL | WKJA | 1-833-235-2031 |
| **CareSource** | Express Scripts (ESI) | 003858 | MA | RXINN01 | 1-800-416-3630 |
| **Peach State Health Plan** | CVS | 004336 | MCAIDADV | RX5439 | 1-844-297-0513 |

**If a patient does not have an identification card:**

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL TECHNOLOGIES by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. GAINWELL TECHNOLOGIES will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.
Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| No, you will need the member's health plan ID number | Yes, you may also use the health plan ID number. | Yes |

**Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:**

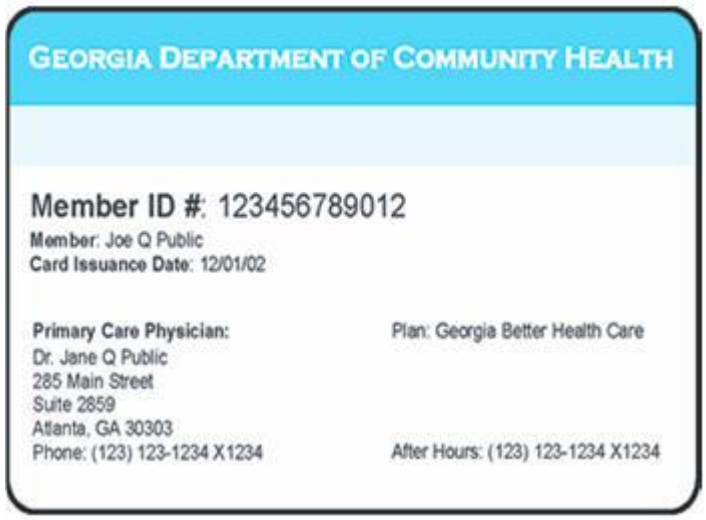
Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.
**Will Medicaid cover prescriptions for members that the health plans do not?**
No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

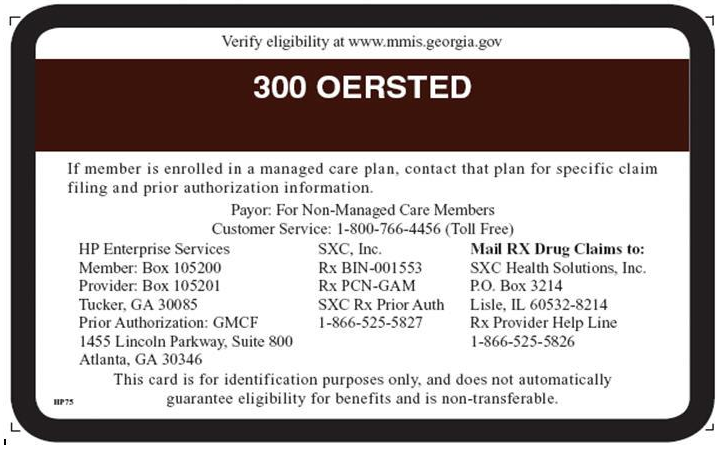
**Who to call to request a PA:**

| Amerigroup Community Care | CareSource | Peach State Health Plan |
|---|---|---|
| 1 (800) 454-3730 | 1 (855) 202-1058<br>1 (866) 930-0019 (fax) | 1 (866) 399-0929 |

# Appendix BB

## Medicaid Card



**APPENDIX CC**
**Incident Types Definitions**

| | Definition |
|---|---|
| Injury Severity Ratings: | 1 - No injury (no treatment required)<br>2 - Injury requiring first aid (small adhesive bandages, cleaning of abrasion, application of ice packs, over the counter medications as physician ordered)<br>3. Injury requiring treatment beyond first aid (medical treatment required by a licensed practitioner - MD, NP, PA, etc. that is not serious enough to warrant hospitalization, such as sutures, broken bones, prescriptions etc.)<br>4. Injury requiring hospitalization (medical intervention and treatment at a hospital, including stays for observation only)<br>5. Death<br>6. Refused treatment |
| Death - Expected | Cause of death is attributed to a terminal diagnosis or diagnosed disease process identified more than 30 days before the date of death, where the reasonable expectation of outcome is death, there is no indication that the individual was not receiving appropriate care. |
| Death - Unexpected | Death due to any cause where the cause of death is not attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation or outcome is death, does not meet the definition of an expected death.<br><br>Examples include but not limited to death from suicide, homicide, medication errors, undiagnosed condition, criminal activity, an accident, or possible abuse or neglect. |
| Suicide Attempt resulting in injury | Self-inflicted harm due to failed suicide attempt. Injury severity scale 2, 3, and 4. |
| Alleged Abuse - Physical | The willful use of physical force to coerce or to inflict bodily harm, pain or mental anguish. Indicators of physical abuse may include, but are not limited to, rough handling, improper use of restraints, injuries not consistent with medical diagnosis or explanation, or unreasonable confinement. |
| Alleged Abuse - Sexual | Any kind of sexual behavior directed towards an individual without their full knowledge and consent. A spouse, partner, family member or other trusted person can perpetrate sexual abuse. Indicators of sexual abuse include, but are not limited to, any nonconsensual sexual contact, inappropriate touching, forced viewing of sexually explicit materials, sexual harassment or sexual assault. |

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|---|---|
| Alleged Abuse - Psychological | Using tactics, such as harassment, insults, intimidation, isolation or threats that cause mental or emotional anguish. It diminishes the person's sense of identity, dignity, and self-worth. |
| Alleged Abuse - Verbal | Verbal abuse is any use of oral, written or gestured language that may be threatening, demeaning, discriminatory, or insulting regardless of their age, ability to comprehend, or disability. |
| Alleged Neglect | Failure to provide essential services (food, water, shelter, medical, etc.) that cause actual or potential physical or medical harm, mental anguish, or mental illness. |
| Alleged Self-Neglect | Failing to perform essential self-care such as depriving oneself of necessities such as food, water, or medication. Consciously putting oneself in harm's way or being unable to handle needs of day-to-day living because of medical, mental health or other disabilities. |
| Alleged Exploitation | Evidence of deliberate intent to manipulate an individual for personal benefit or self-advancement. |
| Alleged Financial Exploitation | Evidence of deliberate intent to misuse funds or assets of an individual for personal benefit or benefit of another. Examples include, but are not limited to, theft, forgeries, unauthorized check-writing, unexplained disappearance of cash or valuable objects, misuse of an insurance policy, or identity theft. |
| Accidental Injury | Injuries to individuals with a known cause that were not a result of aggressive acts to self or others. |
| Fall - Accidental | Uncontrolled, unintentional, downward displacement of the body to the ground or other object. |
| Fall - Purposeful | Willful intent of an individual to cause downward displacement of the body to the ground or other object. |
| Fall - Medical condition | Uncontrolled, unintentional, downward displacement of the body to the ground or other object due to a medical condition. |

| | |
|---|---|
| Choking with intervention | An incident of choking that required intervention to clear the airway. Choking is defined as any episode of airway obstruction by food or foreign object as evidenced by one or more of the following: a) inability to speak when asked if choking (if individual is verbal); b) inability to breath or difficulty taking in adequate breaths; c) movements indicating distress such as grasping for neck or throat; d) turning blue. |
| Medication Error with Adverse Consequences | A failure in the medication process that results in a significant adverse reaction requiring medical attention in an emergency room, urgent care center, or hospital.<br><br>Errors include but are not limited to: omission of a medication, wrong dose, wrong time, wrong person, wrong medication, wrong route, and/or wrong position. |
| Medication Error without Adverse Consequences | A failure in the medication process that does not result in harm. Errors include but are not limited to: omission of a medication, wrong dose, wrong time, wrong person, wrong medication, wrong route, and/or wrong position. |
| Hospitalization - Medical | Any admission to a hospital, either directly or through a facility's emergency room. |
| Hospitalization - Psychiatric | An unplanned, involuntary admission of an individual to a psychiatric treatment facility. |
| ER Admission | Any admission to an emergency room. |
| Aggressive Act for all three types (member against member, member against non-member, staff against member) | Aggressive act resulting in injury of severity ranking 3, 4, and 5. |
| Seclusion or Restraint | The use of physical holding and mechanical restraints and/or solitary confinement of member, which are prohibited per waiver policy. |
| Elopement - Greater than 30 minutes | A cognitively impaired person who successfully leaves unsupervised and undetected from a residential location or day program. |
| Alleged Criminal Act by a Member | Conduct that could result in criminal proceedings. |

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|---|---|
| Violation of Individual Rights | A denial of an individual's rights without good cause regardless of age, race, sex, nationality, ethnicity, sexual orientation, language or religion. Examples include but are not limited to: a denial of individual's rights without the benefit of due process, breaching an individual's confidentiality, purposely allowing an individual's privacy to be invaded or breached, denial of access to the Patients' Rights Advocate, and denial of legal representation. |
| Environmental Threat | An event with direct impact on member health and safety occurring within or around a residential location or day program. These events can result in but are not limited to mortality, illness and/or injury, and disrupts living arrangements requiring intervention or relocation. |
| Media Alert | An incident that may have significant impact upon, or significant relevance to, issues of DCH public concern and/or are likely to be reported in the media. |

## Appendix DD - Nursing Supervisory Visit Form

ADH/ALS/PSS/X - Completed upon request of the Case Management at each supervisory visit that is conducted by the agency nurse, to assist in the determination of the member in Enhanced Case Managment. Rev 4/2021
SNS- Completed at each nursing visit that includes a service/care plan update that is conducted by a Registered Nurse (RN) or at each Case Management ordered SNS visit to facilitate a telehealth visit with the member's PCP.

Client Name: Client Medicaid ID
Dates of Supervisory visits for the last 3 months
Noted changes found during these visits:
Skin (changes/issues)
Weight (changes/issues)
Vitals- BP Pulse Resp. BS Check
Cognition (changes/issues)
Functional (changes/issues)
Home environment (changes/issues)
Medications (changes/issues)
Hospitalizations (changes/issues)
Falls (changes/issues)
ADL/IADL (changes/issues)
Support system (changes/issues)
Other

Provider or RN Name
Provider or RN Signature _____
Date:

Case Management RN Name
Case Management RN Signature _____
Date:
***Send a copy of the completed form to the client's case manager and retain the original in the client's clinical record.**

*Purpose:*

1-To determine ongoing level appropriateness for the member in Enhanced Case Managment
2- To assist the SNS at care plan update for payment of service rendered.
3- To assist in the case management order of a telehealth visit, facilitated by the service provider RN, between the member and the PCP.

*Who completes/When completed:*

ADH/ALS/PSS/X

The *Appendix DD – Nursing Visit Form* is completed upon request by Case Management for ECM eligibility in CCSP, performed at each supervisory visit that is conducted by the service provider RN/LPN, with a copy of the completed form sent to the member's waiver case manager and the original maintained in the member's clinical record. Rev 4/2021

SNS-

*The Appendix DD Nursing Visit Form* is completed during-

1. each service/care plan update that is conducted by the RN, at least every 62 days, with a copy of the completed form sent to the member's waiver case manager and the original maintained in the member's clinical record
2. each home visit where a Case Management ordered, scheduled telehealth visit with the member's PCP and Provider's RN is performed, with a copy of the completed form sent to the member's waiver case manager and the original maintained in the member's clinical record

SNS must have MD orders for skilled nursing with duties performed. Example- medication monitoring. Providers can't be paid for supervisory work only. Can be RN visit request by Case Management for Provider RN facilitator of telehealth visit between member and PCP.
The reimbursement to SNS agencies (private home care providers) for a "supervisory visit" is **ONLY for clients who are receiving *skilled nursing visits*** as part of their CCSP or SOURCE services, regardless of whether they're receiving traditional or enhanced case management.

The "supervisory visit" referred to is actually the RN visit for the care/service plan update that's required at least every 62 days for any member who receives nursing visits from their private home care provider. **If the RN performs the nursing visit tasks specified in the care plan in the same visit the care plan update is performed, the private home care provider can bill for the visit as an RN visit.**

The private home care provider can get paid at the RN rate of $71.50 for these visits if all the above is met.

The reimbursement will also be made when the request by case management is for the Provider RN to facilitate a telehealth visit between the member and his/her PCP.

A service provider can use the form as part of their supervisory visit form or use it instead of the supervisory visit form they are currently using. They can use it at every supervisory visit, even those conducted by the LPN, and have the RN sign off behind the LPN. If their current supervisory visit form contains ALL the information on the appendix DD Form, they can use the appendix DD form instead. Rev 7/2018, 1/2020, 1/2021

**Appendix EE – Physician Change in Services Letter – Rev 4/2019**
**Case Management Agency Name:**
**Case Management Agency Fax and E-mail:**

**DATE:**
**CLIENT NAME: _____ DOB: _____**
**TO: _____ FROM: _____**
The attached Level of Care page was signed by your office and certified on the above named client during a home assessment for (certification/recertification) into the EDWP (CCSP/SOURCE) Services Program. Also attached is the Elderly and Disabled Waiver Program (EDWP) Modified Reassessment Form for _____. The EDWP, which is a Home and Community-Based Services Medicaid Waiver Program, allows states to provide non-institutional services, reimbursable by Medicaid, to individuals at risk of institutional placement or who are receiving institutional care and need help in returning to the community.

Subsequent to the date of your approval on the attached Level of Care page, _____ has experienced a change in circumstances that necessitates a change in his/her plan of care. Below we have listed the changes that prompted a change in services, as well as any planned new services.

**Client changes necessitating service revisions:**

**Changes to plan of care:**

Your signature below approves the changes to the service plan on the above named client, and your signing certifies that your patient requires the intermediate level of care provided by a nursing facility, and that your patient's condition can be managed by the provision of services in the community instead of nursing home placement.

**Signature: _____ Date: _____**

**PLEASE return no later than _____. This fax contains _____ pages, including cover.**

**Thank You,**

**RN/LPN/Care Coordinator**

# Appendix FF – Notice of Intent to Become a EDWP (CCSP and SOURCE) Service Provider

**INSTRUCTIONS: (Complete Parts I – IV.)**

1. Please complete each item of this *Notice of Intent to Become a EDWP (CCSP AND SOURCE) Service Provider*. Refer to *Part I – Policies and Procedures for Medicaid/PeachCare for Kids, Part II – Policies and Procedures for* EDWP (CCSP/SOURCE) *Services Program* Section 601.2 and each applicable EDWP (CCSP and SOURCE) service-specific manual.
2. Submit the completed form to the Gammis applications, each ATN, CCSP and SOURCE, during the online application process, to become an EDWP (CCSP and SOURCE) provider during the open enrollment cycles of March 1st – March 31st or September 1st – September 30th.

***Do NOT mail documents to the Department

**APPLICATION TRACKING NUMBER (ATN) for your online application:** **CCSP (590) ATN: _____**
**SOURCE (930) ATN: _____**

**PART I – AGENCY INFORMATION**

1. Legal name of agency/applicant organization:

   _____

   NOTE: If the agency is regulated by the Department of Community Health, Healthcare Facility Regulation Division (HFRD), the applicant's governing body and agency/facility name **must be identical** to the name(s) listed on the permit issued by the HFRD, as well as, all other documents submitted in your packet.

2. Mailing Address: _____

   _____

   _____

3. County of Mailing Address: _____

4. Street Address/Physical Location: _____

   _____

   _____

5. County of Street Address/Physical Location: _____

6. Business Telephone: _____

7. Fax Number: _____

8. After-Hours Number: _____

9. Business Electronic Mail Address (e.g., username@bellsouth.net):

   _____

10. Contact Person, Title, and Telephone:

    _____

**PART II– SERVICE FOR WHICH APPLYING**

11. Indicate the service for which application is being made.

- ☐ Adult Day Health (ADH)
- ☐ Alternative Living Services (ALS) – Family
- ☐ Alternative Living Services (ALS) – Group
- ☐ Emergency Response Services
- ☐ Skilled Nursing Services
- ☐ Case Management
- ☐ Home Delivered Meals*
- ☐ Home Delivered Services**
- ☐ Out-of-Home Respite Care
- ☐ Personal Support Services
- ☐ Structured Family Care

NOTE: Initial applications (Providers without previous EDWP experience) are limited to one service at time of application, Example- Adult Day Health or Alternative Living Service etc. No combination of services for initial applications except PSS/X and SNS.

*Please submit current Title III status with the Area Agency on Aging, current monitoring results, and a letter from the Area Agency on Aging on letterhead stating that the applying agency is in good standing.

**Submit the Home Health Medicaid Number: _____

**PART III – ENROLLMENT INFORMATION**

12. Is this a "buyout" or change of ownership?
☐ Yes ☐ No

If "yes", list the name and EDWP (CCSP and SOURCE) Medicaid Provider Number of the previous owner/provider agency: _____

_____

_____

13. Is the applicant currently enrolled in the EDWP (CCSP and SOURCE) or any other waiver program or state plan service? ☐ Yes ☐ No

If "yes", list the service, Medicaid Provider Number, and date of enrollment for each service:

| Other Waiver or State Plan Service | Medicaid Provider Number | Date of Enrollment |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**14.** Place a check (√) beside the county(ies) in which the EDWP (CCSP and SOURCE) service will be provided. **NOTE: <u>Up to or ten (10) counties may be requested</u>, but keep in mind you must have the capacity to serve the regions/counties that are checked. Adult Day Health (ADH), Alternative Living Services (ALS) and Out-of-Home Respite providers can only check the one (1) county in which the facility is located.**
***PSS/PSSX applications will submit the HFR D County approval letter with the NOI.**

☐ Statewide

**1 – Northwest GA**

_____Bartow
_____Catoosa
_____Chattooga
_____Dade
_____Fannin
_____Floyd
_____Gilmer
_____Gordon
_____Haralson
_____Murray
_____Paulding
_____Pickens
_____Polk
_____Walker
_____Whitfield

**2 –GA Mtns/ Legacy Link**

_____Banks
_____Dawson
_____Forsyth
_____Franklin
_____Habersham
_____Hall
_____Hart
_____Lumpkin
_____Rabun
_____Stephens
_____Towns
_____Union
_____White

**3 – Atlanta Regional**

_____Cherokee
_____Clayton
_____Cobb
_____DeKalb
_____Douglas
_____Fayette
_____Fulton
_____Gwinnett
_____Henry
_____Rockdale

**4 – Three Rivers**

_____ Butts
_____ Carroll
_____ Coweta
_____ Heard
_____ Lamar
_____ Meriwether
_____ Pike
_____ Spalding
_____Troup
_____Upson

**5 – Northeast Georgia**

_____Barrow
_____Clarke
_____Elbert
_____Greene
_____Jackson
_____Jasper
_____Madison
_____Morgan
_____Newton
_____Oconee
_____Oglethorpe
_____Walton

**6 – River Valley**

_____Chattahoochee
_____Clay
_____Crisp
_____Dooly
_____Harris
_____ Macon
_____ Marion
_____ Muscogee
_____Quitman
_____Randolph
_____Schley
_____Stewart
_____Sumter
_____Talbot
_____Taylor
_____Webster

**7 – Middle Georgia**

_____ Baldwin
_____Bibb
_____Crawford
_____Houston
_____Jones
_____Monroe
_____Peach
_____Pulaski
_____Putnam
_____Twiggs
_____Wilkinson

**8 – Central Savannah River**

_____Burke
_____Columbia
_____Glascock
_____Hancock
_____Jefferson
_____Jenkins
_____Lincoln
_____McDuffie
_____Richmond
_____Screven
_____Taliaferro
_____Warren
_____Washington
_____Wilkes

**9 – Heart of GA/Altamaha**

_____Appling
_____Bleckley
_____Candler
_____Dodge
_____Emanuel
_____Evans
_____Jeff Davis
_____Johnson
_____Laurens
_____Montgomery
_____Tattnall
_____Telfair
_____Toombs
_____Treutlen
_____Wayne
_____Wheeler
_____Wilcox

**10 – Southwest Georgia**

_____Baker
_____Calhoun
_____Colquitt
_____Decatur
_____Dougherty
_____Early
_____Grady
_____ Lee
_____Miller
_____Mitchell
_____Seminole
_____Terrell
_____Thomas
_____Worth

**11 – Southern Georgia**

_____Atkinson
_____Bacon
_____Ben Hill
_____Berrien
_____Brantley
_____Brooks
_____Charlton
_____Clinch
_____Coffee
_____Cook
_____Echols
_____Irwin
_____Lanier
_____Lowndes
_____Pierce
_____Tift
_____Turner
_____Ware

**12 – Coastal**

_____Bryan
_____Bulloch
_____Camden
_____Chatham
_____Effingham
_____Glynn
_____Liberty
_____Long
_____McIntosh

**PART IV – CERTIFICATION**

I hereby certify that my pre-qualification documents to enroll in the EDWP (CCSP/SOURCE) Services Program are complete and contain all required materials in accordance with submission requirements established by the Department of Community Health. I understand that if my pre-qualification documents are not in accordance with submission requirements detailed in the EDWP (CCSP and SOURCE) General Services Manual, my application **will not be returned** and will not be considered to continue in the established enrollment process. I understand that if my application is not considered, I will be notified via email or mail and can resubmit during any specified recruitment cycle.

_____

**Signature** of person legally authorized to act
for the organization or person to whom legal authority is delegated

_____

**Typed** name and title of above person

_____

**Date**

_____

**Typed** name and title of person completing the application

**Appendix GG - Application Checklist Table**
**Documents required by the CVO**

*Use the checklist table below to gather the documents you will be required to attach to your online application based on the specialty listed in red/below. The Credentialing Verification Organization (CVO) and the DCH provider specialist who reviews your application reserve the right to request additional documents as needed to determine if you are fully qualified to be approved as a Georgia Medicaid provider of the service under which you are applying.*

Yes = the document is required and must be uploaded with the application
No = the document is not required for your specialty

Specialty **243** -FI, Fiscal Intermediaries – must complete the process in 1406, Part II Chapter 1400 Policies and Procedures for EDWP (CCSP and SOURCE) Personal Support Services/Consumer Direction/Structured Family Caregiver, addendum and have prior approval from DCH

| **SPECIALTY indicated on the application in the SPECIALTY INFORMATION section.**<br>***If you are applying to be an out of home respite provider in a personal care home under Alternative Living Services or in an Adult Day Health Center, please include Out of Home Respite as a specialty on the application.*** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Required Documents for CVO Review** ***Specialties*** | **Personal Support Services and Skilled Nursing (PSS/SN) 197** | **Alternative Living Services – Group and Family Model (ALS-G/311 and ALS-F/312)** | **Adult Day Health (ADH) 005** | **Home Delivered Meals (HDM) 086** | **Emergency Response Services (ERS) 064** | **Case Management (CM) TCM 030 ECM 331** | **Home Delivered Services (HDS) 087** | **Structured Family Caregiver (SFC) 330** | **Out of Home Respite (OHR) 244** |
| State of Georgia License or Permit, issued by the Dept of Community Health's Healthcare Facility Regulation Division (HFRD). Provisional licenses are not accepted. If skilled nursing is specified as a specialty on the application, Nursing must be an approved service on the license. | Yes, Current and minimum of 9 months previous | Group Model – YES, a Personal Care Home Permit for 7 to 24 beds.<br><br>Family Model - NO, a letter explaining they are a contractor and do not have a state permit. | Yes, and must indicate Adult Day HEALTH Center on the Permit. | No | No | No | Yes, a GA Home Health License | No | Yes, ADH or ALS G permit |
| Current, unexpired Business License | Yes | Yes | Yes | Yes | Yes, if they have an office in Georgia | Yes | Yes | Yes | Yes |
| Secretary of State Certificate of Good Standing or Existence | Yes | Yes | Yes | Yes | No | Yes | Yes | No | Yes |
| IRS form 575c, 147c, or SS4 as proof of Federal employer ID number (FEIN) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Liability Insurance Certificate minimum of 1,000,000 coverage | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |

| **SPECIALTY indicated on the application in the SPECIALTY INFORMATION section.**<br>***If you are applying to be an out of home respite provider in a personal care home under Alternative Living Services or in an Adult Day Health Center, please include Out of Home Respite as a specialty on the application.*** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Required Documents for CVO Review** ***Specialties*** | **Personal Support Services and Skilled Nursing (PSS/SN) 197** | **Alternative Living Services – Group and Family Model (ALS-G/311 and ALS-F/312)** | **Adult Day Health (ADH) 005** | **Home Delivered Meals (HDM) 086** | **Emergency Response Services (ERS) 064** | **Case Management (CM) TCM 030 ECM 331** | **Home Delivered Services (HDS) 087** | **Structured Family Caregiver (SFC) 330** | **Out of Home Respite (OHR) 244** |
| Workers Compen-sation Insurance Certificate | Yes | No | No | No | No | No | Yes | No | No |
| Copy of Ga issued RN License | Yes | Yes | Yes | No | No | Yes | Yes | Yes | Yes |
| Notarized, signed affidavit attesting to 12 months of service experience | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes |
| IRS Form W-9 signed, with FEIN only (no SSN) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Completed Standard Assurance (Appendix RR, Attachment B) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Completed Civil Rights Assurance (Appendix RR, Attachment C) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Completed Letter of Under-standing (Appendix RR, Attachment D) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Completed Letter of Agreement (Appendix RR, Attachment E) | No | Yes | No | No | No | No | No | No | Yes if ALS, No if ADH |

| **SPECIALTY indicated on the application in the SPECIALTY INFORMATION section.**<br>***If you are applying to be an out of home respite provider in a personal care home under Alternative Living Services or in an Adult Day Health Center, please include Out of Home Respite as a specialty on the application.*** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Required Documents for CVO Review** ***Specialties*** | **Personal Support Services and Skilled Nursing (PSS/SN) 197** | **Alternative Living Services – Group and Family Model (ALS-G/311 and ALS-F/312)** | **Adult Day Health (ADH) 005** | **Home Delivered Meals (HDM) 086** | **Emergency Response Services (ERS) 064** | **Case Management (CM) TCM 030 ECM 331** | **Home Delivered Services (HDS) 087** | **Structured Family Caregiver (SFC) 330** | **Out of Home Respite (OHR) 244** |
| Signed Electronic Funds Transfer Agreement (EFTA) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Voided check or bank letter as proof of bank routing number and bank account number | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Title III or Social Services Block Grant funding contract with a Georgia Area Agency on Aging to provide meal services | No | No | No | Yes | No | No | No | No | No |
| Case Management Certification Document | No | No | No | No | No | Yes | No | No | No |
| ServSafe Certificate | No | No | Yes | No | No | No | No | No | No if ALS, Yes if ADH |

| Additional documents to be provided to the EDWP Enrollment Unit/Waiver Unit when requested | PSS/SN | ALS-G | ALS-F | ADH | HDM | ERS | CM | HDS | SFC | OHR |
|---|---|---|---|---|---|---|---|---|---|---|
| Notice of Intent to Apply (Appendix FF of the EDWP (CCSP and SOURCE) General Services Manual) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| HFRD County Approval Letter | Yes | No | No | No | No | No | No | No | No | No |
| Resumes Owner/Director/RN | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Fire Inspection Reports -w/in last 12 mos. | No | Yes | No | Yes | No | No | No | No | No | Yes |
| AAA Consult Document | Yes | Yes | Yes | Yes | Yes | No | No | No | No | Yes |
| Policy and Procedures | Yes | Yes | Yes | Yes | Yes | Yes-list service options | Yes | Yes | Yes | Yes |
| Alzheimer's Disclosure / App H | Yes | Yes | Yes | Yes | No | No | No | No | Yes | Yes |
| Business plan | No | No | No | No | No | No | Yes | No | No | No |
| Sample contract | No | No | Yes | No | No | No | No | No | No | No |
| List of services including fall detection | No | No | No | No | No | Yes | No | No | No | No |
| Applicable Food permit (licensed for 24 or more), HD Inspection, Contract with caterer | No | No | No | Yes | No | No | No | No | No | No if ALS, Yes if ADH |
| Most recent HFR Survey clear of deficiencies or accept POC (601.1D) | Yes | Yes | Yes | Yes | No | No | No | No | Yes | Yes |

**APPENDIX QQ - EDWP Modified Reassessment**

**Section A. Identification**

Date of Visit_____

Member Name: _____DOB _____ Medicaid number _____

Place of Assessment: □ Home □ Hospital □ Nursing Home □ ALS/PCH □ other _____

**Section B. Reason for evaluation**

□ Discharged from Nursing Facility □ Discharge from institutional stay (mental health) □ Internal Transfer □ External Transfer □ Change in function (cognitive or physical) □ Other _____

**Section C.**

**Diagnoses** (if applicable, include diagnosis relevant to nursing facility or institutional stay and/or change in function)

1. _____ 2. _____ 3. _____

**Section D. Goals**

**Community**

Service Recommended _____

Provider _____

Frequency/Units _____

**Nutrition/Weight**

Ordered diet: _____ □ Weight gain (90 days) □ Weight Loss (90 days)

**Skin Care**

□ No skin breakdown □ Decubitus ulcer/stage and location _____

□ Other wound/ulcer (specify) and location _____

□ Wound care provider and frequency _____

**Clinical Indicators**

□ Self-monitoring □ BP □ Blood sugar □ Weight □ Other _____

□ Assisted monitoring □ Dialysis □ Chemotherapy/radiation □ Oxygen

Nursing Facility admit date_____ discharge date _____

**Medication**

□ Self-monitoring □ Compliant □ Noncompliant

□ Needs assistance □ Medication list updated

ADL/IADL Performance

(S-Self; INF-informal support; PSS)

____ bathing __dressing ____ eating ____ transferring _____ toileting ____ walking _____ managing finances _____ errands ____ meal prep _____ laundry _____ shopping _____ transportation

**Transfers**

□ cane □ walker □ wheelchair □ bedbound □ other _____

□ fall in 30 days □ fall in 90 days □ fall with injury in 90 days _____

**Problem Behavior**

□ Alzheimer's □ Dementia □ mental health □ substance abuse □ depression

□ Other _____

**Informal Support/Caregiver**

□ indicators present for caregiver burnout

□ adequate caregiver support/name _____

**Other – Continence, Housing, Hospice, other**

□ UTI/other urinary related infection □ Urinary Incontinence □ Bowel Incontinence

□ Request to move □ Dual enrollment hospice/provider _____

**Additional information** (i.e. home health, PT, OT, ST, etc.)

_____

_____

_____

_____

Member signature_____Date _____

LPN/RN Signature _____Date _____

Supervisor Signature __ _____Date _____

**NOTE:** *The actual form you receive may have different formatting but will contain the same information*.

# Appendix RR – EDWP (CCSP and SOURCE) Standard Assurances

## STANDARD ASSURANCE

Attachment B

_____

(Legal Name of Provider Agency)
assures and certifies with respect to this agreement that as a provider of EDWP (CCSP/SOURCE) Services Program , this agency must:

1. Comply with all EDWP (CCSP and SOURCE) policies and procedures and service standards.
2. Employ appropriate staff as required for the specific service types for which the agency has requested enrollment.
3. Comply with Title VI of the Civil Rights Act of 1964. (See Attachment C.)
4. Be familiar with Section 504 of the Rehabilitation Act of 1973 and comply with the provisions set forth in it.
5. Provide services to all clients determined to be eligible and appropriate for CCSP or SOURCE by the CCSP or SOURCE case management agency.
6. Understand that my agency staff is a mandated reporter of abuse, neglect, mistreatment, and/or exploitation.

_____

Signature of person legally authorized to act for the organization or person to whom responsibility for these assurances is delegated

_____

Typed name of above person

_____

Title

Date Revised: 01/2020

**ASSURANCE OF COMPLIANCE WITH TITLE VI**
**OF THE CIVIL RIGHTS ACT OF 1964**

Attachment C

_____, hereinafter called the "Agency",
(Legal Name of provider agency)

**hereby agrees that** it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 80) issued pursuant to that Title, to the end that, in accordance with Title VI and that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity financed in whole or in part by Federal funds, which the Agency provides or participates directly through a contractual or other arrangement.

The Agency agrees to make no distinction on the ground of race, color, or national origin with respect to admission policy or procedure or in the provision of any aid, care, service, or other benefits to individuals admitted or seeking admission to the Agency.

This assurance is given in consideration of and for the purpose of receiving any and all payments from State agencies receiving Federal grants. The Agency recognizes and agrees that State agency financial payments will be extended in reliance on the representation and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Agency, its successors, transferees, and assignees. The person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Agency.

_____
Name of Provider Agency

_____
Signature of Director or Administrator

_____
Typed name of Director or Administrator

_____
Signature of Owner or Chairman of Board

_____
Typed name of Owner or Chairman of Board

Date Revised: 01/2020

**LETTER OF UNDERSTANDING**

Attachment D

_____,
(Legal Name of Provider Agency)
hereinafter called "the provider," understands and certifies with respect to this agreement that the following terms and conditions shall be met in order to receive recommendation for enrollment in the Community Care Services Program (CCSP) and Services Options using Resources in Community Environments (SOURCE) program:

1. The provider has consistently received a satisfactory rating for any other service it provides that is regulated by the GA Department of Community Health.
2. The provider must participate in EDWP (CCSP and SOURCE) training provided by the GA Department of Community Health.
3. The provider understands that Medicaid enrollment does not guarantee client referrals.
4. The provider must have a satisfactory on-site visit conducted by the GA Department of Community Health or its designee prior to being approved for a provider ID to provide services for CCSP and SOURCE.

_____
Signature of person legally authorized to act for the organization or person to whom legal authority is delegated

_____
Typed name of above person

_____
Title

Date Revised: 01/2020

**ALTERNATIVE LIVING SERVICES (ALS)**
**LETTER OF AGREEMENT**
(To be completed by Alternative Living Services providers only.)

Attachment E

_____,
(Legal Name of Provider Agency)
hereby agrees that no CCSP or SOURCE Alternative Living Services client will be placed in any group or family model personal care home until said home has received a license without restriction from the Georgia Department of Community Health's Healthcare Facility Regulation Division. Evidence of such licensure must be submitted to the Georgia Department of Community Health's EDWP (CCSP and SOURCE) Unit in the Division of Medicaid and/or the Georgia Department of Community Health's Provider Enrollment Unit.

_____
Signature of person legally authorized to act for the organization or person to whom legal authority is delegated

_____
Typed name of above person

_____
Title

_____
Date

Date Revised: 1/2020