Assessment and Care Planning

Chapter 3 describes the intent and process of performing a full long-term services and supports assessment and developing a care plan.

A Home and Community Services Social Service Specialist, Home and Community Services Nursing Facility Case Manager, Area Agency on Aging Case Manager, Developmental Disabilities Administration Case Resource Manager, Nurse Care Consultant, or Care Consultant, is called and will be referred to as a **case worker** in this chapter.

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TABLE OF CONTENTS

Assessment and Care Planning 1
TABLE OF CONTENTS 1
Person-Centered Care Planning 4
Strengths & Preferences 4
Goals 4
Informed Choice 4
Goals and Functions of the CARE Assessment 5
What are the functions of an assessment? 5
Assist the individual to develop a plan that: 5
What is the function of the CARE tool? 5

Home and Community Services/Area Agency on Aging: Who is eligible for an assessment? 5
Home and Community Services/Area Agency on Aging: Prioritizing an Applicant's Assessment 6
Home and Community Services/Area Agency on Aging: Who is eligible for an assessment? ..... **Error! Bookmark not defined.**
Who completes the CARE assessments? 6
Types of CARE Assessments 7
Can a nursing referral result in a Significant Change assessment? 9
Veteran Directed Care (VDC) Assessment 10
What is an Area Agency on Aging/Non-Core assessment? 10
Can an incarcerated individual be assessed? 10
Adding a client to CARE 11
How do I add a client to CARE? 12
When do I inactivate a client record in CARE? 13
Performing a CARE Assessment 13
Steps in performing a CARE Assessment 14
In-person vs. Telephonic Assessments 17
Not eligible for Core services? 18
Limited English Proficient Persons 19
Assessing Status (Informal Supports) 19
Finalizing a CARE Assessment – Developing the Plan of Care 22
Obtain Plan Approval on the Plan of Care 23
Obtaining signatures on the CARE Service Summary portion of the client's plan of care 28
Assessment Completion Timeframes 34
Significant Change Assessment by a Nurse 36
Significant Change Request by an Adult Family Home (AFH) 37
Authorization of Services 38
Exception to Rule (ETR)/Exception to Policy (ETP) 39
Submitting an Exception to Rule Request to the Headquarters Exception to Rule Committee 43
Termination of Services 50
Resources 53
Related Washington Administrative Code Regulations and Revised Code of Washington Laws 53
Acronyms 53

Revision History 54
Appendix 59
Bed Rail Policy 59
Self-Directed Care 63
Necessary Supplemental Accommodations (NSA) 66
What is the Role of the HCS/AAA Case Worker When Care Planning with a Client Who is a Registered Sex Offender? 67
Minimum Standards 69
Case File Standards 79
Forms and Brochures 84
Assessment Location Grid 86
LTSS Exception to Rule Types and Approval Authority 89
Attachments 92
Guide to Electronic Signatures via CARE Assess 92
Voice Signature Technical Training PPT 92
Voice Signature Script 92
Chart of Scenarios for Service Summary Signatures 92
Exception to Rule Frequently Asked Questions for Providers 92
Exception to Rule Frequently Asked Questions for Hospitals 92
Care Planning Advocate Flow Chart 92
How to Identify a Guardian Conservator Nominee 92
Power of Attorney vs. Uniform Guardianship 92
Document Review Checklist for Alternative Decision Maker Authority Form 92

PERSON-CENTERED CARE PLANNING

Person-centered care planning is a dynamic way to learn about the choices and interests that make up a person's idea of a good life – and to identify the long-term services and supports needed to achieve that life. It is not something you, as a case worker, will do to a client, nor is it something you, as a case worker, do for a client. Instead, the client directs person-centered planning with support from a case worker as needed.

Strengths & Preferences

The person-centered care plan must reflect the client's strengths and preferences. A key component of person-centered care planning is learning what a person's strengths are and how they would like to live their life. Case workers should seek to learn what a person is good at, resources or support, past accomplishments, and what others admire about the person. Case workers should also engage the person to understand likes and dislikes across various domains of life. This could include what a "good day" looks like for a person or daily routines. Case workers will document these elements at the start of the care planning process in the CARE Profile screen.

Goals

The person-centered care plan will also include individually identified goals and desired outcomes. Goals are meaningful statements about what a client wants to achieve. Goals should be personal, written in the client's own words, and focused on what the client wants. Goals should be developed based on what matters to the client (interests, values, etc.) and should not focus solely on the client's needs such as health or safety. Case workers will document these elements at the start of the care planning process in the CARE Profile screen.

Informed Choice

The person-centered care planning process offers informed choices to the client regarding the long-term services and supports they receive and from whom. An informed choice occurs when the case worker presents different options to the person and explains what each of the options means for their life. The intent of case worker's explanation is to provide the person with the information needed to understand.

Running down a list of long-term services or setting types without explanation is not sufficient. The person-centered care planning process takes time to appropriately explain the person's options, encourage exploration, and answer questions.

Example.
The case worker may ask, "**If you decided to** self-direct your own care, **this means** you would inform and provide training to the individual provider for those self-directed care tasks. **Is this something you're interested in**?"

GOALS AND FUNCTIONS OF THE CARE ASSESSMENT

What are the functions of an assessment?

To develop a person-centered care plan (or plan of care) with an applicant and/or current long-term services and supports recipient, the case worker must:

- At least every twelve months, perform an in-person interview with the individual requesting long-term services and supports, in their home or place of residence, or another location that is convenient to the individual;
- Obtain and review documentation/information;
- Document the individual's abilities, resources, preferences, and goals;
- Assure that available supports are not supplanted; and
- Use the information to assist in determining eligibility for long-term services and supports programs.

Assist the individual to develop a plan that:

- Is person-centered by incorporating the individual's choices, preferences, strengths, and goals;
- Identifies items and services, within resource limitations (acknowledging health and safety risk factors and personal goals) either by paid resources or other means;
- Provides clear instructions to caregivers of the individual's preferences related to services within program limits;
- Makes providers aware of the client's authorized services to determine if they can adequately perform the tasks assigned; and
- Makes appropriate referrals to community resources based on abilities, preferences and/or mandatory referral policy.

What is the function of the CARE tool?

The state establishes eligibility for services using the Comprehensive Assessment Reporting Evaluation (CARE) tool. The CARE tool functions as an assessment, service planning, and care coordination tool and is used to determine program eligibility and establish the amount of care (daily rate or monthly hours) a client is eligible to receive. See the Resources Section for related program rules that establish total hours and how much the department pays toward the cost of services. The CARE tool is also used to document eligibility for other Community First Choice (CFC) and waiver services such as Personal Emergency Response Systems (PERS), home-delivered meals, Adult Day Care, Adult Day Health, environmental modifications, etc.

Home and Community Services/Area Agency on Aging: Who is eligible for an assessment?

Individuals eligible for an assessment are adults, 18 years of age or older, who:

- Apply for Core long-term care services
- Are likely to be eligible for Medicaid nursing facility care/coverage within 180 days or voluntarily request an assessment to reside in a nursing facility assessment
- Apply for Aging Network services.

Home and Community Services/Area Agency on Aging: Prioritizing an Applicant's Assessment

For Individuals eligible for an assessment who are adults, 18 years of age or older, and apply for Aging Network services, assess these individuals without regard to financial eligibility and prioritize in the following order:

1. Individuals with an Adult Protective Services (APS) case who may need case management or other long-term services and supports
2. Individuals on Hospice
3. Individuals in a hospital or in the community and in jeopardy of imminent harm or institutionalization (hospitalization or nursing facility)
4. Individuals who are otherwise at risk of being in a nursing facility in their present situations
5. Residents of nursing facilities who have imminent discharge potential to a community-based setting; and
6. All other requests for services.

Who completes the CARE assessments?

Home and Community Services: include the Social Service Specialist (SSS) or Nursing Care Consultant (NCC) role types. A Home and Community Services Social Service Specialist and Nurse Care Consultant is called and will be referred to as a **case worker** in this chapter. The HCS case worker completes:

- All Initial assessments,
    - EXCEPTION: Asian Counseling and Referral Service (ACRS) and Chinese Information and Service Center (CISC) complete Initial assessments in King County for specific ethnic populations.
- Annual and Significant Change assessments for individuals residing in residential settings,
- Nursing Facility Level of Care (NFLOC) evaluations unless case managed by the Area Agency on Aging (AAA) or the Developmental Disabilities Administration (DDA). Home and Community Services should coordinate with the Area Agency on Aging or Developmental Disabilities Administration as needed to determine Nursing Facility Level of Care (see Chapter 10 for more information on Nursing Facility Case Management and Relocation),
- New assessments of former Home and Community Living Administration (HCLA)-funded clients, (Individuals who have been terminated from all Home and Community Living Administration services for more than one year and are requesting services again),
- New assessments for individuals currently on non-Core services applying for Core services; and
- New assessments of individuals requesting Adult Day Health only.

Adult Protective Services or Home and Community Services (based on regional office protocol): Adult Protective Services staff complete assessments for protective services.

Area Agency on Aging: include the Area Agency on Aging/Aging Network case manager or nurse role types. An Area Agency on Aging case manager or nurse is called and will be referred to as a **case worker** in this chapter. An Area Agency on Aging case worker completes assessments for individuals:

- Receiving HCLA-funded long-term services and supports in their home after services are initially authorized
- Moving from their own home to a residential or nursing facility setting
- Veteran Directed Care (VDC) assessments for participants in the Veteran Directed Care program
- On non-Core programs with the Aging Network, and
- Receiving Adult Day Health only after services are initially authorized.

Developmental Disabilities Administration: Developmental Disabilities Administration Case Resource Managers (CRM) complete assessments for individuals who are Developmental Disabilities Administration-enrolled and receiving services funded through Developmental Disabilities Administration, for children under the age of 18 who are not Developmental Disabilities Administration enrolled but are eligible for personal care services, or for an individual being screened for a move to a nursing facility by Developmental Disabilities Administration.

Federally recognized Indian tribe: A federally recognized Indian tribe contracted with the Home and Community Living Administration may provide case management services and supports, and complete assessments for individuals 18 and older in their home after services are initially authorized. (WAC 388-71-0503). Providers of home and community based services for the individual, or those who have an interest in, or are employed by a provider of home and community based services for the individual must not provide case management or develop the person-centered service plan.

Types of CARE Assessments

Initial Assessment

Complete an in-person Initial CARE assessment with an individual who requests Core services from Home and Community Living Administration (HCLA) for the first time or for clients who have been terminated from all HCLA -funded services for more than one year and are requesting services again.

Initial/Reapply Assessment

This is an in-person CARE assessment for clients who are reapplying for Core services within one year of the last in-person assessment.

Annual Assessment

To continue to obtain federal funding, the federal government requires an in-person assessment to be performed at least annually to determine program eligibility. A new in-person assessment must be performed and moved to *Current* by the last day of the same month the previous in-person assessment was moved to *Current*. The Plan Period for each assessment is displayed on the Assessment Main screen.

Services may not be authorized on a pending assessment. The assessment must be moved to Current before services can be authorized.

Significant Change Assessment

A Significant Change assessment is necessary to assess changes in client condition so the plan of care can be revised to reflect updates in care tasks and caregiver instructions. Perform an in-person, Significant Change assessment when the client requests one, or when there has been a reported change in the client's cognition, Activities of Daily Living (ADLs), mood and behaviors, or medical condition that will affect the care plan. The reported change may be an improvement or a decline in the client's condition. Always use the Significant Change assessment when assessing a client in-person, within the current plan period, even if there is no change in the client's condition. On the Assessment Main screen "Reason for Assessment" field, indicate the reason for the Significant Change assessment.

Significant Change assessments should be completed (moved to *Current*) no later than 30 calendar days from the date it is determined that there has been a change in the client's condition that warrants a new assessment. If the 30-day timeframe is exceeded, a reason must be documented in a Service Episode Record (SER).

AFH providers who submit a written request via fax, e-mail, or mail to the case worker of a change in the client's condition that warrants a Significant Change assessment, may request a review from the department when the assessment results in an increased daily rate but was not completed within 30 *calendar* days of receipt of a fully completed Form "*AFH Resident Significant Change Assessment Request"* and updated Negotiated Care Plan. If a review is requested, and the department determines the assessment was not completed within 30 *calendar* days due to department error, the increased daily rate must be authorized starting the 31st day from receipt of the written request.

When all required information has been received, the case worker will use the "**AFH Sig Change Request**" Service Episode Record (SER) code in CARE and enter the date the complete written request was received. (CARE will then generate a tickler to send reminders on the 20th and 27th calendar day from the written request date to complete the assessment and move it to Current.)

In some cases (Home and Community Services/Area Agency on Aging), completion of an in-person, Significant Change assessment can determine the date of the next annual reassessment. For example:

- You complete (move to *Current*) a client's Initial assessment on July 6, 2026, which means the Annual assessment must be completed on or before July 31, 2027.
- You complete an in-person, Significant Change assessment on October 15, 2026. This client's Annual assessment date could be changed and would need to be completed on or before October 31, 2027. Additionally, you must confirm that the client is financially eligible before extending services for 12 months.

In some cases, the change in the client's condition may be temporary. If the change appears to be temporary do not assume the next in-person assessment will be an Annual assessment. Depending on the client's situation you may need to reassess the client prior to a year for appropriate service planning.

Can a nursing referral result in a Significant Change assessment?

Yes. The case worker may perform a Significant Change assessment as a result of the Skin Observation Protocol or a nursing referral when one or more Critical Indicators are triggered.

Interim Assessment

Perform an Interim assessment (for in-office use only. Never use for in-person assessments) when:

1. Making changes to assessments that do not involve a reported change in the client's cognition, Activities of Daily Living, mood and behaviors, or medical condition. This may be the result of:
    a. Additional information about the client that is **not** related to a change in the client's condition
    b. A change in the availability of informal support, or
    c. A correction of coding, for example, as a result of a Quality Assurance (QA) or supervisory review.
2. Documenting changes to the client's condition that do not change the CARE Classification.
    a. Information may be gathered via phone by the case worker from:
        i. the client or the client's representative,
        ii. medical professionals,
        iii. personal care providers, etc.
    b. Discuss and document the client's reported changes using the appropriate and consistent lookback periods.

NOTES on Interim assessments:

- The reason for the Interim assessment must be documented on the Assessment Main screen in the "Reason for Assessment" field. The assessor should remove outdated information in this section.
- Triggered Referrals screen:
    - Follow up on any indicators that are relevant to the documented change in assessment coding (reason for the Interim).
    - Indicators may be marked "No" in the "Refer?" dropdown if the Triggered Referral screen was completed at the previous in-person assessment.
- Completing an Interim assessment will not restart the plan period, and an in-person assessment will need to be completed before the plan period expires. If an in-person Significant Change is completed, the plan period will restart, and another in-person assessment will be due within 365 days.
- **IMPORTANT:** The Interim assessment must be moved to *History* and an in-person Significant Change assessment must be completed in the client's residence when the:
    - Interim assessment results in a change in CARE Classification, unless the change in classification was due to a correction of coding after a supervisory or Quality Assurance (QA) review; or

- Interim assessment results in "Not functionally eligible" determination in CARE. For example, clients declining personal care tasks that were previously coded as unmet or partially met.

Veteran Directed Care (VDC) Assessment

Only Area Agency on Aging staff use the Veteran Directed Care assessment type for Veteran Directed Care program participants.

What is an Area Agency on Aging/Non-Core assessment?

An Area Agency on Aging (AAA)/Non-Core assessment is used by AAA staff when assessing a client for non-Core services, under the Senior Citizens Services Act (SCSA), Older Americans Act (OAA), or under locally funded services when providing Aging Network case management.

Can an incarcerated individual be assessed?

Individuals in a jail or prison in Washington are considered residents of the State of Washington. Medicaid financial eligibility determinations can be initiated while an individual is in either a jail or prison facility.

Incarcerated Applicant

The individual, representative, or staff at the jail/prison can be provided with an Application for Benefits or directed to the online application. Applications should be submitted as soon as the individual knows of a potential release date. Referrals for individuals in jails will follow the regular intake process.

Conducting an assessment in a jail or prison setting

Social Service Specialists or nurses may go into jails or prisons to conduct assessments but will need to comply with the security requirements of the jail/prison facility. This may include submitting information for a background check, as well as making specific arrangements with the facility to bring a laptop computer into the jail/prison (this often requires specific security clearance).

Social Service Specialists or nurses should coordinate closely with the jail or prison facility staff to ensure access is provided to:

- the individual,
- staff who work with the individual (such as counselors or medical staff),
- and the individual's medical and behavioral records.

Note: If a client is receiving a Non-Core Senior Citizens Services Act (SCSA) or Older Americans Act (OAA) funded service and then applies for Core Home and Community Living Administration long-term care services, Home and Community Services staff may perform an assessment using the last assessment (via "copy & create" function) that was done by the Aging Network. This process builds upon the assessments that were previously completed and facilitates the exchange of information regarding the client's past functioning.

Client is expected to be incarcerated for more than 30 calendar days

For most clients, if the client will not return home within 30 calendar days of incarceration, the case worker will proceed with termination planning. See Termination of Services for more information.

The exception is the Government Opportunity for Supportive Housing (GOSH) program and incarcerations. If a client is jailed, they are not automatically exited from their GOSH services or subsidy. If the case worker is made aware that their GOSH client is in jail, the case worker will initiate a case staffing with the GOSH Program Manager. See LTC Manual Chapter 6a/HCS Subsidies & GOSH Services for more information.

ADDING A CLIENT TO CARE

Once you receive a request for an assessment, perform an intake, assign the case, and follow-up with clients to schedule the assessment within the required timeframes.

TIMEFRAMES		
	For all applicants (Except skilled nursing facilities. See Chapter 10 for applicable timeframes):	**For applicants currently inpatient at acute care/state hospitals/community psychiatric hospitals:**
Intake	Enter applicants into CARE within 2 working days of receipt of referral.	Enter applicants within 1 working day.
Assignment	Intake Specialist will attempt to contact the client by phone, and if unable leave a message, will create a Custom Tickler out 5 working days in the future to allow time for the client to call back. If unable to reach client, Intake will mail 10-day letter to client. Assign a primary case worker within one working day of conducting the initial	Assign the case so that the case worker has adequate time to make contact with the individual.

	Intake phone interview. If no response after 10 days, case will be inactivated.	
Contact	Case worker will make 2 attempts to reach client by phone within 3 working days of assignment. If unable to reach client, case worker will mail 10-day letter to client. If no response after 10 days, case will be inactivated. However, priority must be given to those individuals in jeopardy of imminent harm or in a nursing facility.	Make contact to schedule an assessment and review Long-Term Services and Supports (LTSS) options regardless of desired discharge setting.
Completion	• From date of intake: Complete the assessment (move to *Current* and authorize services) within 45 days after the date of intake. • From CARE assessment creation date: Once the assessment has been initiated, it must be finalized (moved to Current) within 30 days.	• Assessment start date must be seven days from the date of referral or from the date the client is stable and predictable. • Complete the assessment (move to Current and authorize services) within 30 days of the date of receipt of referral, or from the date the client is stable and predictable.
Exceptions *to this timeframe may occur when:* • *The client requests a longer response time;* • *The client is not available for an in-person contact;* • *There is difficulty in finding an appropriate and qualified provider;* • *Financial eligibility has not been completed; and/or* • *Coordination is needed with interpreter services.* *When the required response time is not met, document the reason for the delay in a Service Episode Record (SER) and describe what follow-up will occur.*		

How do I add a client to CARE?

Determine whether the client is already in CARE using a unique identifier such as a Social Security Number (SSN). This will prevent creation of a duplicate client in CARE. Having a duplicate client in CARE will create problems when linking the client to ProviderOne. If the client does not exist in CARE, add the client to the system and complete the following screens:

1. Client Details
2. Overview: Assign a primary case worker and supervisor.

3. Residence: select the client's Residence Type from the dropdown list and enter the client's residence address[1]. If the mailing address is the same, mark the appropriate checkbox. **Do not delete historical residence records. If the client has moved, create a new residence record.**
4. Client Contact: if the client's mailing address is different than their residence address, indicate the mailing address and contact phone numbers.
5. If the client uses email, enter the email address in the field provided.
6. Contact Details: add all appropriate contacts. If the client did not self-refer, identify the referent here.
7. Financial: Intake may obtain financial information, but the assessor must verify that the client is financially eligible at the time services are being authorized.
8. ProviderOne: link client to correct ProviderOne (P1) record. IMPORTANT: Use caution when linking CARE and ProviderOne records. Compare the demographic information in CARE with ACES (Name, Date of Birth (DOB), SSN must match exactly)[2]. ACES is the primary source for this information when linking to P1.

   When attempting to link a record in CARE you may get a message that indicates there is no record, and you have the option to create a new record. Ensure all the information has been entered correctly into your search and in CARE before creating a new record in P1. This is very important to avoid payment problems.

   See the CARE Help File > Dashboard > Desk-Aid for Preventing Duplicate Client Record Creation in P1 for details and instructions related to linking clients in ProviderOne.

When do I inactivate a client record in CARE?

Inactivate a client record in CARE anytime a client has requested voluntary withdrawal from services or has been terminated because they are no longer eligible. See Termination of Services for more information.

PERFORMING A CARE ASSESSMENT

The CARE tool is used for determining eligibility and benefit level, developing care plans, and authorizing services for individuals served by the Home and Community Living Administration and Developmental Disabilities Administration. Please refer to the CARE Web Assessor's Manual (i.e., Help File) for detailed policy and procedure for completing an assessment in CARE. See Chapter 7/Intro to Medicaid, State

[1] If the client identifies as being unhoused, select "Unhoused" as the Residence Type. Document known special instructions in the Comments box to assist staff in successfully contacting the client.
[2] Rarely, but sometimes, the information may be incorrect in ACES. When this happens, the CARE record still needs to match ACES to link correctly. When ACES information is incorrect, the client should work with their financial worker to correct it.

Plan, and 1915c Waivers and its subsections of the Long-Term Care Manual for policy and eligibility criteria for specific services available for eligible clients.

Functional eligibility for programs assessed in CARE are based fundamentally, upon the assistance an individual receives with personal care tasks. Assistance with personal care means physical or verbal support with Activities of Daily Living because of the individual's functional limitations. This assistance is documented using the CARE tool.

Assistance with personal care tasks is typically provided in the client's residence but may also be provided while in the community if the client chooses. A common example of this would be a client wanting to attend a church or other organization but needs support with personal care while attending. This is supported in federal rules regarding person-centered care and community integration.

Steps in performing a CARE Assessment

If the client's primary language is not English, follow the policy in Chapter 15A/ Communicating with Individuals with LEP & SD, Guidance for AAA Staff or Chapter 15B/ Communicating with Individuals with LEP & SD Guidance for HCLA (formerly ALTSA and DDA) Staff for using an interpreter and translating documents.

1. Contact the client to introduce yourself, purpose of the appointment and assessment process, and schedule an appointment following the contact timeframes.
    a. For clients residing in an Adult Family Home: once an appointment is scheduled, contact the Adult Family Home provider to notify the Adult Family Home or designee in advance of a scheduled assessment appointment. Enter a Service Episode Record (SER) in CARE that documents discussion of the appointment.
2. The following are suggestions:
    a. If there is enough lead-time before the appointment, ask the client or their representative to have a letter from their healthcare provider listing their diagnoses.
    b. Ask the client who they would like to attend the assessment appointment with them. Offer suggestions for who may be helpful in providing useful information, such as an individual helping them, a paid provider, or a representative.
    c. Explain to the client that the assessment will take 2-3 hours. Assessment information will be requested from the client, agency provider(s) and/or Individual Provider(s), facility records/staff (if applicable), and other contacts as appropriate. Check for staff and client availability before the assessment (for residential clients, facility activities may limit the time the client is available for the assessment).
    d. Let the client know you will be using a laptop or tablet and may need to work on a flat surface near an electrical outlet.
    e. In addition to information already gathered (e.g., on an Intake form), document relevant information that an assessor should be aware of prior to making a home visit such as, whether there are locked gates, unmarked roads, or other hazards (such as extreme weather conditions

or broken steps on stairways) that staff may encounter at the address, or if there is a lack of adequate cellular service.

- Ask the client if they or anyone in the home have any concerns conducting a home visit to conduct their assessment. For instance, are there perfume or animal allergens to consider that the client, household member, or staff member must refrain from, are there animals in the home that must be restrained prior to the home visit, any recent illness exposures amongst household members, or any environmental concerns, such as mold, bed bug/cockroach infestations, or do any household members own have weapons, and are these secured?

f. On the day of the appointment, call to confirm and document the appointment confirmation in a Service Episode Record (SER).

2. Assess the client in an in-person interview and gather information related to the individual's functional abilities, goals, personal preferences, and any special instructions the caregiver may need to know to support the individual to complete tasks. At some point during the assessment request that the client speak with you privately in case they would like to share information for which they are not comfortable sharing in front of others. The assessment may be in pending status while you gather additional information to complete the assessment and care plan. During this time:

   a. Complete Consent Form DSHS 14-012. You must use this form to obtain, use, or share confidential information about a client in certain situations. Read the instructions on the Consent form carefully prior to assisting the client to complete the form and emphasize the information in the "notice to clients" section at the top of the form. Supplementing the consent form with the DSHS Notice of Privacy Practices (03-387) is required at an initial assessment and is suggested for subsequent assessments to enhance the client/representative's understanding of how and why information may be shared. Check the box "Other DSHS contracted providers." The case worker should write in "HCLA paid providers". If there are specific questions about sharing information, consent and privacy, please contact the DSHS or HCLA Privacy Officer.

   b. Gather Information

      i. The client should be used as the primary source of information whenever possible.
      ii. Gather information from the client's legal representative or substitute decision-maker, as appropriate. If the client has a guardian or DPOA, get this paperwork and forward it to the Hub Imaging Unit (HIU) for imaging into the client's electronic file.
      iii. Gather other information from other contacts if it is needed to complete the client's assessment.

> If the client does not appear to be able to participate in the assessment process, then the representative/collateral contact providing information must be able to understand and speak English. If not, then an interpreter must be used. Document an SER to explain why the client did not participate and an interpreter was not used.

   c. Discuss Necessary Supplemental Accommodations (NSA). Individuals who have a mental, neurological, physical, or sensory impairment that prevents them from getting program benefits

in the same way as those who are not impaired are considered in need of necessary supplemental accommodation. Read more about NSA.

d. Review all brochures and forms with the client. Also follow the Self-Directed Care Checklist for clients who would like to self-direct their services.

e. Assess for informal support available to fully or partially meet tasks identified in the client's care plan.

f. Complete the "My Goals and Plans" section on the Profile screen in CARE: Documenting and assisting clients to identify goals is an important part of person-centered service planning. Goals can identify what motivates a person, what is important to the person, and what are their desired outcomes regarding their care.

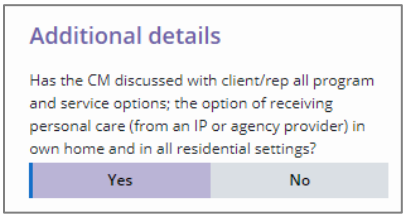
g. For residential clients, document any modifications to client's rights in a Service Episode Record (SER) and in the comments section on the appropriate corresponding CARE screen for which the modification relates. See Chapter 8/Residential Services for details.

h. Review critical indicators from the Triggered Referrals screen. When possible, review while in the home with the client and/or representative as some have specific deadlines for follow-up. The following are some examples of when you would refer to or coordinate with nurses or make other referrals:
   i. Skin Observation Protocol has been triggered. NOTE: The HCLA skin breakdown prevention plan will print on the client's assessment details when potential skin issues exist.
   ii. Other critical indicators have been triggered (e.g., nutritional status affecting the plan of care).
   iii. Depression, Drug/Alcohol Abuse, Suicide, or Pain has triggered consideration of referrals.

3. Verify and Determine Eligibility. **Financial and functional eligibility must be determined concurrently** for clients receiving Core services (such as, CFC, COPES, MPC, New Freedom, etc.). Communicate with financial staff regularly on status of financial eligibility and confirm financial eligibility has been established, or complete Fast Track procedures as necessary. Document financial verification on the Financial screen in CARE or forward documents to HIU for imaging into the client's file before authorizing or re-authorizing services for a new plan period. Develop a proposed plan of care with input from the client and relevant parties and if appropriate, hold an interdisciplinary case staffing to discuss the proposed care plan given a client's particular situation.

4. Have a discussion with clients and present all the programs and services for which the client may benefit based on their needs, goals, and eligibility. Consider any assistive technology that may assist a client to be more independent with performing ADLs, IADLS, or health related tasks. Coordinate and plan for chosen services and supports and document in the client's plan of care. See relevant Long Term Care Manual Chapters for policy and eligibility criteria for specific programs and services available for eligible clients.

5. Have a discussion with clients regarding their choices related to long-term care settings and in-home personal care provider types (an Individual Provider through the Consumer Directed Employer (CDE) or a Homecare Agency provider). Clients should receive enough information about the settings and provider types available to them to make an informed choice of providers.
6. Document the discussion from #4 and #5 above in the Care Plan screen in CARE.



7. Assist clients in identifying a qualified provider. If a client has a difficult time identifying a provider, assist the client to identify barriers preventing the selection of a provider and to resolve issues that may be preventing service delivery. Ensure the client is familiar with the CDE and can access Carina. Check in with the client regularly and assist as needed. If a client is having challenges but is actively seeking a provider, do not terminate a client for the reason of not having a qualified provider.
8. If requested by client/representative, review the plan of care with potential providers.
9. If a client has chosen to have an assessment in a setting other than their home or residence where services are being provided, a visit must be made to the client's residence before the assessment is moved to Current, or within 30 days of the assessment being moved to Current when extenuating circumstances are noted in a Service Episode Record (SER).

Behavior Screen indicator related to Community Behavioral Health Support (CBHS) Services/ 1915i (effective 7/2024)

CBHS services are available to clients in Adult Family Homes, Adult Residential Care Facilities, Enhanced Adult Residential Care Facilities, Assisted Living Facilities and Enhanced Service Facilities. For clients residing/seeking services in these settings:

During the CARE assessment, while providing the client with Home and Community Based Services (HCBS) and options, also provide the client with the CBHS brochure (HCA Form 19-0087). Based on selected diagnoses, a client may be eligible for CBHS Services. If the client is interested in these services, the case worker will review the assessment and for potential CBHS eligibility. If it seems the client is eligible on the Behavior Screen in CARE, update the question "Was a referral made for CBHS/1915i eligibility?" to "Yes". See Chapter 22d/Community Behavioral Health Supports (CBHS) of the LTC manual for more information on CBHS services.

In-person vs. Telephonic Assessments

Clients must be provided the opportunity for an in-person assessment, as in-person assessments remain the requirement. Telephonic or other technological media options may be used only when the in-person

option is not available, due to circumstances or conditions, such as health and safety of client and/or provider, inclement weather, or critical staffing crisis.

Remote assessment delivery through telephone or other technology will be in accordance with State, Federal, and Health Insurance Portability and Accountability Act (HIPAA) requirements. Other technology means any two-way, real-time communication technology that meets HIPAA requirements.

Performing a Telephonic or Other Technology Media-Type Assessment

1. When there is concern that the in-person assessment cannot be done due to a circumstance such as health and safety of client and/or provider, inclement weather, or critical staffing crisis, consult and obtain approval from Regional Leadership/AAA Case Management Director or their designee. Local HCS or AAA offices should use their professional judgement to decide how to respond, balancing health and safety of the client, the worker, and workforce capacity.
2. A Service Episode Record (SER) should briefly document:
    a. Any known information about the circumstance or condition;
    b. Action plan as a result of consultation with Regional Leadership/AAA Case Management Director or their designee
3. Prior to initiating a telephonic or other technology media-type assessment, a private setting must be used to maintain the client's privacy. Verify the client's identity before conducting the assessment; ask the client/formally appointed representative to confirm the client's legal name and date of birth.
4. During the telephonic or other technology media-type assessment, schedule a date for an in-person home visit with the client.
5. CARE MMSE Instructions: For all CARE assessment types, accurately complete the parts of the MMSE that do not require in-person interaction. For the sections that require in-person interaction (Language and Commands sections), select 'no' and note in the "Other factors" text box that the Language and Command sections were not completed because the assessment was completed telephonically or through other technology media. The sections that can be completed telephonically or through other technology media will total 22 MMSE points instead of 30.

Not eligible for Core services?

If a potential client is found to be ineligible for Core services:

- For clients who may benefit from Family Caregiver Support Services, refer them to the local AAA
- For clients over 60, consider a referral to the local AAA office or their partners for Community Living Connections (formerly Senior Information & Assistance)
- Move the assessment to history
- Send a Planned Action Notice and
- Inactivate the client within 14 days unless an administrative hearing is requested

Limited English Proficient Persons

Use the Demographics screen in the Client Details section in CARE to document the client's language details. See Chapter 15A/ Communicating with Individuals with LEP & SD, Guidance for AAA Staff or Chapter 15B/ Communicating with Individuals with LEP & SD Guidance for HCLA (formerly ALTSA and DDA) Staff for specific details related to clients who have limited English proficiency.

Assessing Status (Informal Supports)

Background

As part of the waiver approval process and Code of Federal Regulations (CFR) related to person-centered planning, the Centers for Medicare and Medicaid Services (CMS) require the state to not replace naturally occurring supports with federal funds. One of the purposes of the assessment is to determine availability of informal supports and other non-department paid resources and community resources. Identified informal supports are based on voluntary action and are available so long as the source is willing and able to continue them. The state will inform clients, families, and support systems of options to address needs a client may have for unscheduled tasks and/or supervision beyond the number of hours authorized in an in-home care plan, including residential or nursing facility care (if applicable).

As the employer, the client/representative should determine the provider's schedule, which is then documented by the case worker. When requested by the client or their representative, the schedule may be facilitated by the case worker with input from the client, formal and informal decision makers. The department is obligated to pay for hours worked up to the maximum number authorized in the plan of care.

What are examples of informal supports?

Informal supports are any resources available to fully or partially complete individual tasks (such as ADLS, IADLs, or treatments) identified in the client's care plan. Examples of informal support resources may include family members, friends, church groups, neighbors, Adult Day Health or Adult Day Care (because it is paid through a different DSHS funding source), hospice services, doctor's office services for certain treatments/foot care, home health, congregate meals (served at senior centers, tribal centers, community center), private paid caregivers, caregivers paid through an insurance policy, VA-funded personal care, privately paid Home Delivered Meals, Hospital At-Home services, etc.

Process of Determining Status

For each task, status indicates the degree of unmet need (anticipated informal/non-HCLA paid support) looking forward, regardless of what the status was in the past.

Coding of informal supports are based on an individualized assessment of each task (of an ADL, IADL, or treatment), considering any informal support that is willing and able regardless of the client's living arrangement. No assumptions must be made about informal supports. Determinations are based on an individualized assessment of each client.

For individuals, such as a family member or friend, the case worker must contact the informal support directly to confirm whether they are willing and able to provide the care as an informal support on an

ongoing basis. The case worker will document this confirmation contact in the care plan and/or a Service Episode Record (SER), and add the informal support to the Contact Details screen.

Special Considerations

- An Individual Provider (IP), who is paid by the Consumer Directed Employer to provide care to an HCLA (HCS or DDA) client, may not be considered a source of informal support.
- If an individual requires two-person assistance every time the Activity of Daily Living is performed and only one informal support is available, then the status would be unmet.
- Consideration may include whether the client has unusually high needs for assistance with tasks that may offset a deduction to Status if some informal support is available Do not consider assistance with ADLs that will occur less than weekly, except for Locomotion Outside of Room.
- Do not consider assistance that will be provided by children under the age of 18.

When is the status "met"?

If the informal support(s) is willing and able to fully complete an activity (ADL or IADL) identified in the care plan on an ongoing basis, the status is considered "met."

When is the status "partially met"?

If the informal support is willing and able to provide some, but not all assistance with an activity (ADL or IADL) identified in the care plan on an ongoing basis, the status is considered "partially met." If partially met is chosen, the assessor will need to identify the level of assistance available. Use the Assistance Available chart to determine the percentage.

When is the status "unmet"?

When there is no informal support available to assist with the activity (ADL or IADL), the status is considered "unmet".

Note: If the client uses Paratransit or other public transportation but also requires an HCLA-paid caregiver to assist with transfers, locomotion outside of room, and/or cognitive needs, the status may be "unmet" for Transportation. If the client does not need an escort, code Status based on provision of the transportation only. Medicaid brokerage services must be considered when determining whether or not to assign transportation to a personal care provider.

Assistance Available

Use this chart to determine what portion of a task is "partially met" by an informal support:

- Less than ¼ of the time
- ¼ to ½ of the time
- ½ to ¾ of the time
- More than ¾ of the time

NUMBER OF TIMES/HOURS TASK IS REQUIRED	NUMBER OF TIMES/HOURS TASK IS MET INFORMALLY																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	100%																			
2	50%	100%																		
3	33%	67%	100%																	
4	25%	50%	75%	100%																
5	20%	40%	60%	80%	100%															
6	17%	33%	50%	67%	83%	100%														
7	14%	29%	43%	57%	71%	86%	100%													
8	13%	25%	38%	50%	63%	75%	88%	100%												
9	11%	22%	33%	44%	56%	67%	78%	89%	100%											
10	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%										
11	9%	18%	27%	36%	45%	55%	64%	73%	82%	91%	100%									
12	8%	17%	25%	33%	42%	50%	58%	67%	75%	83%	92%	100%								
13	8%	15%	23%	31%	38%	46%	54%	62%	69%	77%	85%	92%	100%							
14	7%	14%	21%	29%	36%	43%	50%	57%	64%	71%	79%	86%	93%	100%						
15	7%	13%	20%	27%	33%	40%	47%	53%	60%	67%	73%	80%	87%	93%	100%					
16	6%	13%	19%	25%	31%	38%	44%	50%	56%	63%	69%	75%	81%	88%	94%	100%				
17	6%	12%	18%	24%	29%	35%	41%	47%	53%	59%	65%	71%	76%	82%	88%	94%	100%			
18	6%	11%	17%	22%	28%	33%	39%	44%	50%	56%	61%	67%	72%	78%	83%	89%	94%	100%		
19	5%	11%	16%	21%	26%	32%	37%	42%	47%	53%	58%	63%	68%	74%	79%	84%	89%	95%	100%	
20	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%	65%	70%	75%	80%	85%	90%	95%	100%

Less than ¼ of the time	¼ - ½ of the time	Over ½ to ¾ of the time	Over ¾ but not all of the time	Need Met

Example:

Client ate 3x/daily in the lookback. Parents fed client for all meals on weekend days, and breakfast/dinner meals on weekdays. Adult Day Health fed client for all lunch meals on weekdays. Parents report they are willing and able to continue informal support and client chooses Adult Day Health services ongoing.

Number of times task is required: 21 total.

Number of times task is met informally: 16 times by parents + 5 times by ADH = 21 total.

The number of times the task(s) are required are Met (21 times of 21 total) 100% of the time informally.

How do I know when I'm ready to complete CARE?
Does your assessment meet the minimum standards requirements? If yes, you are now ready to complete your CARE assessment.

Finalizing a CARE Assessment – Developing the Plan of Care

Background

Clients can choose from options for personal and healthcare services that are governed by eligibility criteria, payment source requirements, coverage options, and provider qualifications. Twenty-four-hour, paid care is available only in residential or medical facility settings, so case workers must work with clients to maximize all available resources, both paid and unpaid, to develop a plan of care that addresses the health and safety needs of the client. The state identifies the essential tasks to be performed by formal providers in the care plan within program limits. How and when they are performed is determined by the client.

The state has an obligation to educate clients, family members, support systems, and other service providers, informing them that a plan of care is developed based on the resources available and that meeting all needs and providing all services is an expectation that neither the client, family, support system, or case worker may be able to achieve.

How do I get approval on the plan of care from the client?

Before authorizing services, you must obtain the client's approval on the plan of care and finalize the assessment by moving it to Current status.

How do I distribute the plan of care to the client/representative?

Distribute the Service Summary to the client along with a Planned Action Notice (PAN) found in CARE. The Personal Care Results (PCR) or Personal Care Results Comparison (PCRC) will be attached to the PAN. If the PCR or PCRC does not print, attach the CARE Results.

The case worker should ask with the client if they would like a copy of their Assessment Details for their records. If so, then the case worker will distribute the client's Assessment Details as requested by the client/representative.

When the client has a written language identified in CARE other than English, follow instructions for translating CARE documents in Chapter 15A/ Communicating with Individuals with LEP & SD, Guidance for AAA Staff or Chapter 15B/ Communicating with Individuals with LEP & SD Guidance for HCLA (formerly ALTSA and DDA) Staff

Before providing a copy of the person-centered care plan to the client/representative, the case worker should ensure that the care plan is understandable to the client receiving the services and supports, and the individuals important in supporting the client. At a minimum, for the care plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR §435.905(b).

How and when do I distribute the plan of care to the provider(s)?

Mail, fax, or securely email the Service Summary and Assessment Details prior to authorizing/extending services and document the action taken in the Service Episode Record (SER). Distribute the Service Summary and Assessment Details to:

- Consumer Directed Employer (through CARE)
- Agency providers
- Nursing services staff, if applicable
- Residential providers
- The nursing facility, for those residents who are seeking Home and Community Based Services
- Hospital Discharge Planners for those patients who are seeking Home and Community Based Services
- Adult Day Services providers
- Nurse delegators
- Supportive housing providers
- Community Choice Guides
- Client Training Providers

Document in a Service Episode Record (SER) when you have distributed the documents and to whom.

Documenting potential risk in the Plan of Care

1. Document any potential client/provider risks not otherwise documented in CARE using the 'General comments' section on the 'Comments' screen in CARE Web.
   - Document a client's registered sex offender status under "Legal issues" in the Safety screen. (See Appendix section for detailed instruction)
   - Each of these sections will print in the Assessment Details for the provider's awareness.
2. Document in a Service Episode Record (SER) that the specific issue that may be a potential risk to a provider (or other residents in a residential setting) was discussed with the provider.

Obtain Plan Approval on the Plan of Care

To authorize services, the assessment must be in Current status following the client's approval of the plan of care. The client's approval verifies their participation in the development of the plan and consent to services outlined in the plan. You must have documentation of approval from the client or duly appointed representative.[3] Clients are considered legally competent unless deemed incompetent by a

[3] Durable Power of Attorney (DPOA) and Guardian are examples of duly appointed representatives. A DPOA (as a type of Power of Attorney) is the only one that can be used when the client becomes incapacitated. A copy of the relevant POA document is to be maintained in the electronic case record as needed and updated as required. A legally appointed guardian must have both guardianship orders and letters of office, and an unexpired copy must be kept in the electronic case record.

court of law. A reasonable effort must be made to have the client's approval and signature on documents if there is no court order deeming them incompetent.

Even if a client has an active DPOA or guardian, look to the client directly to make choices about Medicaid services, to the extent possible based on authorities and rights restrictions imposed in the orders or documentation. Identify the representative or DPOA/Guardian in the Collateral Contact Screen in the Contact Details screen in CARE Web.

Case workers should provide resources to the client for DPOA execution to assist the client with identifying a future decision-maker for care planning needs if the time comes the client is no longer able to choose a representative or participate in their own decision-making process. This is because representatives must be appointed at the initial or initial/reapply, and at each annual and significant change assessment, whereas a DPOA can be activated at any time after the client is unable to make decisions for themselves. Case worker staff should discuss options with and provide resources to the client for DPOA execution for future long-term care planning needs.

The case worker's role when there are questions about a client's ability to participate in the person-centered planning process

A client's ability to consent can be different based on the type of decision being made. There may be situations when a doctor has determined that a client does not have the ability to consent to a medical decision, but the same client may still be able to participate in the care planning process and consent to services or designate a representative to help them with the process (and to make decisions about their Medicaid services).

The case worker should interact with the client to see if they have the ability to consent to Medicaid services (such as LTSS). To assess the client's ability to participate in planning and provide consent, the case worker should consider the client's ability to receive and process information and express in basic terms their preferences and/or acceptance of options presented to them.

If, during the assessment there is reason to believe that the client's ability to participate in the assessment is significantly impacted, the case worker should be cautious about accepting the client's approval and signature. The case worker should document in a Service Episode Record (SER), the basis for accepting or not accepting the client's approval or signature, including objective facts and observations to support that the client was engaged in the activity and understood what they were signing. It may be appropriate in these situations to staff the case with a supervisor and to consider escalating using the complex case staffing process outlined in Chapter 3 and/or Chapter 9 of the Long-Term Care Manual.

Person Centered Care Planning and Preventing Conflict of Interest

Conflict of interest has the potential to occur when a person assists the client in accessing services and also provides services to the client. Meaning, there is a potential conflict of interest when the entity helping an individual gain access to services is the one that will benefit financially from the individual's receipt of those services. It is important to mitigate conflict of interest to ensure that people have full

freedom of choice regarding services and providers. Providers of home and community-based services for the individual, or those who have an interest in, or are employed by a provider of home and community-based services for the individual must not develop the person-centered service plan.

If an individual's representative is also the client's paid caregiver, that representative can sign the Service Summary on behalf of the client, however, another person must assist the client as their representative for the purpose of care planning, as needed.

In rare circumstances when there is no other option, the case worker may assist the client for the purposes of care planning only. When the case worker is assisting the client for the purpose of care planning, the case worker will indicate this in the client's Service Episode Record (SER) in CARE. This is different than plan of care supervision, the case worker must never identify themselves as responsible for supervising the plan of care on the Cognitive Performance screen in CARE.

Person-Centered Care Planning and Role Types

The client should lead the person-centered service planning process where possible. The person's representative should have a participatory role, as needed and as defined by the person, unless State law confers decision-making authority to the legal representative. There are three types of representatives; authorized representatives, power of attorney, and guardian.

Authorized Representatives (A-Rep)

A client may choose an informal decision maker, a representative who is not a DPOA or guardian, to act on their behalf to make decisions about Medicaid services and supports, including obtaining plan approval, on the client's behalf. An A-Rep may be approved either orally or by completing the DSHS #14-532/Authorized Representative Form. As completions of the DSHS #14-532/Authorized Representative Form are done, the case worker will discuss future long-term care planning discussions with their client(s) in DPOA execution needs. The A-Rep's authority to make decisions, including obtaining plan approval, is time limited and applicable only for the current plan period ***or*** until the client is no longer able to participate in their decision-making process, whichever occurs first.

If the client can indicate their free choice to authorize a representative, the representative may be allowed to make decisions about the client's Medicaid services. Representatives must be appointed at the initial or initial/reapply, and at each annual and significant change assessment. This means that at the initial or initial/reapply, and at each annual and significant change assessment, the case worker must discuss the client's choice to authorize and appoint a representative, by specifically asking the client and documenting in a SER:

- If the client intends for the A-Rep to have financial decisions authority only; **or**
- If the client intends for the A-Rep to also have the ability to assist with transitional planning, including plan approval.

A-REPs are only able to be used when a client can continue to participate in care planning and provide consent. The A-REP designation ends when the individual becomes unable to participate and/or the court determines the individual lacks capacity.

A-Rep does not take the place of a DPOA for addressing current and future client needs. Specifically, when a client can no longer consent to services because:

- A-Rep: addresses current care needs within the current plan period, for a client who can consent to services themselves.
- DPOA: addresses current and future care needs beyond a plan period, for a client who can and cannot consent to services themselves.

It is best practice and strongly encouraged that the case worker discuss options for DPOA execution to meet client needs for long-term future care planning.

Power of Attorney (POA)

If the client can identify an A-Rep, they could also execute a POA. A POA that is durable can assist with care planning in the future, if the client is unable to participate in care planning or choose a representative, this is called a DPOA. Case workers may encourage and provide resources to the client to execute a DPOA.

Power of Attorney (POA) specifics: There are many types of POAs, for HCS to use the POA for care planning and consent, it must contain language specifying the authority of the identified agent to consent to Medicaid services (such as HCS LTSS) outside of a medical setting.

Examples of Medicaid inclusive language include, but are not limited to, ***any*** of the following:

- Agent has authority to manage my government benefits, services, and/or programs;
- Agent has authority to consent to the hiring or discharge of professionals, providers, and/or caregivers;
- Agent has authority to make decisions pertaining to my care;
- Agent has authority to make decisions pertaining to where I receive care and/or where I live/dwell;
- Agent has authority to consent to or engage in discharge/transitional planning and/or admission to facility.

Designating a Durable POA is best practice because it will stay in effect even after the client no longer is able to participate in care planning or provide consent.

An individual can have an A-REP and POA at the same time.

The case worker should review the valid DPOA and/or court documents (court order and letters of office) and scan it to Barcode/DMS, after which care planning with the agent can occur.

Guardian

A guardian and/or conservator is a legal decision maker appointed by the court. The court decides the type of decisions that can be made. A court-appointed guardian and/or conservator is needed when an

individual is unable to participate in care planning and consent to Medicaid services, and either of the below are true:

- There is no DPOA; **or**
- Appointed agent under the DPOA doesn't have Medicaid inclusive authority, and either court has rejected the motion to expand authority or agent is unwilling to file.

Case workers should use the Document Review Checklist for Alternative Decision Maker Authority form to determine whether a potentially identified alternative decision maker, as a guardianship and/or conservatorship, has the legal authority to consent to long-term services and supports on behalf of the client.

Case workers should verify that a copy of the legal decision-maker document is uploaded to Barcode/DMS. For guardianship and/or conservatorship, copies of both the court order and letters of office are required and should be uploaded to Barcode/DMS.

How do I document a representative in CARE?

The case worker should use the Collateral Contact screen to document Authorized Representative, DPOA, or Guardian/Conservator.

The Case Worker's Role & Decision Making Capacity

Until a Court determines that an individual lacks decision-making capacity, the individual still retains their civil right to make their own decisions. It is important for the client to participate in person-centered planning and to honor their choice of representative. Since HCS is not a health care provider, it must follow Medicaid law when looking for client consent to provide Medicaid long-term services and supports. As such, a healthcare directive or healthcare power of attorney is generally not sufficient for obtaining consent for Medicaid services (such as HCS LTSS) outside of a medical setting unless it contains an additional provisional clause specifying authority to consent to services.

Determinations of capacity are very fact-specific, and the necessary level of "capacity" depends on the type of decision that is being made. There may be situations when a doctor has determined that a particular client does not have the ability to consent for purposes of a particular medical decision but that client may still have sufficient capacity to participate in the person-centered planning process or designate a representative to help them with the process (and subsequent decisions about their Medicaid services).

What if there is no DPOA or guardian?

If a case has not been filed with the court, a relative, friend, or other interested party would need to identify a person to serve as guardian and/or conservator on the client's behalf ***and*** file a petition for guardianship and/or conservatorship before the client can transition using LTSS. This legal process is outlined in RCW 11.130 and can take more than 90 days.

What options are available if the legal decision-making document is incomplete or doesn't have the right authorities?

DPOA: If the document does not include Medicaid inclusive language, the agent identified in the DPOA may make a motion to the court under RCW 11.125 to request expansion of their authorities to include the authority to consent to LTSS on the client's behalf.

Guardianship: If the court order does not include Medicaid inclusive language, the guardian and/or conservator may file a motion with the court as outlined in RCW 11.130 to request expansion of their authorities to include the authority to consent to LTSS on the client's behalf.

Case workers may provide resources on the process of filing such a request with the court. An available resource staff may offer is the HCLA- Power of Attorney vs. Uniform Guardianship handout.

What support is available if the case worker needs help?

Training Modules: Training covering topics of consent, capacity, legal decision maker options, guardianship/conservatorship, and HCS' Guardianship and Conservatorship Assistance Program (GCAP) may be accessed on the HCLA Intranet Training site at: Consent, Capacity, Legal Decision Makers, and Guardianship Topics

Escalation: If there are questions it may be appropriate to staff with a supervisor and consider escalating using the process outlined in Chapter 3 and/or Chapter 9 of the Long-Term Care Manual (complex case staffing).

HCS Guardianship and Conservatorship Assistance Program (GCAP): GCAP is a program specifically designed for HCS LTSS clients admitted in acute hospital beds who do not have an identified person willing to serve as an alternative legal decision maker required for transition planning. GCAP partners with hospital legal teams to assist in the identification of a guardian and/or conservator nominee for hospitalized individuals. Hospitalized clients meeting GCAP eligibility criteria, as outlined in WAC 388-106-2100, may be appropriate to refer to GCAP. Please consult your supervisor and submit a GCAP referral for consideration, if appropriate, as outlined in Chapter 9: *How to Make a GCAP Referral* section of the Long-Term Care Manual.

Obtaining signatures on the CARE Service Summary portion of the client's plan of care

42 CFR 441.540(b)(9) requires all person-centered service plans to "be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation." The Service Summary page in the plan of care within CARE is the document used by HCS and AAA to comply with federal person-centered service plan signature requirements.

Once a client's CARE assessment has been completed and moved to Current, the case worker must sign and obtain signatures of the client or their representative agent or guardian and the personal care service providers who are assigned tasks in the plan of care on the CARE Service Summary. The client or their representative agent or guardian and provider may only sign a Current Service Summary. It must not be in Pending or History Status (unless required to remediate a Quality Assurance (QA) finding).

Client Signature

Case workers must obtain the client's or their representative agent's or guardian's signature on the CARE Service Summary for Initial, Initial/Re-apply, Significant Change and Annual assessments. **For Interim assessments**, follow the steps for getting approval on the plan of care:

- when there is a change in CARE generated hours or classification,
- program change,
- addition/deletion of a service, and/or
- provider change.

***See Chart of Scenarios for Service Summary Signatures for full details of when an individual (client), provider or case worker signature is required.**

Case workers may continue to authorize services for a completed assessment using the client's **verbal approval** until the client's signature can be obtained, and the client's physical, electronic, or voice signature must be obtained at the earlier date of 90 days from the assessment *completion* date, or before case transfer; however, verbal approval may not substitute for the client's physical, electronic, or voice signature.

The client may agree to initiate or continue services without agreeing with the hours/daily rate. Document this in a Service Episode Record (SER) and move the assessment to Current.

Centers for Medicare and Medicaid Services (CMS) requires a **person-centered approach** to work with the client to obtain their signature. **Examples of methods that may be offered include, but are not limited to:**

- Completing and moving the assessment to current in the home and obtaining the client's signature electronically in a PDF document using your touch pad, mouse, or touchscreen.
- Using the e-signature feature in CARE supported by Adobe.
- Using the voice signature feature in CARE supported by AmazonConnect. (See voice signature instructions and script in the Attachments section).
- Making an in-person visit once the assessment is completed and moved to Current.
- Obtaining the signature by mail (See instructions in the Attachments section for setting up ticklers in Barcode).
- Utilizing supports identified by the client to assist them with reminders to return the signed form.

If the client has chosen a signature method other than e-signature, send the client a copy of the Current Service Summary with the case worker's signature and a Planned Action Notice (PAN). The Personal Care Results (PCR) or Personal Care Results Comparison (PCRC) will be attached to the PPAN.

If a client chooses electronic communication outside of the e-signature feature in CARE, a faxed or electronic scanned signature is acceptable. If the client prefers, use encrypted email to send the client a PDF version of the Service Summary and PAN/PCR/PCRC. As necessary or requested by the client via a signed *Notice and Consent of Communication via Text or Unencrypted Email* (DSHS Form #27-156) on file, the client may consent to receiving unencrypted email messages.

If the client chooses mail delivery as the method to obtain their signature, include an extra Service Summary with a cover letter and self-addressed, stamped envelope, so that the client can sign, date, and return the signed Service Summary.

If the client chooses voice signature, the case worker may call the client using the Amazon Connect feature in CARE, to review the contents of the plan verbally and obtain the voice signature by phone. CARE will allow the assessment to be moved to Current while connected to a call. This would replace the need to obtain verbal approval prior to obtaining the signature. Upon completion of the assessment (assessment is moved from *Pending* to *Current* status), case workers need to send a copy of the Service Summary to all clients, regardless of whether the client/representative chose to sign the Service Summary via voice signature, and when needed, include the translated version of the Service Summary to the client. Service Summaries for individuals whose signatures were obtained by voice signature, are typically not sent to the HIU for imaging.

For LEP individuals, there is no requirement to obtain separately signed English and translated versions when utilizing an interpreter to complete the voice signature, or the case worker speaks the same language as the client. The voice signature with the interpreter is the sufficient (for both the English and primary spoken language for LEP individuals), since this is a translated while being completed. Instead, once the voice signature is obtained, the case worker will then send the signed Service Summary to Prisma for translation. Prisma will translate the signed Service Summary, including the 'signatures' line. Once received, staff will mail a copy of the translated signed Service Summary to the client and submit a copy of the signed Service Summary to DMS/HIU for imaging and retention.

For detailed information and the script for obtaining voice signatures, see the instructions in the Attachments section.

Document relevant approval/signature steps in a Service Episode Record (SER).

If it is not possible to obtain the client's signature prior to authorizing/extending services:

1. Call the client to review the contents of the plan verbally and obtain verbal consent to receive the services that are documented in their plan of care.

a. Document this conversation via CARE > Service Episode Record (SER) > *Plan Approval* purpose code; and
b. Document that the client has participated in the development of the plan and verbally consents to the services.

Once the client has given verbal consent of the completed plan, work with the client to determine the best way to obtain their signature on the CARE Service Summary.

If a client or provider do not return the signed Service Summary or refuses to sign the Service Summary:

Re-evaluate the person-centered approach used and work with the client/representative and/or provider(s) who are authorized to provide personal care to obtain their signature. The approach used will depend on the individual and it may help to understand the reason for their resistance.

In some cases, a client or provider may disagree with items identified in the plan or how they are worded and will not sign the plan. If this occurs, adjust the plan contents or wording.

Clients may choose to delete certain information; however, if the information is determined to be necessary to address the health and welfare of either the client or the provider, discuss with the client and explain that unless the provider has this information, you may not be able to authorize services.

Do not:

- Include services on the plan for which the client is not eligible;
- Omit information that a caregiver must be aware of to determine that they can meet the client's needs or provide care; or
- Omit information that could impact the health or safety of the client or provider.

If the case worker is unable to obtain the client or provider signature despite exhausting documented person-centered efforts, provide the following documentation in the CARE Service Episode Record (SER):

1. The reason why the signature could not be obtained;
2. The person-centered approach and steps that were taken to obtain the client or provider signature;
3. A statement of the client's verbal plan approval; and
4. What, if any, follow up will occur?

What to do when the client cannot sign

1. If the client appears to have capacity but physically cannot sign documents, the reason should be documented in a Service Episode Record (SER). Signing with an "X" or comparable mark is acceptable if it is witnessed by the case worker or another party who has verified the client's identity and has witnessed them signing the document.

2. If the client appears to not have capacity but there is no Durable Power of Attorney or guardian in place, the case worker should state this in a Service Episode Record (SER). An Adult Protective

Services referral for Self-Neglect should be made. A guardianship may need to be considered for establishment of a formal decision maker for signing and consent purposes.

3. If the client does not appear to have capacity and there is a Durable Power of Attorney or guardian in place, all documents should be signed by the client's decision maker and noted in a Service Episode Record (SER) that the information was discussed with both the client and the client's decision maker while identifying the decision maker in the Contact Details screen. case worker staff should use the Document Review Checklist for Alternative Decision Maker Authority to evaluate a potentially identified alternative decision maker's legal authority to consent to Long-Term Services and Supports on behalf of a client. Refer to the Home and Community Living Administration Trainings Page for additional resources and information.

If alternative decision maker authority cannot be confirmed, is believed to be insufficient, or remains in question after completion of the Document Review Checklist for Alternative Decision Maker Authority form, staff the case with your supervisor **and** staff may escalate the case for Headquarters review through the processes outlined below:

- **Residential, Nursing Facility, and Other Cases**, may be escalated case to Headquarters for questions pertaining to document reviews and sufficiency of authority by submitting a request through the escalation pathway at ALTSAAcuteHospitalGuardianshipCaseStaffing@dshs.wa.gov.
    - Request email should include attached copies of ***both*** the completed Document Review Checklist for Alternative Decision Maker Authority form **and** the specific document(s) you reviewed as well as:
        - Client first and last name
        - Client ACES ID
        - Region
        - Current location of client
        - Brief explanation of your question or concern
    - *Allow 5 business days for completion of Headquarters review. If requesting a Headquarters review, staff should **not** provide communication that a document is insufficient until **after** the Headquarters review is complete.*
- **For Acute Care Hospital (ACH) and/or Guardianship and Conservatorship Assistance Program (GCAP) cases**, refer to Chapter 9/Hospital Assessments for escalation process.
- **Modification of Client Rights,** such as delayed egress consideration, refer to Chapter 8/ Residential Services (section "Documenting modifications to Client Rights").

Provider Signature(s)

1. Case workers must obtain signatures on the CARE Service Summary from all personal care providers authorized, at the earlier date of 90 days from the assessment *completion* date or before case transfer. All providers listed below in this section (a through e) are required to sign the Service Summary as required by CFR. Providers must return the signed Service Summary to the case worker as soon as possible, using a method that protects the client's protected health information (such as secure email, fax, mail etc.).

The following personal care service provider types must sign the CARE Service Summary that is in Current status when the provider is added to the plan of care:

a. Consumer Directed Employer
b. Home Care Agency
c. Adult Family Home
d. Assisted Living Facilities
e. Enhanced Services Facilities

2. Case worker must also obtain the provider's signature when there is a change in their task assignment. For changes in providers during the plan period, case workers should obtain signatures at the earlier date of 90 days from the *authorization start date* or before case transfer.

3. Plans of care must continue to be sent to the provider prior to authorizing services.

More about signatures

1. When the ONLY change to a client's care plan is a change of a paid or unpaid provider:

   a. A new assessment may not be required
   b. A new client signature is not required
   c. A personal care provider signature may be required if there is a change in the paid task assignment
   d. The Service Summary in CARE must be updated and the updated version filed in the client's electronic case record (ECR) via the HCS Imaging Unit (HIU). If the changes made do not require a signature, on the signature line, write "signature not required".
   e. Print/send the Service Summary to the client and the provider and document the client's request and consent for these changes in a Service Episode Record (SER).
2. Client and provider signatures must be obtained on Current assessments only. Signatures on plans of care that are in Pending or History are not valid approvals of the plan of care.
3. Obtain all required signatures prior to transferring a client's case to another office. There may be extenuating circumstances which prevent the case worker from obtaining required signatures. In these rare situations, the local office must exhaust and document person centered approaches to obtain the required signatures and then discuss the matter with the receiving office directly, before transferring the case.
4. If there is more than one provider in the plan, it is acceptable to have the provider(s) sign in the blank space below the signature lines if they are signing the same copy.
5. Although it is ideal for all required signatures to be on one document, or as few documents as possible for the purposes of records management in the HIU, obtaining all required signatures is the most important priority. It is acceptable to have required signatures on separate Service Summaries stored in the HIU. If the complete Service Summary is sent to HIU prior to obtaining client and provider signatures and then the client or provider subsequently returns the signature page, staff do not need to send the entire Service Summary to HIU again. In this scenario only the additional signature pages would need to be uploaded to HIU.

6. Signatures may be in any format (e.g. written, electronic, stamp, typed, etc.) that denotes the signatory agrees to the plan of care. Signature means at least the signatory's first and last name, but the CFR does not require a date or title. See instructions in the Attachments section on using electronic signatures. Obtaining an electronic signature in the client's residence has many advantages including:
    - reduced or no ongoing tracking required
    - in-person, person-centered review of the assessment with the client and/or provider to enhance understanding of the contents
7. Staff using the DSHS network can upload signed Service Summaries to HIU electronically and the document will be visible in the ECR within 24 hours. Local HCS and AAA offices will need to develop methods for monitoring and measuring the outcomes of the client and provider signature policy.

Residential Rate and In-Home Adjustments on the Service Summary

In-Home Adjustments
For Long-Term Services and Supports in-home assessments, if a client requests fewer hours to be authorized than are indicated on the Care Plan screen, document this in a Service Episode Record (SER). Use the In-home *Personal care adjustments* field in the Care Plan screen in CARE to document the number of monthly hours the client is choosing not to utilize. Select, *Client voluntary hour reduction* from the *Reason* dropdown. This will result in the adjusted number of monthly hours to print on the Service Summary.

For Long-Term Services and Supports in-home assessments, indicate adjustments for waiver services and/or Headquarters approved personal care Exception to Rule using the In-home *Personal care adjustments* field in the Care Plan screen in CARE. This will result in the adjustment to total hours to print on the client's Service Summary. (For details about waiver deductions see Chapter 7 subsections)

Residential Rate Adjustments
For LTSS residential assessments, if a client is receiving personal care in a residential setting and there are adjustments to the rate indicated on the Care Plan screen, document this in a Service Episode Record (SER).

Use the *Residential rate adjustments* field in the Care Plan screen in CARE to select from the *Reason* dropdown and enter the *rate adjustment*. This will result in the adjusted *Total daily rate* to print on the Service Summary.

Assessment Completion Timeframes

For all assessment types, the assessment must be moved to Current status within 30 calendar days from the date the assessment was created in CARE.

If an assessment cannot be moved to Current within 30 days of the date it was created, document the reason in a Service Episode Record (SER). The Plan Period end date will automatically calculate using the

last day of the month that the in-person assessment occurred. For example, if an assessment was created on 1/20/2025 and was moved to Current on 3/4/2025, 1/31/2026 will be automatically calculated as the Plan Period end date on the *Assessment Main* screen.

For Initial and Initial/Reapply assessments, CARE will require a delay reason be selected when the assessment is moved to Current after 30 calendar days.

These delay reason codes will be used in assessment timeliness reports and by HCS headquarters to identify justifiable reasons that assessment completion may be delayed. When evaluating timeliness in reporting for the division's strategic measure, delay reasons will be considered.

CARE Delay Reason Codes for Initial and Initial/Reapply Assessments		
Code	**Description**	**Examples**
CR	Client specific reason/request	• Difficulty reaching client for verbal approval after multiple attempts • Client changing mind about desired care plan • Client requesting more time
FE	Financial eligibility	• Financial eligibility not yet determined and fast track is not an option
DO	Awaiting documentation	• Awaiting medical records and/or treatment documents to complete assessment
IP	Individual provider	• Unable to identify qualified IP • Awaiting completion of IP hiring process through CDE
AP	Home Care Agency provider	• Awaiting homecare agency staffing
RP	Residential provider	• Difficulty locating and securing move to a residential setting
TH	Temporary hospitalization/SNF admit	• The client was temporarily admitted to a hospital or SNF and you are awaiting transition planning and/or plan approval.
NR	No other reason	• No other applicable reason noted here for assessment remaining in pending status

Significant Change Assessment by a Nurse

A nurse may conduct a home visit or consultation when a critical indicator or Skin Observation Protocol is triggered. Nurses will document concerns and recommendations via CARE > Nurse Comments, or a paper form, if they do not have access to CARE.

If the case is referred to the nurse and the assessment is in:

Pending status: the nurse can complete any screen using the original look-back periods for assessment data. The nurse would then consult with the case worker regarding the assessment and/or recommendations.

Current status: The case worker must decide who should initiate the pending assessment. If:

- The nurse creates a pending Significant Change assessment and completes applicable screens, after consulting with the nurse, the case worker can complete the remaining screens with a client visit.
- The case worker will create a pending assessment, initiate the assessment, then refer to the nurse for a visit and completion of the appropriate screens.
- Regardless of the nurse's changes, the case worker is responsible for moving the assessment from *Pending* to *Current* status.
- If the nurse wants a record of their changes, the nurse may print out the pending assessment after making changes or adding new information before returning the case to the case worker.

Significant Change Request by an Adult Family Home (AFH)

When a written request from an AFH provider demonstrates that there has been a change in a client's condition that warrants a Significant Change assessment, the Department must complete the assessment within thirty (30) ***calendar*** days of receipt of a fully completed Form 15-558 (AFH Resident Significant Change Assessment Request) and updated Negotiated Care Plan.

> When a Significant Change Assessment is requested for AFH residents currently on hospice services, the timeline for case workers will be within ten (10) **business** days.

An AFH provider may request a significant change assessment by:

- Completing DSHS 15-558 *Adult Family Home Resident Significant Change Assessment Request* by providing complete and detailed information about the resulting change in the client's condition and the care provided*;*
- Updating the Negotiated Care Plan with the changes noted; **and**
- Submitting the DSHS 15-558 *Adult Family Home Resident Significant Change Assessment Request* **and** the updated Negotiated Care Plan to the case worker.

When the case worker receives the written request and updated Negotiated Care Plan, the case worker must:

- Review the request to determine if the changes meet the criteria of a Significant Change as defined in WAC 388-76-10000.
- If the request does not meet the criteria in WAC, document the reason(s) in a Service Episode Record (SER) and notify the AFH provider.
- If the request is not complete or lacks sufficient detail to determine if a Significant Change Assessment is warranted, the case worker will contact the AFH provider and request additional information.
- The case worker will enter a Service Episode Record (SER) when the request is received and for each interaction with the provider to obtain the information needed.
- When all required information has been received, the case worker will use the *AFH Sig Change Request* Service Episode Record (SER) Purpose Code in CARE and enter the date the complete written request was received. (CARE will then generate a tickler to send reminders on the 20th and 27th calendar day from the written request date to complete the assessment and move it to current.)
- Complete the significant change assessment and move it to Current no later than 30 calendar days from the date the complete written request was received.

If the assessment results in an increase to the daily rate and the 30-calendar day timeframe is exceeded, the Adult Family Home provider may request a review by the department. If the Adult Family Home provider requests a review, the
Field Services Administrator (FSA) or designee will:

- Review the assessment to determine if it was not completed within 30 calendar days due to department error, and
- If due to department error, instruct the case worker to authorize the increase to the daily rate starting on the 31st calendar day from the date of the complete written request.
- Keep a record of the number of reviews completed and the results of each review.

Authorization of Services

Prior to authorizing payment for any long-term service or support, the following must be completed:

1. Program Eligibility - the case worker has determined financial eligibility and functional program eligibility as determined by a Current CARE assessment
2. The client has chosen the program/services from which they are eligible:
   - All services (paid through HCLA or not) must be indicated on the plan of care
   - Do not delay implementation of other identified services for which the client is eligible as indicated by their Current assessment, if a personal care provider has not yet been identified. For example, community transition items may need to be purchased or the authorization of a Community Choice Guide (CCG) to assist with hiring a caregiver
3. The client has approved the plan of care and given consent for services
4. The client has chosen a qualified provider(s)
5. Qualified provider(s) are selected from the ProviderOne database in CARE > *Supports* screen
6. Tasks are assigned to qualified provider(s) in CARE > *Supports* screen; and
7. Verification of any client responsibility and/or room & board
8. Complete all authorizations in CARE. See Social Service Authorization Manual (SSAM) for detailed instructions on authorization of services.
9. Complete electronic form DSHS 14-443 in Barcode. A 14-443 should only be sent for a MAGI client when they need to be transitioned to S02 and are losing MAGI coverage.

Payment for most services cannot occur while the client is an institutional setting (hospital, nursing facility or jail). Exceptions may exist with Roads to Community Living/Chapter 29 and state-funded service packages (Washington Roads/Chapter 5a). See policy chapter for specific service in question. Payment authorizations for personal care services must be adjusted or ended during the time client is in an institutional setting.

When do I transfer the case?

Transfer the active case to the appropriate AAA office or HCS residential SSS when the assessment has been moved to *Current*, case worker has confirmed that at minimum one paid service is authorized, and

you have a signed/dated Service Summary returned from the client. Refer to Transfer Protocol in Chapter 5.

When do I move an assessment to Current?

Move the assessment to *Current* status:

- After the client has provided verbal plan approval (consented) to the services identified in the assessment and plan of care; and
- Prior to sending a Planned Action Notice for services.

When do I move an assessment to History?

- The assessment will automatically be moved to History once a newly created/pending assessment is moved to Current.
- You may manually move an assessment into History*:*
  - When the client is no longer receiving services due to ineligibility;
  - When the client declined services;
  - Before sending the Planned Action Notice, if the client has requested an Administrative Hearing, after being found functionally ineligible; or
  - When a Pending assessment has been created and is no longer valid or cannot be completed, due to reasons such as the client moves out of state, declines assessment, etc. Document the reason in Reason for assessment on the Assessment Main screen and/or via a Service Episode Record (SER) note.

Exception to Rule (ETR)/Exception to Policy (ETP)

Services and Service levels are determined by rule and policy. An exception to rule (ETR) or exception to policy (ETP) is an internal process to request exceptions to Washington Administrative Codes (WACs) or policies in order to provide services or levels of services beyond the normal allowance. Home and Community Living Administration and Developmental Disabilities Administration policies identify the rules for which exceptions may be granted and the approving authority for the requested exception. WAC 388-440-0001 is the Department of Social and Health Exceptions to Rule WAC.

Before authorizing any exceptions to rule (ETR), you will need to get local or Home and Community Services headquarters approval, depending on the type of request.

Local Exception to Rule/Exception to Policy

The local, regional/AAA level must review and render decisions for the following ETR/ETP requests where services/rate exceeds program limits *before* they can be authorized:

- The maximum allowed for environmental modifications;
- The maximum allowed for specialized medical equipment and supplies;
- The rate for COPES transportation services;
- The maximum units allowed for COPES client training;
- The maximum units allowed for Community Choice Guide (CCG);
- The maximum allowed for COPES Community Support: Goods and Services;
- The maximum allowed for Community Transition and Sustainability Service (CTSS); or
- Requests to exceed Residential Social Leave.

For Home and Community Services/Area Agency Aging: At a minimum, a Field Approver must render a decision on a local Exception to Rule request. Field Review is optional based on local agency policy.

Types of Exception to Rule Requests That Must Be Submitted and Reviewed by Headquarters

Headquarters must review and render decisions for the following Exception to Rule requests before they can be authorized:

- Any requests to authorize personal care services beyond the maximum hours/budget/daily rate generated by CARE. A new request must be submitted for each subsequent Annual, Significant Change or Initial Re/Apply assessment.
- Any request to authorize a combination of personal care, home-delivered meals (including Older American's Act), and/or Adult Day Care services beyond the maximum number of hours or daily rate generated by CARE.
- COPES skilled nursing services requests. See Chapter 7d for information about when an Exception to Rule is required.
- All requests related to CHORE such as requests to pay a spouse provider an amount in excess of Medical Care Services (MCS), requests to exceed program maximum hours/month of 116, and requests to remain on the program in order to keep spouse provider when client becomes financially eligible for Medicaid Personal Care or Community First Choice.
- Private Duty Nursing requests that exceed 16 hours/day of Private Duty Nursing services.
- Private Duty Nursing requests to authorize Private Duty Nursing and in-home personal care that, in total, exceed the maximum hours generated by CARE.
- Community First Choice Program's Community Transition Services (CTS) requests that exceed the limit.
- Community First Choice Program's Assistive Technology (AT) and/or Skills Acquisition Training (SAT) purchases/services in excess of the Community First Choice state fiscal year (SFY) annual limit.
- All bathroom equipment authorized using service code SA875 (excludes urinals, transfer poles and handheld showers which are authorized using service code SA421). See Bathroom Equipment ETR training found here.
- Lift Chairs when furniture portion exceeds rate maximum of $1800 (typically necessary solely for double or triple width chairs). See *Service Code Data Sheet* for SA419 for more information.
- Durable Medical Equipment (DME) [4]for the following situations:

[4] The term Health Care Authority (HCA) uses on their website for Medicaid "Durable Medical Equipment" (DME) was changed effective 5/1/25 to "Medical Equipment and Supplies" (MES). This term, "MES", will not be used for

- An item is covered by insurance, but the client does not meet the medical criteria for the item to be paid for by insurance (example: client *needs* a heavy-duty hospital bed to live successfully in a community setting but does not meet the weight criteria for coverage by medical insurance).
- The item is never covered by insurance, but it may be *necessary* for a client to live successfully in the community [example: fully electric bed is *needed (*not just for convenience), but insurance only covers a semi-electric bed].

Personal Care Exception to Rule is always attached to a specific assessment. When an assessment is moved to history, any attached Exception to Rule automatically moves to history; however, Interim assessments do not move an Exception to Rule to history. The Exception to Rule will attach itself to the new Interim assessment. If the Interim assessment did not result in a change in classification, in-home hours, or residential rate, you may rely on the current Exception to Rule until its end date. If the Interim assessment changed the classification, in-home hours, or residential daily rate, then it must be resubmitted to Headquarters for review.

Headquarters Personal Care Exception to Rule (ETR) Committee Reviews

The Headquarters Exception to Rule Committee reviews the:

- Current and/or pending CARE assessment in detail (the assessment that the Exception to Rule is attached to),
- Recent Service Episode Record (SER) documentation notes, **and**
- The Exception to Rule request itself.

After an Exception to Rule is reviewed and submitted by the local office, the Headquarters Exception to Rule Committee makes the final decision and takes into consideration the following:

1. The exception would not contradict a specific provision of federal law or state statute; and
2. The client's situation differs from the majority; and
3. It is in the interest of overall economy and the client's welfare; and either
    a. It increases opportunities for the client to function effectively; or
    b. A client has an impairment or limitation that significantly interferes with the usual procedures required to determine eligibility and payment and/or the client is at serious risk of institutionalization.

Who can request a personal care Exception to Rule?

A client may request an Exception to Rule or a case worker may request an Exception to Rule on the client's behalf.

HCS programs (such as COPES and RCL) that include DME services. HCS will continue to use the term "DME" to minimize any confusion for clients, families and staff.

In-Home Client Exception to Rule Request for Personal Care Hours

1. If a client requests additional in-home personal care hours/budget above the CARE generated amount, the case worker must have a conversation with the client and/or client representative to discuss the request and to identify how the frequency and duration of the assistance with personal care tasks differs from the majority. case worker will use their professional judgment to determine if an ETR is appropriate or provide case management services to see if other options are more appropriate (e.g., using split shifts to maximize coverage when appropriate, informal supports, or other waiver and/or Community First Choice options such as Home Delivered Meals, Adult Day Health, Adult Day Care, Personal Emergency Response System (PERs), Assistive Technology, etc.)

2. If the client's initial request for an Exception to Rule is denied at the field level either verbally by the case worker or in CARE by the Field Reviewer, a Notice of Decision on Request for an In-Home Personal Care Exception to Rule (DSHS Form 15-429) via CARE > *Notices* screen, must be sent to the client. Clients do not have administrative hearing rights for initial Exception to Rule request decisions. If the Exception to Rule request is denied at the field level the client may request a review by the Headquarters Exception to Rule Committee. The client may ask for a review by contacting the case worker or by writing the Headquarters Exception to Rule Committee directly. These instructions are indicated on the 15-429 form mailed to the client. case worker will submit the requests for Headquarters review through CARE using the standard Exception to Rule Categories and Types and indicate the client's request by checking the *Client requested ETR HQ review* checkbox. **Only use this checkbox if the initial request was denied locally and the client has requested a review by Headquarters**.

3. **If the client directly contacts the Headquarters Exception to Rule Committee requesting review of an initially denied Exception to Rule, the Exception to Rule Program Coordinator will**:
   - Notify the field reviewer, field approver, or supervisor of the client's assigned office of the request for review; and
   - Forward any communication sent to the Exception to Rule committee by the client/client representative to the field office.

   The field office will:
   - Contact the client regarding the client's request for review if the communication received by the client contains new or additional information that was not reported in the initial request.
   - Submit a new Exception to Rule request to the Headquarters Exception to Rule Committee through CARE using the standard Exception to Rule Categories and Types and indicate the client's request by checking the *Client requested ETR HQ review* checkbox.

4. The Headquarters Exception to Rule Committee will make an individualized determination to approve, partially approve or deny the Exception to Rule request based on WAC 388-440-0001.

Submitting an Exception to Rule Request to the Headquarters Exception to Rule Committee

Exception to Rule Requests for in-home clients

1. **For In-Home Personal Care Exception to Rule**

   Create an Exception to Rule within CARE utilizing the appropriate Category and Type for all Exception to Rules. See the Exception to Rule chart for types and approval authority. To complete the Exception to Rule request in CARE:

   a. Use the *Date Range* dropdown to select either Plan Period or Custom. Use custom only for short-term/temporary or time specific requests.

   b. Use the *Hours* field to indicate the number of ADDITIONAL hours requested above the CARE generated hours.

   c. In the *Request Description* tab, note the CARE-generated personal care hours, the additional amount requested by the assessor or client, the schedule now, and the proposed schedule. Include any specific information about how personal care needs are addressed by formal and informal supports and any gaps in service you are proposing to address through the Exception to Rule request.

   d. In the *Justification for Request* tab, outline the specific personal care tasks performed that is different from the majority in support of the request. This information should describe how the client's situation differs from the majority (in client's classification).

   e. In the *Alternatives Explored* tab, detail other options that have been attempted or explored (such as, split shifts, community supports, waiver and/or Community First Choice services, etc.)

   f. Process for Field Review or Field Approval depending on local office policy. The Exception to Rule must have Field Approval before processing to Headquarters.

   g. Headquarters will review and finalize Personal Care Exception to Rule requests within seven (7) business days of receipt.

   h. Headquarters will review and finalize Personal Care Exception to Rule requests within three (3) business days when the processing comments of the request indicate the client is awaiting discharge from inpatient settings.

   i. Once the Exception to Rule decision has been finalized the primary case worker assigned in CARE will receive Tickler notification. The case worker must review the Exception to Rule outcome decision to confirm whether the request was approved, partially approved, or denied and to confirm the begin/end dates of an approved Exception to Rule as the dates may be something other than "plan period".

When an Exception to Rule request has been approved for the plan period, the Exception to Rule Committee Decision Date is always the effective date of the Exception to Rule and the effective date of the authorization of payment.

2. **For initial personal care Exception to Rule requests that are:**

    a. **Approved/Partially Approved**, include the additional hours via CARE > *Care Plan* screen > *Personal care adjustments* > *HQ Approved Personal Care ETR*. This will result in the adjustment to total hours to print on the client's Service Summary, to send to the client for signature. Authorize CARE generated benefit and approved ETR amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).

    b. **Approved/Partially Approved, or Denied**, send a Notice of Decision on Request for an In-Home Personal Care Exception to Rule (DSHS Form 15-429) via CARE > *Notices* screen, to the client. Clients do not have administrative hearing rights for initial Exception to Rule request decisions.

3. **For Exception to Rule requests that were approved in the previous plan period, or are being requested to extend a custom date range:**

    a. **Approved/Partially Approved, denied, reduced, or terminated**, note any approved hours via CARE > *Care Plan* screen > *Personal care adjustments* > *HQ Approved Personal Care ETR*. This will result in the adjustment to total hours to print on the client's Service Summary, to send to the client for signature. Send a services Planned Action Notice to the client indicating the approval, denial, or reduction in hours. The client has an administrative hearing right for Exception to Rules authorized in the plan period that immediately precedes the new Exception to Rule request. Authorize CARE generated benefit and approved Exception to Rule amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).

    Example:

    A client's 2022 CARE assessment resulted in 158 hours of personal care. The case worker submitted an ETR request for 100 additional hours and it was approved. The total number of hours approved and authorized in 2022 was 258 hours. This client's 2023 CARE assessment also resulted in 158 hours, and the case workersubmitted an Exception to Rule request for 125 additional hours. If the Exception to Rule request is partially approved for 100 hours, the total number of hours for which the client is eligible is still 258. Send a services Planned Action Notice for the 258 hours. Send a **Notice of Decision on Request for an In-Home Personal Care Exception to Rule** (in CARE > Notices screen) for the additional 25 hours that was requested but not approved.

4. **When a client's total in-home personal care hours/budget including an Exception to Rule are reduced or terminated, send a Planned Action Notice to the client.**

    Example:

    A client's 2024 CARE assessment resulted in 158 hours of personal care. The case worker submitted an Exception to Rule request for 100 additional hours and it was approved. The total number of hours approved and authorized in 2024 was 258 hours. This client's 2025 CARE assessment resulted in 115 hours and the case worker submitted an Exception to Rule request for 100 hours that was approved. The total number of hours

for which the client is eligible is 215. Send a services Planned Action Notice indicating a reduction from 258 hours to 215 hours.

5. If an Exception to Rule was approved and authorized in the plan period preceding a new request and the new Exception to Rule requests personal care hours/budget above the amount of the previous Except to Rule request, the additional amount is considered an initial request. Based on the decision for the additional amount by the Exception to Rule committee, follow the policy above for initial requests.

Exception to Rule requests for residential clients

An Exception to Rule to the published daily rate of a residential setting may be appropriate in situations where a client may have exceptional needs that differ from the majority and meet additional criteria as described in WAC 388-440-0001. Exception to Rules are reviewed and decided based upon individualized needs for assistance with personal care or skilled care, how those differ from the majority of clients in the same classification group, and any specific information provided by the Social Service Specialist and the provider.

Except for specific rates bargained in the Collective Bargaining Agreement (CBA) and relevant Memorandums of Understanding (MOUs), there is no standard rate (hourly or daily) used in determining the amount of an Exception to Rule. Unless specific rates are called out in the Collective Bargaining Agreement, do not communicate that there are standard methodologies or rates used in the Exception to Rule process as it conflicts with the intent of Exception to Rule.

The focus of conversations about whether a provider will admit a client should be based upon the needs of the client as documented in the assessment and plan of care. Similarly, any conversation around an Exception to Rule with a provider should focus on the personal care needs of the client and, how those needs differ from the majority.

Exception to Rule approvals are at the sole discretion of the department and are reviewed based upon the individualized circumstances presented. It is an expectation that when an Exception to Rule is submitted by an SSS/NCC that they understand and can articulate why the request is being made. If the SSS/NCC does not agree that an Exception to Rule is necessary, the request can and should be denied at the local level. Adult Family Home providers can request that an Exception to Rule be reviewed by the Headquarters Exception to Rule Committee when it is not initiated by the local office.

Because Adult Family Homes are authorized using a daily rate, when an Exception to Rule is requested, the daily amount being requested must be identified. The Exception to Rule Committee will review, considering the individualized needs of each client, and make a final determination based on the assessment, plan of care, and the Exception to Rule documentation. The amount approved by the Exception to Rule Committee will be added to the CARE generated daily rate based on the conclusion that the client's needs look different from the majority of others in the same classification group. Per WAC 388-76-10195, it is the responsibility of the Adult Family Home to ensure enough staff are available in the home to meet the needs of each resident. Unless required under a specialized contract, it is not

the responsibility of Home and Community Services division to determine staffing levels. The needs of the individual should be clearly documented in the assessment and plan of care.

Adult Family Home provider notices about Exception to Rule requests:
The Adult Family Home Council Collective Bargaining Agreement (CBA) requires the state to provide a written notice to an Adult Family Home provider who's current or referred client's level of care is being considered through the Exception to Rule process during the initial discussion with an Adult Family Home provider.

Provider notices will only be sent electronically, and be in the form of postcards, which must be provided to the Adult Family Home provider(s) by field staff during initial discussion with an Adult Family Home provider of a potential Exception to Rule request for current or referred client.

For residential personal care Exception to Rule:

1. Use the *Date Range* dropdown to select either Plan Period or Custom. Use custom only for short-term/temporary or time specific requests.
2. Use the *Rate* field to indicate the ADDITIONAL rate requested above the CARE generated rate.
3. In the *Request Description* tab, note the CARE Classification and daily rate generated by CARE (including any add-on outside of CARE, such as, but not limited to, Specialized Behavior Support or Expanded Community Services) and the additional amount requested by the assessor.
4. In the *Justification for Request* tab, outline the specific personal care tasks performed that is different from the majority in support of the request. This information should describe how the client's situation differs from the majority (in client's classification).
5. In the *Alternatives Explored* tab, detail other options that have been attempted or explored (such as, assistive devices that have been considered or utilized, community and behavior supports, waiver and Community First Choice services, etc.).
6. Process for Field Review or Field Approval depending on local office policy. The Exception to Rule must have Field Approval before processing to Headquarters.
7. Headquarters will review and finalize residential personal care Exception to Rule requests within seven (7) business days of receipt.
8. Headquarters will review and finalize Personal Care Exception to Rule requests within three (3) business days when the processing comments of the request indicate the client is awaiting discharge from an Acute Care Hospital.
9. Once the Exception to Rule has been finalized, the primary case worker assigned in CARE will receive a Tickler notification. It is important to review the Exception to Rule outcome decision to confirm if the request was approved, partially approved, or denied, and to confirm the start/end dates of the approved ETR, as they may be something other than "plan period."

    a. For initial residential personal care Exception to Rule requests that are:

i. **Approved/Partially Approved**, note the additional rate on the Service Summary, initial and date, and send to the client for signature. Authorize CARE generated benefit and approved ETR amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).

ii. **Initiated, Not initiated, Approved, or Denied**, send a Notice of Action Exception to Rule (CARE > Notices screen) to the client. For Adult Family Home requests, use Notice of Action Exception to Rule for Adult Family Home Daily Rates (CARE > Notices screen), and send a copy of this completed form to the client and the Adult Family Home provider. For all other residential settings, (such as Assisted Living, Adult Residential Facility, etc.) use Notice of Action Exception to Rule (excluding Adult Family Home, via the CARE > Notices screen). If the Exception to Rule is approved or partially approved, include, and confirm in CARE, the approved time period. The start date must not be prior to the Headquarters Exception to Rule Committee decision date. The end date cannot exceed the end date of the plan period. Clients do not have administrative hearing rights for initial Exception to Rule request decisions.

b. For residential Exception to Rule requests that were approved in the previous plan period or are being requested to extend a custom date range:

1. **Approved/Partially approved, reduced, or terminated,** note any approved rate on the Service Summary, initial and date, and send to the client for signature. Send a services Planned Action Notice to the client indicating the approval, denial, or reduction in rate. The client has an administrative hearing right for the Exception to Rule authorized in the plan that precede the new request. Authorize CARE generated benefit and approved Exception to Rule amount in the payment system (see *Authorizing Personal Care Exception to Rule in CARE* section below).

d. If an Exception to Rule was approved and authorized in the plan period preceding a new request and the new Exception to Rule requests personal care rate above the amount of the previous Exception to Rule request, the additional amount is considered an initial request. Based on the decision for the additional amount by the Exception to Rule committee, follow the policy above for initial requests.

NOTE for all in-home and residential personal CARE Exception to Rule decisions: If an Exception to Rule request was approved/partially approved for hours/budget/rate and the case worker makes a change that effects the classification or the hours/budget/rate, the case worker must submit a new request if it is still warranted.

Determining appropriate notice for Exception to Rule (ETR) requests and decisions

ETR Request Types	Planned Action Notice Should Include:	-In-Home ONLY- Notice of Decision for ETR (15-429)	-AFH ONLY - Notice of Action ETR AFH (05-256)	-AL/ARC/EARC ONLY - Notice of Action ETR (05-246)
ETR rate/hours are requested for the first time *Client did not have this ETR in the preceding plan period.*	Only CARE generated rate/hours	Based on setting, use appropriate Notice of Decision/Action Form through CARE > Notices screen, to communicate the outcome of the initial ETR request.		
ETR continuation requested and approved *Client had the same ETR in the preceding plan period.*	Combine CARE generated rate/hours + ETR rate/hours	Do not use Notice of Decision/Action.		
ETR continuation AND an additional amount requested *Client had some of the ETR rate/hours in the proceeding plan period, but more is requested this time.*	CARE generated rate/hours + only ETR rate/hours that were approved in the preceding plan period	Based on setting, use appropriate Notice of Decision/Action Form through CARE > Notices screen, to communicate the outcome of the NEWLY requested amount.		
ETR continuation requested but denied. *Client had the same ETR rate/hours in the preceding plan period, but the request was denied this time.*	Communicate this information as part of the PAN whether the total rate/hours increased, decreased, or stayed the same.	Do not use Notice of Decision/Action.		

Home and Community Services/Area Agency on Aging Complaint Procedure

When a client does not have an administrative hearing right on an initial Exception to Rule decision, they have the right to make a complaint to the Department. Complaints related to initial Exception to Rule decisions made at the field level (such as COPES waiver services such as environmental modifications, specialized medical equipment, client training, etc.) will be reviewed as follows:

For local Initial Exception to Rule decisions made by Home and Community Services:

1. The client may make a complaint in writing to the Field Services Administrator (FSA). The Field Services Administrator will make a decision about the complaint within ten days of the date it was received, send a letter informing the client of the decision, and that the decision may be reviewed by the Regional Administrator (RA) at the client's request.
2. If the client makes a written request asking the Regional Administrator to review the Field Services Administrator's decision, the Regional Administrator will make a decision about the complaint within ten days of the date it was received and send a letter informing the client of the final decision.

For local Initial Exception to Rule decisions made by an Area Agency on Aging:

1. The client may make a complaint in writing to the Area Agency on Aging Case Management Director/Program Manager. The Area Agency on Aging Case Management Director/Program Manager will make a decision about the complaint within ten days of the date it was received, send a letter informing the client of the decision, and that the decision may be reviewed by the Area Agency on Aging Director at the client's request.
2. If the client makes a written request asking the Area Agency on Aging Director to review the Program Manager's decision, the Area Agency on Aging Director will make a decision about the complaint within ten (10) days of the date it was received and send a letter informing the client of the final decision.

For HCS/AAA Initial Exception to Rule decisions made by Headquarters:

1. The client may make a complaint in writing to the Home and Community Services State Unit on Aging (SUA) Office Chief. The Office Chief will make a decision about the written complaint within ten days of the date it was received, send a letter informing the client of the decision, and that the decision may be reviewed by the Home and Community Services Director at the client's request.
2. If the client makes a written request asking the Home and Community Services Director to review the Office Chief's decision, the Director will make a decision about the complaint within ten days of the date it was received and send a letter informing the client of the final decision.

When responding to a complaint it is important to address, at a minimum, the specific concern perceived by the client and explain how all the information was reviewed (such as the CARE assessment, any additional information provided in the complaint, or information from other relevant sources) to make a decision. The case worker may want to discuss the care plan with the client to identify service gaps that may be addressed using other available resources. ***If you must respond to a complaint that relates to an initial denial of a personal care Exception to Rule, please consult with the Home and Community Services CARE Management Unit Manager.***

Authorizing Personal Care Exception to Rule in CARE

When an Exception to Rule is approved for the Plan Period:

The authorization start date on the authorization service line must match the Exception to Rule Committee Decision Date, which may require an authorization service line split mid-month. Exception to Rule approvals cannot be backdated. The authorization start date must never be prior to the Exception to Rule Committee Decision Date. Authorize the total amount (CARE-generated hours/rate generated + the approved ETR amount) on one service line in the following full month.

The authorization end date on the authorization service line must match the plan period end date, via CARE Assessment Main Screen > Plan Period > End Date.

Example:

A client's CARE assessment resulted in 158 hours of personal care. The case worker submitted an ETR request for 100 additional hours and it was approved on the 10th of the month. The case

worker authorizes the CARE-generated hours served between the 1st and the 9th of the current month. The case worker then reasonably authorizes the remaining balance of the CARE-generated hours + the approved ETR amount between the 10th and the last day of the current month. Effective the 1st of the following month, the case worker authorizes 258 hours, the total amount (CARE-generated hours + the approved ETR amount). The authorization end date will match the plan period end date.

When an Exception to Rule is approved for a custom date range:

The authorization start date on the authorization service line must match the Custom Start Date on the Exception to Rule screen entered by the Exception to Rule Committee, which may require an authorization service line split mid-month. Exception to Rule approvals cannot be backdated. The authorization start date must never be prior to the Exception to Rule Committee Decision Date. Authorize the total amount (CARE-generated hours/rate generated + the approved Exception to Rule amount) on one service line in the following full month.

The authorization end date on the service line must match the Custom End Date in the Exception to Rule decision screen. **This (custom) authorization end date may not be extended without approval of a new Exception to Rule request by the Headquarters Exception to Rule Committee.**

Example:

A client's CARE assessment resulted in 158 hours of personal care. The case worker submitted an ETR request for 100 additional hours and it was approved on the 10th of the month. The case worker authorizes the CARE-generated hours served between the 1st and the 9th of the current month. The case worker then reasonably authorizes the remaining balance of the CARE-generated hours + the approved ETR amount between the 10th and the last day of the current month. Effective the 1st of the following month, the case worker authorizes 258 hours, the total amount (CARE-generated hours + the approved ETR amount). The authorization end date will match the custom end date.

When the Managed Care Organizations (MCO) funds Behavioral Health Wraparound Support (BHWS) for in home or Community Behavioral Health Supports (CBHS) for residential client:

- For information and instruction on MCO Behavioral Health Wraparound Supports (BHWS) please see LTC Chapter 22a/Apple Health Managed Care and Apple Health Medicare Connect (D-SNP).
- For Community Behavioral Health Supports (CBHS) services for residential clients, please see LTC Chapter 22d/Community Behavioral Health Supports (CBHS).

Termination of Services

Terminate services when:

- The client is no longer financially eligible.
    - The client's Public Benefits Specialist (PBS) will send a termination letter to the client and case worker staff receive a 07-104 (65-10) termination tickle in Barcode. case worker staff will end-date current RACs and service authorizations through the end of

the month of financial eligibility as indicated in the PBS's termination notice. The case worker should allow a 30-day grace period following the client's last day of financial eligibility, before inactivating the client from CARE. If financial eligibility is not reinstated by the end of the month following the date indicated in the termination letter or 07-104, the client remains financially ineligible, and the case may be inactivated from CARE. The case worker could consider setting the 30-day tickler in CARE to remind them to go back and check on the status.

- A client chooses to decline *all* services for which they are eligible. Consider that many clients have other services in addition to personal care.
- The *Challenging Cases Protocol* (see Chapter 5) has been exhausted.
- The client is deceased. When the client was eligible through MAGI, send Condolence Termination Letter (DSHS Form #07-099) to the client's representative/estate.
    - If you are a case worker inside the DSHS firewall, you may access the Condolence Termination Letter via Forms Picker: DSHS Form #07-099
    - If you are a case worker outside the DSHS firewall, you may access the form here.
- Client who is incarcerated and is not returning to their home and community-based setting within thirty (30) calendar days.
    - For personal care service authorizations (see SSAM > Authorization Overview > Timely Creation and Modification of Authorizations for more information):
        - For in-home personal care: change the End Date of the service line to the date after the date of incarceration.
        - For residential personal care: change the End Date of the service line to the day before the date of incarceration.
    - RACs should be ended the same day the client was incarcerated.
    - Ten to the end policy does not apply, but no less than ten (10) days' notice must be given.
    - The date of notice will be the date the Planned Action Notice is created.
    - Amend the Planned Action Notice to ensure the Effective Date is ten (10) days from the date of the notice.
    - If the Planned Action Notice is returned as undeliverable, send the Planned Action Notice /envelope to HIU for scanning into the client's electronic case record (ECR) to show it was undeliverable.

Steps to take when a client no longer meets program eligibility:

- Termination Planning (See Chapter 5 > *Goals / Functions* section)
- A Planned Action Notice (in CARE) is required anytime there is an approval, increase, denial, reduction, or termination of a service (see Chapter 5).
- Notify the Public Benefits Specialist (PBS) of a client's ineligibility using form 14-443 in Barcode (except for MAGI clients whose cases are not handled by Public Benefits Specialists). The Public Benefits Specialist will determine Medicaid financial eligibility for other programs.

Note: Medicaid Personal Care and Community First Choice program clients receiving Social Security Income would continue to receive a Medicaid Services Card for Apple Health regardless of the receipt of personal care services.

RESOURCES

Related Washington Administrative Code Regulations and Revised Code of Washington Laws

Revised Code of Washington (RCWs) are laws passed by the Legislature. Washington Administrative Code (WACs) are regulations adopted by state agencies to implement those laws.

42 CFR 441.540(b)(9)	Person-centered Service Plan
RCW 7.70.065	Informed consent—Persons authorized to provide for patients who are not competent *This RCW applies in hospital and SNF settings only.
RCW 74.39A.525	Overtime Criteria
RCW 74.39.050	Individuals with functional disabilities-Self-directed Care
WAC 388-106-0010	What definitions apply to this chapter?
WAC 388-106-0050	What is an assessment?
WAC 388-106-0055	What is the purpose of an assessment?
WAC 388-106-0060	Who must perform the assessment?
WAC 388-106-0065	What is the process for conducting an assessment?
WAC 388-106-0070	Will I be assessed in CARE?
WAC 388-106-0075	How is my need for personal care services assessed in CARE?
WAC 388-106-0080 TO 0145	CARE Classifications
WAC 388-472-0020	How does the department decide if I am eligible for NSA services?
WAC 388-115-05640	Self-directed care — Who must direct self-directed care?
WAC 388-440	Exception to Rule

Acronyms

A complete list of the department's acronyms can be found here.

AAA	Area Agency on Aging	IADL	Instrumental Activities of Daily Living
ACP	Address Confidentiality Program	IP	Individual Provider
ACRS	Asian Counseling and Referral Service	LEP	Limited English Proficient
ADA	Americans with Disabilities Act	LTSS	Long-Term Services and Supports
ADL	Activities of daily living	MCO	Managed Care Organization
AFH	Adult Family Home	MMSE	Mini-Mental State Examination
AH	Apple Health (Medicaid)	MPC	Medicaid Personal Care
ALF	Assisted Living Facility	NCC	Nurse Care Consultant
APS	Adult Protective Services	NFLOC	Nursing Facility Level of Care
ARC	Adult Residential Care	NGMA	Non-Grant Medical Assistance
AREP	Authorized Representative	NSA	Necessary Supplemental Accommodations

AT	Assistive Technology	NSA/CP	Negotiated Service Agreement/ Care Plan
CARE	Comprehensive Assessment Reporting Evaluation	OAA	Older American's Act
CCG	Community Choice Guide	P1	ProviderOne
CDE	Consumer Directed Employer	PAN	Planned Action Notice
CFC	Community First Choice	PBS	Public Benefits Specialist
CFR	Code of Federal Regulation	PCRC	Personal Care Results Comparison
CISC	Chinese Information and Service Center	PCR	Personal Care Results
CM	Case manager	PDN	Private Duty Nursing
CMS	Centers for Medicare and Medicaid Services	PERS	Personal Emergency Response Systems
COPES	Community Options Program Entry System	QA	Quality Assurance
CRM	Case Resource Manager (DDA)	RA	Regional Administrator
CTS	Community Transition Services	RCL	Roads to Community Living
DDA	Developmental Disability Community Services	RCW	Revised Code of Washington
DES	Department of Enterprise Services	RSW	Residential Support Waiver
DME	Durable Medical Equipment	SAT	Skills Acquisition Training
DMS	Document Management System	SBS	Specialized Behavior Support
D/POA	Durable/Power of Attorney	SCSA	Senior Citizens Services Act
DSHS	Department of Social and Health Services	SDC	Self-directed Care
EARC	Enhanced Adult Residential Care	SER	Service Episode Record
ECR	Electronic Case Record	SES	Specialized Equipment and Supplies
ECS	Expanded Community Services	SNF	Skilled Nursing Facility
ESA	Economic Services Administration	SOP	Skin Observation Protocol
ESF	Enhanced Services Facility	SS	Social Services
ETR	Exception to Rule	SSAM	Social Service Authorization Manual
FSA	Field Services Administrator	SSN	Social Security Number
HCA	Health Care Authority	SSS	Social service specialist
HCLA	Home and Community Living Administration	VDC	Veteran's Directed Care
HCS	Home and Community Services	WAC	Washington Administrative Code
HIU	HCS Imaging Unit	WWL	Work Week Limit
HQ	Headquarters		

REVISION HISTORY

Date	Made by	Change(s)	MB #
6/2020	Debbie Blackner	Added additional situations when an HQ ETR is required (bathroom equipment, lift chair that exceeds furniture maximum and when specific DME scenarios).	
6/2020	Debbie Blackner	Added COPES services CCG and Community Supports: Goods and Services to the Minimum Standards table	
6/2020	Debbie Blackner	Bed rail policy added	
6/2020	Rachelle Ames	Updated Case File Standards to include: • updated list of documents to be scanned to the ECR • removal of language related to paper files • update translated documents section to be consistent with Chapter 15	
6/2020	Rachelle Ames	Updated Timeframes table included in the "Adding a Client to CARE" section	
12/2020	Rachelle Ames	Removed incorrect RCW reference from "What to do when a client cannot sign" section	

Date	Made by	Change(s)	MB #
12/2020	Rachelle Ames	Updated Minimum Standards "Supports screen" section to reflect current CARE functionality	
12/2020	Rachelle Ames	Removed "BHO" from MCO references to accurately reflect current terminology	
12/2020	Rachelle Ames	Updated "Forms/Brochures" table with updated DSHS 14-225 form instructions	H21-013
1/2021	Rachelle Ames	Updated procedure related to ETRs and Interim assessments to be consistent with updated CARE functionality	
1/2021	Rachelle Ames	Added clarification about consent form and who to contact with questions about privacy	
1/2021	Rachelle Ames	Updated "What notice to use…" in ETR Section	
3/2021	Rachelle Ames	Eliminated policy to assess shared benefit and added policy to include IP Informal Support Attestation	H21-002
9/2021	Rachelle Ames	Updated Minimum Standards table related to emergency plan to be consistent with CARE Web	
9/2021	Rachelle Ames	Added ETR FAQ Document attachments developed as part of an HCS statewide workgroup	
9/2021	Rachelle Ames	Added 72-hour ETR turnaround timeframe when client is in an acute care hospital	
9/2021	Rachelle Ames	Updated link to SDC publication	
9/2021	Rachelle Ames	Updated reference to 14-443 and MAGI clients when the client is no longer MAGI	
9/2021	Rachelle Ames	Updated ETR Approval/Authority table to current field practice	
9/2021	Rachelle Ames	Updated how to document potential risk in the plan of care with updated CARE Web screen locations	
9/2021	Rachelle Ames	Clarified decision-making authority in "Getting Approval on the Plan of Care" section	
9/2021	Rachelle Ames	Updated Significant Change Request by an AFH section	H21-061
12/2021	Rachelle Ames	Updated "Brief" assessment type to "VDC" assessment type	H21-087 H21-047
12/2021	Rachelle Ames	Clarified "When to inactive a client record in CARE" section	
12/2021	Victoria Nuesca	Added updated "Care Planning Advocate" flow chart to "Attachments" section	H15-054
6/2022	Rachelle Ames	Edits related to IPs becoming employed by the CDE	H21-083 H22-027
9/2022	Victoria Nuesca	Updated language from provider to "caregiver" to not exclude IPs hired by CDWA	H15-054
9/2022	Rachelle Ames	Addition of Voice Signature option and Script Attachment	
5/2023	Dru Aubert	• Updated how to document the number of monthly hours the client is choosing not to utilize, and adjustments for waiver services and/or HQ approved personal care ETRs. • Updated the AAA CM or nurse completes VDC assessment types for participants in the VDC program.	H22-046
8/2023	Dru Aubert	• Updated Voice Signature attachment>FAQs in "Appendix" section. • Added timeframe Service Summary signatures must be obtained. • Updated "ETR requests for residential clients" section. • Added when to include the IP Informal Support Attestation form under "Special Considerations" section.	H21-002
12/2023	Dru Aubert	• Removed PACE from LTSS ETR Types and Approval Authority section. • Added assessment policy update to assess Adult Day Care (ADC) as Informal Support (WAC 388-106-0010). • Updated Voice Signature attachment>FAQs in "Appendix" section, related to HIU submission. • Specified DSHS contracted providers should be added to the written Consent Form (DDA-only).	H23-078
2/2024	Dru Aubert	• Updated *Assessment Location Grid* to state hospital assessments need to be within 7 days from the date of referral.	

Date	Made by	Change(s)	MB #
		• Included Community Psychiatric Hospital Setting into *Timeframes* table • Updated Voice Signature attachment>FAQs in "Appendix" section. • Added combined *Notice of Consent of Communication via Text or Unencrypted Email* (DSHS Form 27-156).	
6/2024	Dru Aubert	Eliminated policy to assess IP as a source of informal support (SUBSTITUTE HOUSE BILL 1942) and retire DSHS Form 27-203 "Individual Provider (IP) Attestation of Informal Support".	H24-025 H21-002 *(amended 6/6/24)*
7/2024	Dru Aubert	• Updated "How and when do I distribute the plan of care to the provider(s)?" section to add hospital discharge planners (for those patients who are seeking Home and Community Based Services), Community Choice Guides, and Client Training Providers. • Clarified "More about signatures" section that a signature may be in any format that denotes the signatory agrees to the plan of care, including *typed*. • Removed duplicative "IP Overtime" section, that can be found in Chapter 11, Working with the Consumer Directed Employer. • Updated "Minimum Standards" section to describe the process and expectations of developing and completing a care plan, post assessment interview completion, to be used when transferring a case from one office to another. • Added to "Steps in performing a CARE Assessment" to include Community Behavioral Health Support (CBHS) Services/1915i (effective 7/2024). • Added 'Individuals on Hospice' to priority list of assessment eligibility.	
10/2024	Dru Aubert	• Updated *Forms and Brochures* section > *Consent Form* > *Information Included* section to clarify the most recently signed form by the client/representative replaces a previously signed form, and that clients must indicate what records are covered by the consent. • Added to "Steps in performing a CARE Assessment" to include screening for any relevant information that an assessor should be aware of prior to making a home visit. • Added clarity to linked DSHS forms to differentiate if the SSS/CM/CRM is inside the DSHS firewall, they may access some linked DSHS forms in chapter via Forms Picker, and for public access (or an CM outside the DSHS firewall), they may access via embedded icons, provided below the linked options throughout chapter. • Clarified "Getting Approval on the Plan of Care" that, if an individual's representative, is also the client's paid caregiver, that representative can sign the Service Summary on behalf of the client, however, another person must assist the client as their representative for the purpose of care planning. • To receive updates related to ACES.Online, Barcode, or Washington Connection (WACONN), social services and case management staff and Public Benefits Specialist and Regional financial program staff that use ACES.online and/or Barcode should subscribe to IT Solutions topics available in GovDelivery.	H24-050
04/2025	Anna Mitchell	• Added policy related to Telephonic and Virtual assessments from MB H23-053. • Clarified "Getting Approval on the Plan of Care" related to utilizing a representative agent or guardian for approval and escalation pathways. • Updated information related to MCO funded ETRs. • Clarified 14-225 is required for clients on RCL. • Updated version of DSHS Privacy Practices to 03-387 which removes the signature page as it is not required.	

Date	Made by	Change(s)	MB #

		• Clarified policy related to the Consent form 14-012.
		  ○ Added reference to RCWs 70.02.230, 70.02.050 and 70.02.220.
		  ○ Added The 14-012 includes the following phrase on page 1: "DSHS may still share information about you to the extent allowed by law."	

07/2025	Dru Aubert	• Added footnote that the term Health Care Authority (HCA) uses (on their website) for Medicaid "Durable Medical Equipment" (DME) was changed effective 5/1/25 to "Medical Equipment and Supplies" (MES). This new term, "MES", will not be used for HCS programs (such as COPES and RCL) that include DME services. HCS will continue to use the term "DME" to minimize any confusion for clients, families and staff. • Per the department's reorganization of DSHS to merge some administrations to Home and Community Living Administration effective 5/1/25, updated Developmental Disabilities Administration (DDA) to Developmental Disabilities Community Services (DDCS) naming, and Aging and Long-Term Support Administration to Home and Community Living Administration (HCLA) naming. • Added to "Significant Change Request by an Adult Family Home (AFH)" that, when a significant change assessment is requested for residents currently on hospice services, the timeline for case managers will be within ten (10) business days. Per AFHC CBA 25-27 Negotiated Changes. • Added to "Steps in performing a CARE Assessment" that, Adult Family Home providers or designees will be notified in advance of an assessment meeting. Per AFHC CBA 25-27 Negotiated Changes. • Added to "Who completes the CARE assessments?" that, CMs from a contracted federally recognized Indian tribe complete assessments for individuals 18 and older in their home after services are initially authorized. (WAC 388-71-0503) • Added to "Forms and Brochures" that first and last names must be used for specific individual names (collateral contacts) added to a consent form. • Removed escalation pathways from "Getting Approval on the Plan of Care" section due to changes in Guardianship and Conservatorship Assistance Program and associated escalation pathways ending 6/30/25. Added Document Review Checklist for Alternative Decision Maker Authority Form. • Clarified wording in "Timeframes" section, from "in" to "inpatient" regarding applicants in an acute care/community psychiatric hospital setting. • Added section, "What is the Role of SSS/CMs in Determining Decision Making Capacity?", formerly housed in Chapter 9a/Acute Care Hospital (ACH) Assessments. The policy applies to all settings, not solely ACH.	H25-012
9/2025	Dru Aubert	• Added examples of informal supports and clarified informal supports include resources available to complete treatments, in addition to ADLs and IADLs. Clarified for individual informal supports, to confirm they are willing and able to provide the care as an informal support on an ongoing basis looking forward. • Added to Client Rights and Responsibilities and Acknowledgement of Services forms that the most recent form presented by the SSS/CM/CRM and signed by the client replaces previously signed forms. • Added to Consent Form, that when using the form, be accurate and specific as possible (such as utilizing agency names for an individual home health agency serving the client). • As an option, added a client may choose a representative by completing the DSHS #14-532/Authorized Representative Form, and the representative may	H25-048

Date	Made by	Change(s)	MB #
		act on their behalf to make decisions about Medicaid services and supports, including obtaining plan approval to their plan of care. • Updated Acute Care Hospital to inpatient setting terminology, supporting the merge of State Hospital and Acute Care Hospital policy in these settings. • Added consideration to Termination of Services, to create a custom Tickler in CARE to allow a 30-day grace period following the client's last day of financial eligibility, before inactivating the client from CARE when an individual is no longer financially eligible for LTSS. • Added to Minimum Standards, explaining that when a client declines personal care and does not want to have a paid personal care provider, the client's assessment must accurately reflect the client's chosen status of "Client Declines" which means "the client will not want assistance with the task".	
5/2026	Dru Aubert	• Updated Forms & Brochures > Estate Recovery Information to align with LTC Ch 7h/Appendices > Estate Recovery section. • Under Minimum Standards > amend definition of "Family" IPs to mean IPs who are related by blood, marriage, or adoption. • Clarified a client may request a significant change assessment. • Clarified when an interim assessment results in "Not functionally eligible" determination, a significant change assessment must be completed. • Added section to the Appendix, "What is the Role of the HCS/AAA Case Manager When Care Planning with a Client Who is a Registered Sex Offender?" • Removed duplicative section, "Plans of care that include Individual Providers (IPs) through the CDE", which is housed in LTC Chapter 11/Working with the Consumer Directed Employer (CDE). • Included providers to align with same approach and policy if a client does not return the signed Service Summary or refuses to sign the Service Summary. • Updated policy related to the Document Review Checklist. • Clarified section "Authorizing Personal Care ETRs in CARE" to reaffirm the authorization service line must match the ETR Committee Decision Date. • Updated Timeframes table > Assignment box for intake specialists. • Linked attachments updated.	H21-092
6/2026	Dru Aubert	• Updated the Timeframes Table's Contact and Completion rows to amend assessment processes and timelines, specific to column, Applicants currently Inpatient at acute care/state hospitals/community psychiatric hospitals. • Add a statement to redirect social services staff to LTC Manual Chapter 10, Nursing Facility Case Management and Relocation, for applicable timeframes related to applicants current inpatient in a skilled nursing facility setting. • Clarified policy on when to perform an interim assessment, removing callout specific to skilled nursing facility setting.	
7/2026	Dru Aubert	• Added section, "Person Centered Care Planning" • Updated all former HCS/DDA/AAA naming conventions for a social service specialist, case manager, case resource manager, nurse care consultant, etc. to "case worker". • Added HIPAA requirement around Address Confidentiality Program, to Minimum Standards • Added policy to Termination Planning, specific to incarcerations for more than 30 calendar days	

Date	Made by	Change(s)	MB #
		• Updated section, "How do I distribute the plan of care to the client/representative?" to ask the client if they want a copy of their Assessment Details for their records. • Edited section, Obtaining Plan Approval, relating to types of representatives, training resources, and preventing conflict of interest. • Added section on addressing residential or in-home adjustments on the Service Summary. • Added section, "Headquarters Personal Care Exception to Rule (ETR) Committee Reviews". • Updated "Chart of Scenarios for Service Summary Signatures" to current branding and logo. Added scenario "An Interim to Address SOP Indicator Triggered from Any Face-to-Face Assessment"	

APPENDIX

Bed Rail Policy

Bed rails (also called side rails or safety rails) are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of shapes and sizes. Full and half bed rails are covered by Apple Health (AH) with no prior authorization. Medicare does not pay for bed rails of any length.

One-quarter and one-eighth length bed rails are never covered by AH or Medicare. These are frequently referred to as mobility bars/rails, bed support handles, standing bars and bed canes. Some ¼ and ⅛ length bed rails were recalled in December 2021 (see MB H22-010).

Although bed rails have potential benefits for some individuals, potential risks of bed rails include:

- Strangulation, suffocation, bodily injury or death because an individual is caught between rails or between the bed rails and the mattress.
- Skin bruising, cuts, and scrapes.
- A higher risk of serious injuries from falls because sometimes individuals fall while trying to climb over bed rails. When that happens, the individual is often more seriously injured than if the person had fallen out of a bed without rails.
- Feeling agitated, isolated or unnecessarily restricted because the bed rails prevent individuals from moving freely.
- Loss of the ability to independently perform routine activities such as going to the bathroom or retrieving something from a closet because the individual is prevented from getting out of bed.

The use of any type of bed rail poses a potential safety risk regardless of care setting. The best way to prevent trapping or harming clients is to refrain from using bed rails and to encourage the use of safer alternatives. Bed rails must not be used as a restraint.

Bed rails are sometimes requested by a client who receives long-term services and supports (LTSS). At times, a new or reapplying client already has and uses a bed rail. The Bed Rail Policy must be followed in its entirety (Steps 1-10) for bed rails of any length in each of the following scenarios:

- For all DSHS clients receiving paid services in a community residential setting, including when:
  - The residential provider will supply the bed rail.
  - When insurance will pay for the bed rail (such as Apple Health).

  - If the client is admitting to a residential setting with bed rails they already have/use, unless a bed rail evaluation (DSHS Form 13-906) is on file and there has not been a significant change in condition that impacts the client's ability to safely use the bed rail.
- When a bed rail will be purchased through a social services (SS) authorization, regardless of client's setting (residential or in-home).

A bed rail evaluation is recommended in all other situations, including when:

- Apple Health will pay for the bed rail for a client receiving LTSS in an in-home setting.
- The client has a completed bed rail evaluation (DSHS Form 13-906) in their electronic case record or file, but there has been a significant change in cognitive or physical condition that may impact the client's ability to safely use the bed rail.
- For new or reapplying in-home clients who already have and use a bed rail, unless a bed rail evaluation is on file and there has not been a significant change in condition that impacts the client's ability to safely use the bed rail.
- At a minimum, Steps 1 and 2 below should be completed and documented in a CARE Service Episode Record (SER) or for MAC/TSOA, in a GetCare Progress Note.

Requests for New or Replacement Bed Rail of Any Length (including if an item has been recalled)

1. Provide the client a copy of the FDA brochure *"A Guide to Bed Safety"*. The brochure is focused on institutional settings, but the information applies to any home and community-based setting.
2. Discuss with the client, their representative (if applicable) and providers:
   a. The risks of entrapment, injury and death from bed rails per *"A Guide to Bed Safety*."
   b. Explain to the client and/or representative that there are alternatives to bed rails and that a specialist can help the client determine what alternatives are best through an individualized evaluation. Alternatives may include roll guards, foam bumpers, low beds, a trapeze or standing transfer poles. Other alternatives may be recommended as part of the evaluation.
   c. Document the date the bed rail discussion occurred with the client and representative (if applicable) and the requirement for the individualized bed rail evaluation in a CARE Service Episode Record (SER) or a Progress Note in GetCare.
   d. The client can choose not to participate in the evaluation; however, without a completed evaluation:
      - A bed rail cannot be used in a residential setting for a DSHS LTSS client.
      - A SS authorization cannot be used to purchase a bed rail, regardless of size or service code used: SA878 (full or half-length bed rail) or SA421 (¼ or ⅛ length rails).
3. The client requests a referral from their primary care provider for a bed rail evaluation from a physical therapist (PT) or occupational therapist (OT):
   a. The bed rail assessment is paid for by the client's AH medical plan. COPES Client Training cannot be authorized for this evaluation. Exception: if the client's item has been recalled and there is an emergent need.

b. The client must be referred to a physical therapist or occupational therapist that is in their AH provider network (managed care) or a provider with a Core Provider Agreement (fee for service).

c. The therapist may be employed or contracted by agencies such as home health or outpatient therapy clinics. For a client transitioning from a skilled nursing facility, this could be a SNF therapist.

d. Following established procedures, the therapist requests an expedited prior authorization (EPA) from the client's AH plan prior to completing the assessment.

e. Step 3 is not necessary if:

- A SNF therapist will complete the assessment.
- If the evaluation is performed in conjunction with another task the provider is authorized to complete, and the provider will not claim the AH procedure code for bed rail assessment (97165/modifier: GO).

4. The case worker requests the therapist's contact information from either the primary care provider or client.

5. The case worker completes Section 1 of DSHS form 13-906 and emails it to the therapist who will perform the assessment (note: Please make sure to use the most updated version).

6. The PT or OT:
   a. Completes the evaluation using generally accepted standards of practice and documents their recommendation(s) regarding the safe use of bed rails or alternative devices in Sections 2 and 3 on DSHS form 13-906 provided by the case worker .
   b. Returns the completed form to the case worker and sends a copy to the client's primary healthcare provider.
   c. If unsure the intent of the bed rail recommendation, the case worker should clarify the results with the physical/occupational therapist.

7. The CARE case worker :
   a. Documents the results of the evaluation in the "Comments" section on the *Bed Mobility* screen.
   b. Discusses the results with the client, provider, and representative (if applicable).
   c. Provides the residential provider a copy of the form (if applicable).
   d. Submits the completed form with a Packet Cover Sheet - Social Services (DSHS Form 02-615) to HIU via Hotmail.
      - If you are an case worker inside the DSHS firewall, you may access the Packet Cover Sheet - Social Services (DSHS Form 02-615) via Forms Picker: DSHS Form #02-615
      - If you are a case worker outside the DSHS firewall, you may access via here.

8. The GetCare case worker :
   a. If unsure the intent of the bed rail recommendation, the case worker should clarify the results with the physical/occupational therapist.
   b. Discusses the results with the client and provider(s).

c. Documents the results of the evaluation and the discussion with the client and provider(s) in a Progress Note.
d. Uploads the completed DSHS Form #13-906 into the client/care receiver's electronic file cabinet in GetCare.

9. Based on the results of the evaluation documented in the completed DSHS Form #13-906, and the informed decision by client and/or representative, complete one of the steps below.

   a. **Recommendation is an alternative device:** depending on the item, follow all established procedures for either AH durable medical equipment (DME) or specialized equipment and supplies (SES) to assist the client with obtaining the recommended item(s).

   b. **Recommendation is full or half-length bed rail(s):** client/vendor follows established AH DME procedures (with case worker assisting, as necessary). Note:

      - AH pays for one pair of full or half bed rails every 10 years *with no prior authorization*. The client provides a prescription from their healthcare provider to a DME provider who will dispense the bed rail.
      - If a client has damaged their full or half bed rails or they have been lost before the 10-year limit has expired, the DME vendor should request a limitation extension (LE) from the client's AH plan.
      - If the LE is denied and the client is enrolled in a LTSS program that includes DME, a SS authorization can be created in *Reviewing* status using blanket code **SA878**. Upon confirmation the client has received the item, the authorization is changed to *Approved* status and the DME vendor will be able to claim using the product's HCPCS in the SS medical portal in ProviderOne.

   c. **Recommendation is one-fourth or one-eight length bed rail (also known as bed canes, mobility bars/rails, bed support handles, standing bars, and many other names):** a SS authorization is appropriate if client desires to use the item, and the client is enrolled in a program that includes SES.

      - **Best Practice:** Utilize a *DME* vendor with the SES contract to authorize ¼ or ⅛ length bed rails. When requesting the quote, verify the item has not been recalled and that it meets the ASTM standard for adult portable bed rails.
      - Create the authorization in Reviewing status using **SA421** after completing all other steps. Upon confirmation the client has received the item, the authorization is changed to Approved status and the DME vendor will be able to claim in the SS portal.

   d. **Use of a bed rail is NOT recommended** due to concerns about the client's ability to safely use it:

      - If the client resides in (or is transitioning to) a residential setting, the client will not be able to use a bed rail, per policy. Alternative devices or equipment can be requested by the client, if recommended in the evaluation.

- If the client resides in (or is transitioning to) an in-home setting:
  - If the bed rail is being paid for by the client's AH plan and the client/representative is making an informed decision based on the results of the evaluation, the client can request a prescription for a bed rail from the primary care provider and follow up with a durable medical equipment vendor. Document informed decision in a CARE Service Episode Record (SER) or GetCare Progress Note.
  - A SS authorization cannot be used to purchase a bed rail, regardless of length.

10. If a client is not enrolled in Apple Health:
    a. For clients enrolled in TSOA: if client's private insurance does not pay for the evaluation, TSOA funds can be used to pay for it.
    b. If a full or half-length bed rail is recommended following the evaluation, a social services authorization can be created in *Reviewing* status using blanket code **SA878**. Upon confirmation the client has received the item, the authorization is changed to *Approved* status and the Durable Medical Equipment vendor will be able to claim using the product's HCPCS in the SS medical portal in P1.
    c. If a one-fourth or one eighth length bed rail is recommended (also known as bed cane, mobility bar/rail, bed support handle, standing bar, and many other names), follow all instructions in 8.c. above.

Self-Directed Care

An adult with a functional disability living in their own home can direct and supervise a paid personal care aide (Individual Provider) to help with health care tasks that they cannot do without assistance because of their disability. Examples of Self-Directed Care (SDC) tasks include help with medications, injections, bowel programs, bladder catheterization, and wound care. Self-Directed Care under Chapter 74.39 RCW must be directed by an adult client for whom the health-related tasks are provided. The adult client is responsible to train the Individual Provider in the health-related tasks which the client self-directs.

For potential self-directed care (SDC) cases, you may refer to the Self-Directed Care Checklist (below) as a reminder of things to consider when doing an assessment. At the conclusion of the assessment process and plan development, obtain the client's signature of agreement to the plan.

Self-Directed Care Checklist

This checklist is not mandatory and does not need to be put in the client's file. The checklist is designed to help staff remember things they should consider in self-directed care (SDC) cases and indicate what additional coordination is needed to assist the individual to self-direct their care.

Remember to ask the individual (client) and yourself these questions when assessing or reassessing a case:

1. Does the individual live in their own home (e.g., a residence that does not require licensure)? Self-directed care can only happen in a private home. Self-directed care (RCW 74.39.050) does not apply to clients living in licensed facilities.
2. Does the individual have an Individual Provider (IP) through the CDE under CFC, MPC, New Freedom or Chore programs? HCS/AAA/DDA clients who are presumed competent, receiving CFC, MPC or any waiver program, and live in a private, non-licensed home can legally self-direct an individual provider. • An IP can be a family member. • The IP cannot perform health care tasks for anyone else, only the person who has hired them to perform those tasks.
3. Does this individual have a functional disability that prevents them from performing a healthcare task for themselves? The individual must be over 18 years of age. The client could have a traumatic brain injury (TBI), mental health or developmental disability and self-direct if the disability does not prevent them from having the ability to explain the procedure and to supervise the IP. There are varying degrees of function with every disability. The healthcare practitioner who prescribed the treatment or medication has the responsibility to ascertain if the individual understands the treatment or medication administration and can follow through on the SDC task.
4. Has the case worker informed the individual of the SDC option at the time of Initial assessment and reassessment? The SDC publication should be given to clients who potentially could self-direct their care, no matter what setting they are in.
5. Does the individual have a legal guardian? (Only guardianships of the person limit personal decision-making. Guardianships of the estate only limit financial decision-making.) The individual self-directing is presumed competent. The health care practitioner who prescribed the treatment has the responsibility to ascertain if the person understands the treatment and can follow through on the SDC task just as they would when a person without a disability goes to the doctor and is given a prescribed treatment. No additional verification is needed.
6. Did the individual inform the prescribing health care practitioner of their intent to self-direct? Is the prescribing health care practitioner's name, address and telephone number documented in the CARE assessment?
7. Has the individual provided the case worker with the source of the treatment order? The case worker should document in the CARE assessment the source of the treatment information. Examples are directions from the client, prescription container/Rx script, written directions from the prescribing health care practitioner, protocols from a professional association or protocols from a rehabilitation facility or institution manual. An actual copy of the treatment order or written directions is not mandatory but may be helpful for more complicated health-related tasks.

8. On the *Treatment* or *Medication Management* section of the Medical screen in CARE, has the case worker documented SDC tasks and selected "Self-Directed Care (IP only)" as a Provider Type for the treatment listed on the Treatments section?
9. Does the client want to self-direct any portions of her/his care? The law does not require the individual to self-direct their healthcare. **The law does not have a task list.**

The responsibility of the client (person with the disability) is to:

- Inform the prescribing healthcare practitioner who ordered the treatment or medication of the intent to self-direct;
- Inform the case worker;
- Inform and provide training to the IP for those SDC tasks and ensure the Individual Provider has a copy of the current Service Summary and Assessment Details;
- Possess the necessary knowledge and ability to train the IP to those tasks;
- Supervise the performance of the IP; and
- Ask for assistance in training, if necessary.

The case worker must:

- Inform the client of the SDC option. Share the SDC publication with the client at the time of assessment and reassessment; and
- Coordinate with the client to identify the SDC tasks and who will perform them and then, document on the *Treatments* and *Medication Management* sections of the Medical screens in CARE; and
- Provide copies of the current Service Summary and Assessment Details to the client and the IP.

Problem Solving: If the case worker feels that the way the client instructs the tasks to be done is potentially harmful or if the assessment reveals that the client has cognitive issues, memory loss, disorientation, or impaired judgment and the client is requesting to self-direct, the case worker will:

- Discuss the situation with the client.
- Consult with a nurse consultant and case management supervisor.
- Clearly document concerns in a Service Episode Record (SER).
- After obtaining a signed Consent Form (DSHS 14-012) from the client, confer with the prescribing health care practitioner.
  - If the prescribing health care practitioner agrees the tasks are being done in a harmful manner, the case worker will not authorize the SDC tasks to be done.
  - If the client refuses to give permission to consult with the prescribing health care practitioner and concerns remain, the case worker must consult with their supervisor to determine whether to authorize SDC tasks. The supervisor will thoroughly review the case and determine whether SDC should be authorized.
- Outcomes of the discussion with the client, and any other actions taken by the case worker and/or client, must be clearly documented in a Service Episode Record (SER).
- If SDC is not authorized, the case worker must develop an alternative plan of care, offer it to the client and document this in a Service Episode Record (SER).

- If SDC is not authorized, the IP may still be paid to perform other ADLs and IADLs if they meet the other requirements to be an IP. The IP may refuse to do SDC tasks at any time. The law does not force the IP to do SDC tasks they are not comfortable doing.

Necessary Supplemental Accommodations (NSA)

Clients who have a mental, neurological, physical, or sensory impairment or other problems that prevent them from getting program benefits in the same way as those who are not impaired are considered in need of necessary supplemental accommodation. (See WAC 388-472-0020)

Developing Necessary Supplemental Accommodations (NSA)

Discuss with clients any issues that would hinder their ability to access DSHS programs and services and determine if they require any necessary supplemental accommodation services to ensure that they can submit the necessary information to the Public Benefits Specialist (PBS) for an initial (or on-going) determination of eligibility for Medicaid. If the client requires or requests NSA:

1. Select "Yes" on the *Care Plan* screen that the client has a need for an "NSA".
2. Identify any special needs the client may have which would impact their ability to complete the initial application for public assistance and any reviews for ongoing eligibility.
3. Identify the family member, significant other, or other individual who can be identified as the person the PBS can contact (may require Consent – DSHS Form #14-012).
4. In the comment box labeled "NSA Description" on the *Care Plan* screen indicate how client's need for an NSA will be met and by whom.
5. Assist clients who are unable to manage this issue independently if no NSA is identified.
6. Indicate and describe the NSA on the 14-443 sent to the PBS through Barcode.

EXAMPLE: The client has significant cognitive impairment and cannot be responsible for the application and eligibility review process. Her daughter, who is her DPOA, will be identified as the contact person for the financial application and eligibility process.

EXAMPLE: The client cannot read. All forms must be sent to the designated representative.

EXAMPLE: The client has a hearing impairment so staff should not contact the client by phone or would need to use the TTY system when appropriate.

Implementing the Necessary Supplemental Accommodation (NSA)

In addition to documenting NSA information on the *Care Plan* screen, you must:

1. Describe the needed special accommodations to the PBS on form 14-443. Include the address of the person identified as the client's representative.
2. Document in a Service Episode Record (SER) that this information was added to the 14-443 to the PBS via Barcode.

3. Add the identified NSA to the Contact Details screen and select the Contact Role of "Personal NSA".
4. If the client does not have anyone to assist them, indicate that the case worker will need to arrange for or provide assistance with, completing forms, obtaining needed information, explaining the department's adverse actions, requesting fair hearings, and providing follow-up contact on missed appointments. case worker may be notified by a PBS that the client needs further assistance with their Medicaid eligibility reviews to ensure that there is no interruption in Medicaid eligibility.

HCS/AAA case records must be identified if the client has specific needs (e.g., large size print for forms, hearing impairment, cognitive impairments, limited reading ability, etc.) that are in addition to the required accommodations that are already recognized in HCS policy. Although all HCLA LTSS clients are treated as if they are NSA, only develop an NSA plan and mark the case "NSA" in CARE if the client has specific NSA needs.

What is the Role of the HCS/AAA Case Worker When Care Planning with a Client Who is a Registered Sex Offender?

During the assessment process, assessors will gather information from the client or representative about any legal or safety issues.

When a client has been identified as a registered sex offender, case workers must verify this information by:

- Checking the Washington Sex Offender Public Registry (www.wasor.org), or
- Through record review (e.g., court or other reliable documents.), or
- By contacting the headquarters email inbox at so.notifications@dshs.wa.gov if otherwise unable to verify sex offender status.

See LTC Manual Chapter 9/Hospital Assessment "What is the Role of Case Managers When Assessing a Client with a Known Legal History?" for more detail on gathering information from the client or representative about any legal issues.

When information is learned during the initial, significant change, or annual assessment process that a client is registered as a sex offender:

- Document in CARE by selecting the correct sex offender status in the Legal Issues section on the Safety screen after information has been verified.
- Use the Legal Comments box to include any additional information the authorized service provider (such as a personal care provider or community choice guide) may need to know to determine whether the authorized service provider can meet the client's needs.

If the client is under supervision, document the supervision status, including the length of the supervision period, the conditions of supervision, and required frequency of check-ins with the Community Correction officer. Record the client's registered sex offender information in the Behavior Screen by:

- Selecting Deliberate Sexual Violence. Include the specific sexual offense for which the client was convicted (such as rape, child molestation, or child rape), date the offense occurred, and relevant personal interventions; and
- Add Law Breaking Activities.

If information is learned about a client's sex offender status outside of the initial, significant change, or annual assessment, complete an Interim assessment using the instructions above for documentation in CARE. If an interim is completed, ensure the interim assessment is provided to the authorized service provider(s).

After completing a CARE assessment and during the process of helping the client select a provider (or for a current provider who hasn't already been notified), clearly communicate that the client is registered as a sex offender.

Sex Offender Notification Letter to Personal Care Providers
Complete and send the appropriate Sex Offender Notification letter (https://www.dshs.wa.gov/office-of-the-secretary/forms) to the personal care providers below when becoming aware that a client is registered as a sex offender and the provider is providing care to the client:

- Consumer Directed Employer and home care agencies: DSHS Form #16-253 Sex Offender Notification to Home Care Agency and Consumer Directed Employer (Home and Community Services)
- Residential Care Providers (all types): DSHS Form #16-255 Sex Offender Notification to Facility (Home and Community Services)
    - Note: additionally, complete the DSHS #10-234A Individual with Complex Behavior when referring a client to residential settings.

Prior to sending a letter to the provider, check Service Episode Records (SERs) to see if a letter has already been sent to that provider. Case worker staff may also check the client's Electronic Client Record (ECR) in Barcode for a copy of the letter (DDA does not use ECR). If there is no evidence of a previous letter, send a letter to the provider.

MINIMUM STANDARDS

The intent of Minimum Standards is to describe the process and expectations of developing and completing a care plan, post assessment interview completion. Use the Minimum Standards when transferring a case from one office to another.

CLIENT STANDARDS	
Interpreter required	Follow guidelines outlined in Chapter 15A/B.
Residence History	When client changes residence, start a new line (+). Do not edit the old line as this prevents history from being built. Use the Multi-Client Residence tab for in-home clients when appropriate.
Residence Type	Select the appropriate Residence Type from the dropdown. If the client is living with others, use the *Collateral Contact* screen to document their name(s) and their relationship to the client.
Contact Details	List all household members and anyone who has contact with the client. When adding a new contact or removing an old contact from the Contacts table, use "+ Add new contact" and "Delete selected contact" buttons. Do not use "Edit" elements of *Contact Details* to replace the information in the table. Backspace or delete should only be used to make a correction to a current contact record, not to change the contact to a new individual or organization. **Emergency Contact:** List the name and phone number of the person who should be contacted in case of an emergency, (i.e., temporary backup care, wildfire, power outage, etc.). Contacts other than an in-home personal care provider and/or household member should be considered first. **Informal support:** List the name and phone number of the client's informal support and select the Contact Role of "Informal Caregiver." This may be a family member, a friend, neighbor, or community resource. If the informal support is a person, it is not required that they live with the client rather than that they visit regularly and are willing and able to respond to the needs that the client may have. This role must be assigned when status in ADL and IADL screens indicate met or partially met tasks. **Substitute decision maker:**

	When the client has a legal substitute decision maker, the assessor must not accept or seek the person's decisions without a copy of the paperwork that confirms the legal relationship. When the client has only an informal decision maker, this arrangement can only continue if the client can tell this person what they want. The assessor will need to confirm any decisions made by the informal decision maker with the client. A General Power of Attorney may only be used if the client is cognitively intact. **Individual Provider(s):** as known, list first and last name of each known and intended (client chosen) Individual Provider (IP), and their relation to the client, when services are provided by the Consumer Direct Care of Washington (CDWA). When determining familial relationships, these are individuals who are related by blood, marriage, or adoption. For the purpose of determining family IPs, "Family" means one or more of the following relatives: spouse or registered domestic partner; natural, adoptive, or stepparent; grandparent; child; stepchild; sibling; stepsibling; uncle; aunt; first cousin; niece; or nephew. **Healthcare providers:** List the name and phone number of the client's primary healthcare provider and any other healthcare provider(s) who have a role in the client's plan of care. If the client does not have a primary healthcare provider, make sure the client has an emergency contact.
HIPAA	Document if the client requests a particular method of communication or other related issues or restrictions. **Address Confidentiality Program (ACP):** Use the "confidential communication" type in the HIPAA screen to note a client participating in the ACP program. Case worker staff who need to visit the client will maintain residential addresses in a locked location within the office and this information will only be given to providers on a need-to-know basis. A substitute mailing address (given by the ACP program) is the only address to be maintained in electronic records.
Financial	Financial eligibility must be verified and active (i.e., not in pending status) for the functional program being authorized (including Fast Track). Financial eligibility verification must occur at least annually. Indicate the method of verification (ACES online, financial award letter, etc.) on the *Financial* screen.
ASSESSMENT	

Reason for Assessment	State the reason for this assessment, documenting the client's or referent's perception of the problem. For reassessments, delete the old reason for assessment and enter the current reason/circumstances for the reassessment.
Source of information	The client must be the primary source of information unless they cannot participate because of mental or physical reasons.
Planned living arrangement	Select "Lives with paid provider" on the Assessment Main screen if the client and their paid provider live together. Select "Multi-client household" on the Assessment Main screen if there are other clients in the household. If both apply, select "Multi-client household."
Adult Family Home (AFH) Evacuation Level	Select the Evacuation Level from the dropdown on the Assessment Main screen. All AFH plans of care and negotiated plans of care must identify the resident's level of evacuation capability (see WAC 388-76-10870).
Medications	Include information about each prescribed medication, if available, with at least the route of administration
Diagnosis	Confirm the diagnosis with the client's healthcare provider when inconsistencies are noted, or the source of the information is not reliable. Document the source of the information. Use *Functional Limitations*, indicators, and/or comment boxes to provide information regarding the client's physical functioning.
Treatments	• Check the treatment definitions to ensure an accurate description of the client's needs. • Identify all providers for each treatment. • Rehab/Restorative Training (walking, transfer, bed mobility, etc.) over the past 14 days. Before you can select these activities be sure that: a. Measurable objectives and interventions are included in the therapist's care plan; b. Caregivers are trained in techniques that promote client involvement; c. Programs are periodically re-evaluated by a skilled professional. Document this in the Service Episode Record (SER) or comment box; d. Time spent on each program must be at least 15 minutes a day; e. You document in the comment box that the plan has been viewed, or a copy is in the file. All criteria mentioned above must be met before "Walking" can be selected. This item does not include a recommendation by a healthcare provider that the client walk on a regular basis.

Self-directed care	Document self-directed care (SDC) tasks on the screen in which the task is addressed. Typically, these will be documented on the *Treatments* section on the Medical screen using "Self-Directed Care/IP only" as the provider type or on the *Medication Management* section (Administration of Medications). Include the name of the healthcare provider prescribing the task as well as a description of the task being self-directed in the applicable comment box(es). Identify the SDC provider and schedule on the *Supports* screen.
Behavior	A current behavior must be addressed with a current intervention(s), provide individualized caregiver instructions (person-centered to the client's interests) in the comment box. When caregiver instructions are the same for multiple behaviors, one comment box of the caregiver instruction is sufficient. For other behaviors that the caregiver instruction applies to, indicate so in the comment box.
Depression	If the client has a score of 10 or higher, document a discussion about a referral to a healthcare provider or mental health resource. Follow the Guidelines for Referrals.
Memory	If the response to the Short-Term Memory question is not consistent with the client's ability to recall the 3 items in the MMSE as well as other information in the assessment, document the inconsistency in the applicable Comment box.
MMSE	Administer the MMSE to each client: • At the Initial assessment. • Whenever the period from the last MMSE equals 12 or more months. • When a significant change assessment is completed because of a reported change in cognition. The MMSE may be omitted when the client is under 18, has moderate to profound intellectual disability, has severe delirium/dementia, or is non-verbal. Use the *Other Factors* Comments box to document client characteristics that may affect the score.
Suicide	If the client answers "yes" to any of the questions, discuss a referral to an appropriate healthcare provider; follow the Guidelines for Referrals. If the client has a plan, the means to carry it out and a time planned, contact the local mental health professional or crisis clinic.

Supervision of providers	If the client is unable to always supervise the in-home provider, identify an informal support person (not a paid caregiver) who can provide supervision. Only clients who are coded as "Independent" or "Difficulty in New Situations" may supervise their paid provider. When no informal support can be identified to meet this need, document in the comment box how monitoring of the case will occur. To increase contact, place the client on targeted case management and consider using more than one IP or an agency caregiver.
Emergency plan (Evacuation/Back-up Plan)	**Evacuation plan** • The intent of an evacuation plan is to document how the client and/or providers would respond to emergency situations. • Discuss evacuation/emergency planning with the client and document the plan by selecting standard language on the Safety Screen under "In-home evacuation plan." • Use the Comment boxes to add client-specific information if necessary. **Back-up plan of care** • If lack of immediate care would pose a serious threat to the health and welfare of the client, include a backup plan. Examples of clients who fall into this category are those who use devices that require electricity or constant monitoring; or clients who require continuous monitoring for a medical condition. • Discuss the backup plan with the client and backup caregiver. – CARE Web: Document in the Client Safety screen using the selections under "Caregiver instruction(s) and safety concerns." Use the Comments box to add client-specific information if necessary. • Identify the back-up caregiver on the *Collateral Contact* screen.
Potential for abuse and neglect	Follow Adult Protective Services (APS) guidelines. If there are no indicators of abuse or neglect, select "None observed or reported" in the Legal Issues section on the Safety screen.
Alcohol/Substance abuse CAGE interviews	Follow the guidelines on the Substance Use screen and the Guidelines for Referrals.
Explanation of inconsistencies	Use Comment boxes to explain inconsistencies or conflicting information in relevant screens. For example, when one ADL is scored Independent, and another, scored Total Dependent, Comment boxes must document explanation.

ADL and IADL screens	Use the bucket selections to provide a clear description of the client's strengths, preferences, limitations, and caregiver instructions. Use the Comment box, if necessary, to provide specific instructions to the caregiver that are not available in the buckets. **Status (Looking forward):** If the client will receive non-HCLA-paid informal support for any ADL or IADL, the assessor will select Met or Partially Met and identify the amount of support under Assistance Available (Looking Forward), using the chart provided in the Assessing Status section or CARE Web Assessor Manual/Help screen. Examples of non-HCLA-paid informal support are family members, neighbors, Adult Day Care, or Adult Day Health. If a client declines personal care and does not want to have a paid personal care provider, the client's assessment must accurately reflect the client's chosen status of "Client Declines" which means "the client will not want assistance with the task". **NOTE:** if a Need is documented on the Medical screen that DME or an assistive device might be helpful, please see the Appendix > Bed Rail Policy.
Guidelines for Referrals	When a non-mandatory referral is indicated (e.g., Depression score of 10 or more or pain score of four or more, etc.), document a discussion with the client in the Comments box on the appropriate screen. Discussion may consist of providing information sheets developed at the local level for self-referral. If the client requests assistance with a referral, document this in CARE on the corresponding screen[5]. Include the date you referred the client and who is responsible to follow through.
CARE PLAN	
Client is eligible for:	Program selected must match services authorized in ProviderOne. For example, if a client is converted from CFC to CFC+COPES, the correct program must be selected in the Care Plan screen and the correct program authorized in the payment system.
Necessary Supplemental Accommodation (NSA)	Include an NSA Description, if applicable. This is appropriate if the client has a special need (mental, neurological, physical, or sensory impairment – does not include Limited English Proficiency) that prevents them from getting program benefits in the same way that a person without an impairment would get them. Indicate and describe the NSA on the 14-443 sent to the PBS through Barcode.

[5] Adult Protective Services (APS), Suicide, and Skin Observation Protocol (SOP) are mandatory referrals.

Referrals to Nursing Services	If a Critical Indicator is listed on the *Triggered Referral* screen, enter the date a referral was made and the reason for the referral. If a referral was not made, identify why a referral was not necessary. Follow the nursing services policies outlined in the Chapter 24, Nursing Services.
Supports screen	• All tasks identified in the Supports Screen must be assigned unless a task is awaiting coordination • Document a schedule when the client has a preferred schedule. Do not identify more hours than what the client is eligible for and what is authorized in the payment system • Unmet tasks are assigned to at least one paid provider. Assign providers using the paid providers search function or "providers from current plan" tab, NOT the contacts or resources tabs • Partially Met tasks are assigned: – to at least one paid provider from the paid providers search or the "providers from current plan" tab, AND – and at least one informal support from the contacts or resources tab • Met tasks are assigned to an informal support only from the contacts or resources tabs
Community First Choice (CFC) Services	CFC Services must be included in the client's plan of care prior to authorization. In addition, the assessment must support the client's eligibility for CFC. **Personal Care:** • Relief Care: Personal care hours may be authorized to an alternate provider. Document a relief care provider in the Contact Details screen and assign tasks in the Supports Screen if a relief care provider is in place. • Nurse Delegation: If nurse delegation is in place, identify Nurse Delegation and IP or Agency as providers in the *Treatments* section of the Medical screen and assign the nurse delegator and paid personal care provider(s) to the task on the *Supports* screen. For medication management, assign the nurse delegator and paid personal care provider(s) on the *Supports* screen. – For treatments, if nurse delegation is not yet in place, identify Nurse Delegation and IP or Agency in the *Treatment*s section as providers and add a comment that the task will be delegated when the provider completes the training. – For medication management, if nurse delegation is not yet in place, state in the Comments box that the task will be delegated when the provider completes the training. – In the meantime, if the treatment/medication management is being performed by an informal provider, identify the informal provider on the *Supports* screen and assign the task. Reassign the task to the

	delegating nurse and paid provider after the IP and/or agency provider has completed the Nurse Delegation training. **Skills Acquisition Training:** • A client may choose to use some of their personal care hours for Skills Acquisition Training (SAT) authorized to an agency provider, IP, or supported living provider. • Document on the ADL or IADL screen who will be providing the SAT and what task the client is wanting training on (e.g. learning to shave with electric razor with non-dominant hand due to stroke on dominant side – this would be listed in the Comments box on the Personal Hygiene screen) **Back-up Systems:** • **Personal Emergency Response System (PERS):** select "PERS unit" and/or "PERS installation" from the Walk/Locomotion equipment list. Assign a contracted PERS provider on the *Support* screen. Following LTC chapter 7b, "Community First Choice (CFC)," document the client's eligibility for PERs unit in the *Safety* screen. • **Relief Care:** document a relief care provider in the Contact Details screen and assign tasks in the Supports Screen if a relief care provider is in place • **Caregiver Management Training:** document date materials were sent or the web link provided on the CFC screen in CARE. If more than one type of material was issued, choose only one, adding both is not required. • **Community Transition Goods or Items:** select "Community Transition Goods or items from the Programs list in the *Treatments* section. Describe the type of goods or items the funding will be for in the corresponding Comments box. Address in the Care Plan, including assigning a provider on the *Supports* screen when appropriate. • **Community Transition Services (CTS):** select "Community Transition Services" from the Programs list in the *Treatments* section. Describe the type of services the CFC CTS funding will be for in the corresponding Comments box. Address in the Care Plan, including assigning a provider on the *Support*s screen when appropriate. See Chapter 7b for eligibility criteria and more information. • **CFC state fiscal year (*SFY) annual limit:** CFC SFY annual limit comprises of purchases/payments for both Assistive Technology (AT) and Skills Acquisition Training (SAT). If items/services are to exceed this limit, an ETR request to the CFC Program Manager is necessary. See Chapter 7b for more information. *SFY is July 1 to June 30. – **Assistive Technology (AT):** Includes add-on services to the basic/standard PERS (e.g. fall detection, GPS, Medication

	Reminder/Dispenser) and other adaptive/assistive items/devices that will increase an individual's independence or substitute for human assistance with an ADL, IADL or health-related task. Document in the relevant screen in CARE and select "Assistive Technology" from the corresponding equipment table. Please consult the CFC Covered AT Items list to confirm that desired item is approved. See Chapter 7b for more information. – **Skills Acquisition Training (SAT):** may be purchased using CFC SFY annual Limit. See Chapter 7b for more information. – **Budget Calculator in CARE:** use to identify, track, and calculate the use of a client's CFC SFY Annual Limit. This is especially useful and helpful to quickly look at what the client has already used and if the case is transferred to another case worker.
COPES Waiver Services	Waiver services must be included in the client's plan of care (Assessment Details or Service Summary) prior to authorization. In addition, the assessment must support the client's eligibility for each service. • **Environmental Modification**: select environmental modification in the *Environment* section on the Safety screen and describe the project in the comment box. Assign a contracted Environmental Modification provider on the *Supports* screen. • **Skilled Nursing**: select "Skilled Nursing/Waiver" from the Treatments list in the *Treatments* section of the *Medical* screen. Describe the type of skilled care in the Comments box. Assign a provider on the *Supports* screen. • **Client Training**: select "Client Support Training/Waiver" from the Rehab/Restorative Training list in the *Treatment* section of the *Medical* screen. Describe the type of training in the Comments box. Assign a provider on the *Supports* screen. • **Adult Day Health (ADH)**: select "Adult Day Health" from the program list in the *Treatments* section of the *Medical* screen. Assign a provider on the *Supports* Screen. (Status adjustments must be coded in the relevant CARE screens for the assistance with ADLs and IADLs provided by ADH staff while at the ADH) • **Adult Day Care (ADC)**: select "Adult Day Care" from the Programs list in the *Treatments* section of the *Medical* screen. Assign a provider on the *Supports* screen. (Status adjustments must be coded in the relevant CARE screens for the assistance with ADLs and IADLs provided by ADC staff while at the Adult Day Care center)

	• **Specialized Medical Equipment**: select "Specialized Medical Equipment" from the appropriate equipment table and describe the item in a Comments box for that ADL. Assign a provider on the *Supports* screen. • **Client Transportation**: assign a provider to Transportation need on the *Supports* screen. • **Home-Delivered Meals**: assign a provider to Meal Preparation task on the *Supports* screen. Document the hour adjustment in the In-home Adjustments tab on the Care Plan screen and assign the paid provider on the *Supports* screen. • **Wellness Education:** select "Wellness Education Service" from the Program list in the *Treatments* section of the Medical screen and use the provider type "other". Assign "Smart Source, LLC" as the provider on the *Supports* screen. • **Community Choice Guide (CCG):** select "Community Integration" from the Program list in the *Treatments* section of the *Medical* screen. Document CCG tasks via Pre-*Transition & Sustainability* screen > *Sustainability Goals* screen. Assign the paid provider on the *Supports* screen. • **Community Support:** Goods and Services (available only for individuals moving from a licensed residential setting to in-home): Select "Other" from the Program list in the *Treatments* section of the Medical screen. Describe the Community Support needed in the corresponding Comments box. Assign a provider on the *Supports* screen.
Environmental Modifications/ Durable Medical Equipment	Enter the date the Durable Medical Equipment or Environmental Modification is expected to be completed/obtained in the "Act By" field. The Follow Up screen must include updated detail in the Comment Box of current status/steps taken, related to "Who Acts."

Case File Standards

This section outlines standards for what is required in the electronic case record, record retention, obtaining original documents/signatures, and utilizing the Document Management System in Barcode.

Home and Community Services HUB Imaging Unit (HIU) and Electronic Case Records (ECR)

The Hub Imaging Unit (HIU) is a subset of the Barcode application which was written and is maintained by Economic Services Administration (ESA). The HCS Hub Imaging Unit manages and stores documents creating an electronic case record (ECR) eliminating the need for a paper case file. Once a document arrives at the Hub Imaging Unit, it is scanned and indexed to the appropriate client and assignments based on each office's set of assignment rules or Assignment Matrix and then will display as a *Tickle* assignment on the appropriate workers *Barcode To-Do* list.

What should be sent to Hub Imaging Unit for imaging into Electronic Case Record?

The following documents that have not been superseded by a more recent version:

- 14-225 Acknowledgement of Services
- 14-012 DSHS Consent
- 16-172 Client Rights and Responsibilities
- (Durable) Power of Attorney and/or Guardianship paperwork and documents, if not submitted previously
- 10-234 Individual with Challenging Support Issues
- 10-234A Individual with Complex Behaviors
- 14-534 Specialized Dementia Care Program Eligibility Checklist
- Residential clients' Negotiated Care Plan or Negotiated Service Agreement
- Least Restrictive Alternative (LRA) documents
- **ANY OTHER CRITICAL CLIENT INFORMATION THAT IS NEEDED FOR CONTINUITY OF CARE AS DETERMINED BY CASE WORKER AND SUPERVISORS.** Be mindful of the volume of documents sent for imaging. Send only the critical documents or pages**.**

Medical records including Medical Administration Records (MAR) are NOT required to be scanned into the client's electronic case record (ECR). If there is something identified in a medical record that is determined to be critical for the ECR and for service continuity, be mindful of the volume of pages sent for imaging. Send only the critical portions of the medical record.

Original Signatures and Electronic Transmission

Certain forms require that the original signatures be available in the client's file. To meet this requirement, the Secretary of State's Office has certified imaged documents as originals only if documents sent to Hub Imaging Unit (HIU) are as the client originally submitted the item to a DSHS office. Example: If the client returned the original signed document, this original signed document must be sent to the HIU. HIU does have the ability to accept faxed documents directly from clients or providers and these items will be considered "original" documents, but they must be submitted by the client or provider.

If a site has received an electronic transmission, such as fax or PDFs as attachments to e-mails, these will be accepted as originals if the site first prints these items and sends to the HIU to be imaged to the client's ECR. Electronic records and signatures created are considered original source documents.

Organization of Electronic Case Record

Client documents are housed and managed digitally within the electronic case record (ECR), which is part of the Barcode application's HCS Hub Imaging Unit (HIU). The ECR can be accessed from the Barcode Welcome Screen (select AU search), or from within CARE > Launch Menu (rocket ship icon:), or, once the client is in view (barcode icon:). When viewing a client's ECR, you can search by document type and specify the timeframe (history).

Documents are sent to HIU to be scanned into and associated with the client's ECR. HIU staff scan each document and identify the type of document based on a list of general categories, assign the document a code from those categories and match the document to the client. The document then runs against a matrix from the site that sent the document to HIU. This matrix identifies how each document type is to be assigned for each office. A complete list of document codes is available in Barcode and on the HIU SharePoint website.

Training and additional information about HIU and ECR is available at the Home and Community Living Administration Training Page.

Documents contained in the client's electronic case record cannot be deleted by the HIU after they have been submitted for imaging unless there are exceptional circumstances (such as, a client is protected by address confidentiality program).

Adult Protective Services (APS) documents: APS documents must never be sent to HIU and should not be included in the ECR. The APS investigator will provide a paper copy to the client's case worker in order for any appropriate Service Episode Record (SER) documentation to occur and then the case worker must then destroy using a secure destruction method (shred box) according to Administrative Policy 5.04. APS maintains paper files and can be contacted to access APS documents on a need-to-know basis. Please refer to APS Policy & Procedure.

Frequently Asked Questions about the Electronic Case Record (ECR) and the HCS Imaging Unit (HIU)

Q How will staff receive training to use Barcode and ECRs?

A Articulate trainings are available to social work, technical and supervisory staff and available at the Home and Community Living Administration training site.

Q How will Hub Imaging Unit (HIU) staff assign documents?

A HIU staff do not assign any work. HIU staff are tasked with imaging documents, identifying the document type/office, and then matching these imaged documents up to existing clients. Once these processes are completed, the HIU system will run all newly received documents against the identified office's matrix. The matrix is a set of rules for a site that tells HIU how to assign each type of document.

Q What happens to documents that cannot be matched up to a client?

A Each site has a Mystery Mail view (accessible from your To-Do list) that will display all documents that arrived for your office but could not be matched to a client. If you can identify the matching client to a document found here, you or the HIU can link the document in the system.

Q How will staff be notified of any Barcode/HIU outages?

A To receive updates, social services and case management staff and Public Benefits Specialist and Regional financial program staff that use Barcode should subscribe to IT Solutions topics available in GovDelivery: Washington State Economic Services Administration (govdelivery.com)

Q How do I use the two different types of coversheets? (The Social Services Invoice / Receipt Packet Cover and Financial Document Packet Coversheet)

A The PACKET COVER SHEET - SOCIAL SERVICES (DSHS Form #02-615) is used by the case worker to submit final invoice(s) and/or receipts to HIU for imaging. By using the Social Services packet coversheet, the document will be indexed as a Social Services Receipt, rather than an RX (an RX is a type of financial document).

Note: All home care agencies have been informed to include the code SSR when sending letters regarding client's unpaid participation so these items can be indexed correctly. Staff must ensure receipts have an SSR cover sheet attached.

The PACKET COVER SHEET - FINANCIAL (DSHS #02-614) is used to keep documents that are of a different type together so they can be indexed as a single document, most often used for NGMA or Overpayment Packets.

A document coversheet is not needed if a doctor's report is being sent to the HIU or just because a document has several pages. Do not mix the dates when using the batch cover sheet. The date on the cover sheet is the date that will be used even if other documents have different dates. The date stamped on the document should be the date received at the office.

- If you are a case worker inside the DSHS firewall, you may access the PACKET COVER SHEET - FINANCIAL (DSHS #02-614) via Forms Picker: DSHS #02-614
- If you are an case worker outside the DSHS firewall, you may access here.

Q What should staff do if a client document gets placed in the wrong electronic file?

A Request an Hub Imaging Unit (HIU) Document fix. From within a client's electronic case record (ECR), highlight the document that has been indexed incorrectly and from the toolbar, select "Document Tools" and from the dropdown menu "Request HIU Doc Fix"; then select the best description of the problem from the dropdown list. For further clarification to the nature of the request, use the "Additional Comments" section. Hit "submit". The requestor will receive a confirmation email that the issue was resolved.

Q Can staff request documents be deleted that have already been sent to the HIU for imaging?

A No, documents cannot be deleted unless there are exceptional circumstances such as Adult Protective Services (APS) or a client protected by address confidentiality program (ACP).

Q Can I complete assignments for workers in other offices?

A Only if you also have an account in that office. Staff may only complete assignments for others if they are sure the other staff person does not need to see the assignment.

Q What is the Department policy on imaging CARE Service Summaries?

A All versions of the Service Summary should be imaged in the event of a fair hearing request covering the usual record retention period of 6 years. CARE retains past versions of Service Summary in most instances when a new Service Summary is created; however, if changes are made to a Current assessment in the plan of care e.g. change of providers, you will want to send an updated Service Summary to be imaged to the electronic case record (ECR). If the complete Service Summary is sent to imaging and then the client returns the signature page, staff do not need to send the entire Service Summary to HIU again, just the signature page.

Q Should staff include a copy of the drawing and simple sentence that is administered to the client through the MMSE during the CARE assessment?

A Retaining this document is optional but can be useful to note cognitive changes from one assessment to another. Because this document is also used by CSD, it is coded as a Doctor Request (DR) type document rather than a CARE Case Manager (CAR). The form is generated in CARE to be easily scanned to the correct ECR.

Q I have a client enrolled with the Address Confidentiality Program (ACP). How will staff record the client's physical address and coordinate care planning?

A If your client is enrolled in ACP, the actual residential address must not be maintained in Barcode or in CARE. Case worker staff who need to visit the client will maintain residential addresses in a locked location within the office and this information will only be given to providers on a need-to-know basis. When coordinating with service providers, case worker staff will contact the client first to provide an opportunity for the client to coordinate themselves. If client instead prefers the case worker to coordinate instead, the case worker will ask for their Consent to share the physical address with the provider, explaining to the client that this is only to coordinate services and provide the necessary services and/or care to the client. A substitute mailing address (given by the ACP program) is the only address to be maintained in electronic records. The client may request communication occur only in a preferred way such as e-mail, a particular phone number or contact time. This information must not be maintained in the electronic record.

Q What is the policy concerning the storage of translated documents in the client's ECR?

A When sending documents to the HIU, staff must send the English and translated versions together except for the CARE documents listed below. These documents do not have to be sent in English and may be sent in the translated version only:

- Assessment details
- Care Results
- Planned Action Notices
- Personal Care Results (PCR) or Personal Care Results Comparison (PCRC) – In-home and Residential

- Service Summary generated by a new CARE assessment

  For signed Service Summaries obtained in methods other than voice signature, if changes are made to a Current assessment in the plan of care e.g. change of providers, there may not be a historical record, so this document must be sent in English along with the translation to HIU. While the translated version of documents may be signed by the client who is not fluent in English (Limited English Proficiency (LEP)), the English versions of all documents that require client signature are the official versions and must be signed by the LEP client.

  For signed Service Summaries obtained via voice signature, once the voice signature is obtained, the case worker will then send the signed Service Summary to Prisma for translation. Prisma will translate the signed Service Summary, including the 'signatures' line. Once received, staff will submit a copy of the signed Service Summary to HIU for imaging and retention.

For Braille Transcription:

1. See Chapter 15A/B for complete instructions for obtaining Braille Transcription
2. The ADA/LEP Program Manager will send an e-mail to the field staff who requested the translation. The case worker will send this e-mail to HIU for imaging. The e-mail will include:
   - A statement that the text was transcribed into Braille and sent to the client;
   - Confirm the date the Braille notice was sent by postal mail with USPS tracking number to the client;
   - Whether or not the notice was returned as undeliverable by the post office and, if so, the date of the notice

Q Where can staff get additional HIU supplies (envelopes, completed stamps)?

A **For HCS staff:** Templates to place the envelope orders have been transferred to your sites. Staff should be able to order these through the normal process. HCS sites will reorder any "Completed" stamps needed for staff.

- **For AAA Staff:** We are not able to transfer templates to your areas for reorder. Sites needing more envelopes or "Completed" stamps* must send an e-mail to Melanie McGuire, melanie.mcguire@dshs.wa.gov. The subject line of your E-mail should read: ATTN: HIU Supplies/Barcode Site # (#= your Barcode site number). Melanie will be placing orders on the first of each month.

- Please continue ordering "Completed" stamps through your sites supply channels if they are available. Remember stamps must be in black ink.

Forms and Brochures

FORM/BROCHURE TITLE	REQUIREMENTS
Medicaid and Long-Term Care Services for Adults Brochure (DSHS #22-619)	Review with the client at the Initial assessment.
Voter Registration (ABVR) forms	At least annually, during in-person visits, continue to ask the client if they would like to register to vote and if they need assistance with filling out the form. Use Agency Based Voter Registration (ABVR) forms and complete the voter registration screen in CARE.
Estate Recovery Information	Refer to Chapter 7h/Appendices. To meet disclosure requirements, you must provide the following documents to all prospective and new clients and verbally explain both the estate recovery program and the community service options available: • WashingtonLawHelp.org info on Estate Recovery for Medical Services Paid for by the State and; • Home and Community Services (HCS) publication: Medicaid and Options for Long-Term Care Services for Adults (DSHS 22-619x) • Estate Recovery Information Sheet • Estate Recovery Repaying the State for Medical and Long Term Care (LTC) DSHS form 14-454
Self-Directed Care (DSHS Form #22-388)	Review with the client at the Initial assessment or when Self-Directed Care (SDC) is first authorized.
Client Rights and Responsibilities (DSHS 16-172) **Available in CARE*	Review with the client at the Initial (or at the Significant Change/Annual if the form has not been signed). Have the client sign two copies; one copy for the client's file and leave one copy with the client. If an updated version of a signed form exists, have the client sign the updated form. The most recent client rights and responsibilities form presented by the case worker and signed by the client replaces previously signed forms.
Acknowledgement of Services (DSHS 14-225) **Available in CARE*	At the Initial, Annual, or Significant Change assessment, review with the client who is considering Community First Choice (CFC), COPES waiver, Residential Support Waiver (RSW), New Freedom, Medicaid Alternative Care (MAC), and Roads to Community Living (RCL) program. Have the client sign two copies; one for the client's file and leave one copy signed also by the case worker, with the client. If an updated version of a signed form exists, have the client sign the updated form. The most recent acknowledgement of services form presented by the case worker and signed by the client replaces previously signed forms.
DSHS Notice of Privacy Practices (DSHS 03-387) **Available in CARE*	Review the form with the client at the initial assessment. Provide a copy of DSHS Privacy Practices to the client/ARep.

Consent Form (DSHS 14-012) **Available in CARE*	Prior to gathering information from contacts or sharing information with others, you must have the client review and sign the consent form annually. The consent form is utilized by multiple agencies under DSHS. Each agency's use of the consent form is independent of another's. When using the form, be accurate and as specific as possible (such as utilizing the agency's names for an individual home health agency serving the client). It is insufficient to write generic terms such as "hospital" or "physician" on the consent form. Staff must identify the specific facility, clinic, or individual by name, otherwise the consent is not valid for that party. For individually named contacts, first and last names are necessary when completing the form. The most recent consent form presented by the case worker and signed by the client replaces previously signed forms, as the expression of the client's intention of what to disclose. *Information Included* section: Clients must indicate what records are covered by the consent. If any records include information, such as a diagnosis, medication, treatment, or instructions relating to mental health (RCW 71.05.620), HIV/AIDS or STD testing or treatment (RCW 70.02.220), or drug and alcohol services (42 CFR 2.31(a)(5)), the client must mark these areas specifically to give permission to share these records. *The 14-012 includes the following phrase on page 1: "DSHS may still share information about you to the extent allowed by law."* Specifically, regarding mental health information: RCW 70.02.230 applies to mental health information as it provides more protection than HIPAA, which HIPAA allows. RCW 70.02.230 allows certain disclosures without patient authorization, including under RCW 70.02.050. In turn, RCW 70.02.050(1) states A health care provider or health care facility may disclose health care information, except for information and records related to sexually transmitted diseases which are addressed in RCW **70.02.220**, about a patient *without the patient's authorization* to the extent a recipient needs to know the information, if the disclosure is: *(a) To a person who the provider or facility reasonably believes is providing health care to the patient.* So, in a case involving necessary treatment, mental health records can be released without patient authorization.
FDA Bed Rails Brochure "A Guide to Bed Safety"	Provide to the client, family, and personal care providers, when a request for new bed rails is made. Include Translated Versions for LEP recipients as needed.
Notice and Consent of Communication via Text or Unencrypted Email (DSHS #27-156)	Have client sign when they indicate they (client) would like to receive communication by text messaging or email, via unencrypted email. Place signed copy in client's ECR.

Assessment Location Grid

TO	From hospital…[6]	From SNF…	From residential…	From in-home…
Hospital (Rehab/ Transitional Care units)	HCS will coordinate with the discharge planner and assess within 7 days of referral or when ready to discharge to the community, whichever is earlier.	N/A	N/A	N/A
In-home	• HCS performs initial assessments for Medicaid applicants requesting long-term care services (except for Asian Counseling and Referral Service (ACRS) and Chinese Information Service Center (CISC) clients). • AAA/DDA will update the care plan or perform a Significant Change assessment for existing in-home clients who are returning home within 30 days of their hospital admit. The AAA will transfer the case to HCS if the client's out-of-home hospital stay exceeds 30 days.	• HCS performs an initial assessment for Medicaid conversions; • HCS/AAA/DDA performs a Significant Change assessment if there has been a significant change in an existing client's condition. • The AAA may transfer the case to HCS if an existing in-home client's out of home stay exceeds 30 days. AAA and HCS may negotiate whether to transfer the client, if it appears the client will return home within a reasonable timeframe. Continuous Hospital and SNF days are totaled to determine days out of the home.	HCS performs an initial assessment (for new clients) or a Significant Change assessment and/or updates the *Care Plan* screen to reflect the change in setting.	HCS performs initial assessments for Medicaid applicants requesting in-home long-term care services (except for Asian Counseling and Referral Service (ACRS) and Chinese Information Service Center (CISC) clients).

[6] HCS must also complete assessments prior to patients being discharged from Eastern or Western State Hospital.

TO	From hospital…[6]	From SNF…	From residential…	From in-home…
Residential	• HCS performs initial assessments for Medicaid applicants requesting long-term care services. HCS informs the client of choices of settings. • For existing clients, HCS/DDA will perform an Interim or Significant Change assessment, if needed.	When clients are ready for discharge, HCS performs an initial assessment for Medicaid conversions and a Significant Change assessment for existing clients.	HCS/DDA updates the *Care Plan* screen to reflect changes if it is a different setting (e.g. AFH to AL).	AAA/DDA shall make any changes to the plan and/or perform an in-person assessment if the client's condition has changed since the last assessment.
SNF	HCS will review the record and use the NFLOC screen to determine that the resident meets institutional status per WAC 388-106-0355 for: • MPC and Chore clients • Medicaid recipients/applicants (clients who are receiving Medicaid, but not home and community programs) • Individuals who require a Level II PASRR but are not otherwise receiving DSHS services (regardless of payor source); and • Clients who are requesting or need Alien Emergency Medical. • Clients who are requesting State-funded Long Term Care for Non-Citizens (LTC-NC) program; **Note:** The NFLOC screen may be completed after admission to the nursing facility.	• For residents who, after being admitted, convert to Medicaid payment, HCS will review the record to determine that the resident meets institutional status per WAC 388-106-0355 and notify financial using the 14-443 and complete the NFLOC screen. The client must have first paid privately to be considered a conversion. • For a client on the N-Track (MAGI): If the client is covered by the AH MCO rehab or skilled nursing benefit, then no NFLOC is required. • If a MAGI client is not admitting to the nursing facility under a benefit covered by the MCO, enrolls in an AH MCO after date of admit, or if the client's rehab or skilled nursing benefit is ending (or has ended) with the AH MCO, the facility will notify HCS for an intake. HCS must determine NFLOC and notify HCA by completing form 15-442 in Barcode.	For CFC+COPES clients, HCS updates the care plan to reflect the change in setting. For MPC clients HCS performs a Significant Change assessment or completes the NFLOC screen prior to admit. The client's medical chart, nursing assistant notes, and staff interviews and other records can be used to supplement interviews with the client to assess activities of daily living, cognition, etc. to perform the NFLOC assessment.	• For CFC+COPES clients, the AAA updates the care plan to reflect the change in setting. • For MPC clients and Chore clients who don't already meet NFLOC, the AAA/DDA performs a Significant Change assessment or completes the NFLOC screen prior to move to SNF. • If the client is to remain out of the home less than 30 days, the AAA/DDA maintains the case. • If the AAA/DDA maintains the case, pursue Housing Maintenance Allowance. • For new Medicaid applicants, HCS explains all options available prior to admit. If NF is chosen, HCS completes a NFLOC. *While HCS approves moves to a SNF, all CFC and CFC+COPES clients

TO	From hospital…[6]	From SNF…	From residential…	From in-home…
		• No assessment is required when the client is moving from one facility to another.		are eligible for (and may choose) to reside in a SNF. See Chapter 10/Nursing Facility Case Management and Relocation, related to admitting to a SNF from a community setting.

LTSS Exception to Rule Types and Approval Authority

NOTE: All Exception to Rules (ETR) sent to Headquarters for approval must have been processed to Headquaters by a Field Approver first.

ETR Category	ETR Type	Waiver Type	Outcome Value Rate ($), Unit (Each), Quantity (?)	Approval Authority
Medicaid Personal Care (MPC)	Personal Care: In Home	N/A	Hours	HQ Approval by ETR Committee
	Personal Care: Residential	N/A	Rate	
Community First Choice (CFC) Personal Care	Personal Care: In Home	N/A	Hours	
	Personal Care: Residential	N/A	Rate	
	Personal Care: Limitation Extension	N/A	Hours	HQ Approval by ETR Committee
New Freedom Personal Care	Personal Care: In Home	N/A	Hours	HQ Approval by ETR Committee
	Personal Care: Limitation Extension	N/A	Hours	
Residential Support Waiver Personal Care	Personal Care: Residential	RSW	Rate	HQ Approval by ETR Committee
Waiver Services (Ancillary Services for COPES recipients)	Environmental Modifications	COPES	Rate, Units, Quantity	Field Approval (AAA or Regional)
	Special Medical Equip and Supplies	COPES	Rate, Units, Quantity	
	Transportation Services	COPES	Rate, Units, Quantity	
	Skilled Nursing: Rate or Hours	COPES	Rate or Hours (treat Hours as RN visits)	HQ Approval by Skilled Nursing Program Manager

ETR Category	ETR Type	Waiver Type	Outcome Value Rate ($), Unit (Each), Quantity (?)	Approval Authority
	Client Training: Rate or Hours	COPES	Rate or Hours	Field Approval (AAA or Regional)
Community First Choice (CFC) Services	Community Transition Services	N/A	Rate, Units, Quantity	HQ Approval by CFC Program Manager
	Exceed CFC Annual Service Limit	N/A	Rate, Units, Quantity	
State Only	Chore Hours (to exceed CARE)	N/A	Hours	HQ Approval by ETR Committee
	Chore Spouse Provider	N/A	N/A	HQ Approval by Chore Program Manager
	Office of Attorney General Filing Status	N/A	N/A	HQ Approval by Guardianship Program Manager
	Residential Discharge Allowance	N/A	Rate ($), Unit (Each), Quantity (1)	Field Approval (Regional)
PDN (Private Duty Nursing)	Private Duty Nursing >16 hrs/day	N/A	Hours	HQ Approval by PDN Program Manager
	Personal Care In-Home	N/A	Hours	HQ Approval by ETR Committee HQ/ PDN Program Manager
Bedhold (initiated by Bedhold Unit only)	Bedhold-not hospital or Skilled Nursing Facility (associated assessment is not required)	N/A	NA	HQ Approval by Bed Hold Program Manager
Social Leave	AFH/BH Leave >18 days/yr	N/A	NA	Field Approval (Regional)
	NH Leave >18 days/yr	N/A	NA	

ETR Category	ETR Type	Waiver Type	Outcome Value Rate ($), Unit (Each), Quantity (?)	Approval Authority
Other Use for Assistive Technology (contact Linda Garcia), or Financial	Other (Associated assessment is not required)	N/A	All fields enabled	Varies
RCL –Personal Care	Personal Care In-Home	N/A	Hours	HQ Approval by ETR Committee
	Personal Care: Residential	N/A	Rate	
	Personal Care: Limitation Extension	N/A	Hours	
RCL/WA Roads-Services	Client Training: Rate or Hours	N/A	Hours	Field Approval (AAA or Regional)
	Community Integration (e.g. CCG)	N/A	Rate, Units, Quantity	
	Community Transition Services	N/A	Rate, Units, Quantity	
	Environmental Modifications	N/A	Rate, Units, Quantity	
	Skilled Nursing: Hours (Treat as RN visits)	N/A	Hours	HQ Approval by Skilled Nursing Program Manager
	Skilled Nursing: Rate	N/A	Rate	
	Special Medical Equip and Supplies	N/A	Rate, Units, Quantity	Field Approval (AAA or Regional)
	Transportation Services	N/A	Rate, Units, Quantity	

ATTACHMENTS

To view any attachment(s) for the LTC Manual, you may view at DSHS internet website here.

Guide to Electronic Signatures via CARE Assess

Voice Signature Technical Training PPT

Voice Signature Script

1. Translated Voice Signature Script, for staff use

Chart of Scenarios for Service Summary Signatures

Exception to Rule Frequently Asked Questions for Providers

Exception to Rule Frequently Asked Questions for Hospitals

Care Planning Advocate Flow Chart

How to Identify a Guardian Conservator Nominee

Power of Attorney vs. Uniform Guardianship

Document Review Checklist for Alternative Decision Maker Authority Form