Community First Choice (CFC)

Chapter 7b describes the Community First Choice (CFC) program which is a Medicaid State Plan option granted under 1915(k) of the Social Security Act. CFC provides services that enable eligible individuals to remain in, or return to, their own communities through the provision of coordinated, comprehensive and economical home- and community-based services (HCBS).

Ask the Expert

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WHAT IS COMMUNITY FIRST CHOICE (CFC)?

Community First Choice (CFC) is a Medicaid State Plan option granted under 1915(k) of the Social Security Act. Level of care eligibility for CFC includes those who, without home- and community-based attendant services and supports that are provided under CFC, would require the level of care provided in a/an:

- Hospital;
- Skilled Nursing Facility (SNF);
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);
- Institution providing psychiatric services for individuals under age 21; or
- Institution for Mental Diseases (IMD) for individuals aged 65 or over.

Home and Community Services (HCS)	Nursing Facility Level of Care (NFLOC)
Developmental Disabilities Administration (DDA)	Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/IID) Level of Care **or** Nursing Facility Level of Care (NFLOC)

One of the services provided under CFC includes personal care, which is assistance with the following Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks (for example, nurse delegation and PERS units). Assistance for IADLs is available only when the client also needs assistance with ADLs.

ADLs and IADLs as listed in Washington Administrative Code (WAC) 388-106-0010 include:

ADLs	Bathing Body Care Dressing Eating Personal hygiene Toilet use	Medication management Transfer Bed mobility Locomotion outside room Locomotion in room & immediate living environment Walk in room & immediate living environment
IADLs	Meal preparation Ordinary housework Essential shopping	Wood supply *(when sole source of heat)* Travel to medical services Telephone use

Clients may receive other services available through the CFC program when they meet all the eligibility and sub-eligibility requirements. Other services available through CFC include:

- Relief Care
- Nurse Delegation (ND)
- Personal Emergency Response Systems (PERS)
- Assistive Technology (AT) benefit
- Skills Acquisition Training (SAT)
- Community Transition Services (CTS)
- Caregiver Management Training (how to select, manage, and dismiss personal care providers)

Clients may need other services in addition to those available under CFC,

- HCS/Area Agency on Aging (AAA) Clients:
  - May also receive services through the Community Options Program Entry System (COPES) waiver. If they qualify for CFC and are both functionally and financially eligible for COPES waiver services, they can enroll in and be on both programs simultaneously in order to access additional needed COPES services.
    - In CARE on the Care Plan screen, the dropdown selection of the Client's chosen program would be CFC+COPES.

      Note: The "+" means "and". When a client is on CFC+COPES, they are enrolled in both the CFC program and in the COPES waiver program.
- DDA Clients:
  - May also receive services through CFC and either the Basic Plus, Core, Children's Intensive In-Home Behavioral Support (CIIBS), or Individual and Family Service (IFS) waivers.
  - Clients must receive prior approval from DDA Headquarters to enroll on a waiver program.

Medicaid Personal Care (MPC) is also a Medicaid State Plan program. MPC is available to those clients who do not meet the institutional level of care noted above. See Long-Term Care (LTC) Manual Chapter 7c for information on MPC.

CFC ELIGIBILITY

Before CFC services can be authorized by HCS/AAA or DDA, the client must meet **ALL** the following eligibility criteria:

Age

- For services through HCS/AAA, an individual must be 18 years of age or older.

- For services through DDA, an individual:
  - Who meets DDA's determination of a developmental disability may be any age.
  - Under the age of 18, who do not meet DDA's determination of a developmental disability but have functional disabilities may be served by DDA until age 18.
    - DDA will refer young adults aged 18 and older to HCS.

Functional Eligibility

To determine functional eligibility, a personal care assessment, also known as a Comprehensive Assessment Reporting & Evaluation (CARE) assessment, must be completed. To be functionally eligible for CFC, a client must:

- Meet NFLOC as outlined in WAC 388-106-0355(1), ***or***
- Meet ICF/IID as outlined in WAC 388-828-3080 and 388-828-4400, ***or***
- Likely need an institutional level of care within 30 days unless services are provided.

Financial Eligibility

To be financially eligible for CFC, a client must be eligible for Categorically Needy (CN) or Alternate Benefit Plan (ABP) scope of care in the community. See LTC Manual Chapter 7a for more information regarding financial eligibility for LTC programs.

CFC CARE SETTINGS

Clients enrolled in CFC may choose to receive services in one of the following Home- and Community-Based Settings:

- The client's own home
- Adult Family Home (AFH)
- Assisted Living (AL) facility
- Adult Residential Care (ARC) facility
- Enhanced Adult Residential Care (EARC) facility
- In community settings, personal care tasks specified in the CARE plan may be provided outside the client's home:
  - To support a client in community activities or to access other services in the community.
  - To assist a client to function in the workplace or as an adjunct to the provision of employment services.

CFC SERVICES

In addition to personal care services, clients can receive other CFC services if they have a documented need and the item or service is applicable, not covered by another source, and is cost-effective. A CFC client may receive any CFC service or item they are eligible for, with or without personal care.

Personal Care is a service under CFC. The CFC program and a waiver program are two separate Medicaid Long-Term Services and Supports (LTSS) programs. Although it is *not* common situation since most clients need assistance with ADLs/IADLs,

A CFC client may receive any CFC service or item they are eligible for, with or without personal care.

- An HCS/AAA in-home client can choose to access CFC services or COPES services (if financially eligible for COPES) without choosing a paid in-home personal care provider.
    - Here are some examples of an HCS/AAA in-home client being on services without a paid in-home personal care provider:
        - A CFC eligible client discharging from a Skilled Nursing Facility (SNF) and who needs/wants help getting resituated in the community, so they access CFC Community Transition Services (CTS). Once in their own home, they are able to take care of themselves independently and do not need/want any personal care service or any other services. Therefore, the client chooses to end/withdraw their CFC services.
        - A CFC+COPES client chooses to only attend Adult Day Health (ADH) or Adult Day Care (ADC), which are COPES services, and to not receive CFC in-home personal care services. See LTC Manual Chapter 7d and LTC Manual Chapter 12 for more information on ADH and ADC services.
        - A CFC client who is eligible for and needs/wants/accepts a PERS unit, can have a PERS unit authorized when they have a need/want for personal care but do not have a current paid personal care provider authorized.
    - **Please note**, a client must continue to meet functional (and financial) eligibility:
        - 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".
            - Please see the LTC Manual Chapter 3 for information on scoring status.
            - Minimum Standards listed in LTC Manual Chapter 3 must be met especially when transferring a case from one office to another.
        - When a client is assessed next, the client must meet functional eligibility by having an unmet or partially met need with at least three of the ADL task(s) listed in WAC 388-106-0355 in order to continue to receive CFC services for the next CARE plan.
- A DDA client eligible for a DDA waiver (i.e., B+, IFS, Core, etc.) can access an eligible waiver service without choosing a paid in-home personal care provider. Please note, this is *not* a common situation.

Other Funding Sources

Federal rules require that CFC services not replace other services that clients are able to access under Medicaid, Medicare, health insurance, LTC insurance, and/or other community or informal resources available to them.

- If a client has other insurances or resources, those resources should be used prior to authorizing CFC services.
  - If another resource is identified but denies the service, document this denial in a SER note, ***and***
  - Submit any paper documentation of the denial to the client's:
    - Electronic case record (ECR) in Document Management Services (DMS) for HCS/AAA client.
    - Electronic file in the Records Management Tool (RMT) for DDA client.
- CFC services may not supplement the reimbursement rate from other resources or be used to pay for something that is covered by another resource to pay a higher rate.
- Requesting an Exception to Rule (ETR) is not allowed for the above circumstances.

Providers of CFC services must meet certain qualifications and be contracted through the Department of Social and Health Services (DSHS) or the local AAA prior to services being authorized.

Each local AAA maintains a list of eligible contracted providers for use by HCS, AAA and DDA staff.

Prior to authorizing any service, verify that the client's need for this service is documented/described/identified in the client's CARE assessment which will then reflect the need in the client's CARE service plan and printed on the Assessment Details/Service Summary.

Personal Care Services

WAC 388-106-0010 – "Personal care services" means physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to functional limitations. Assistance is evaluated with the use of assistive devices.

Personal Care Services

- Personal care assistance enables clients to accomplish tasks that they would normally do for themselves if they did not have a disability/functional limitation. Assistance may:
  - Include hands-on assistance (actually performing a task for the person) or cuing to prompt the client to perform a task.
  - Be provided on an episodic or on a continuing basis.

- Includes assistance with ADLs and IADLs – see table on page 3
  - IADLs may not comprise the entirety of the service for a client, they must also have unmet need for and ***accept*** assistance with ADLs.

- May include tasks completed outside of the client's home as specified in the CARE plan to:
  - Support clients in community activities or to access other services in the community.
  - Assist a client with ADL needs in the workplace or as an adjunct to the provision of employment services.

Personal Care Service Providers

Clients may choose as the provider of their personal care:

- For In-Home,
  - An Individual Provider (IP) employed through the Consumer Directed Employer (CDE) contracted provider for Washington state, Consumer Direct of Washington (CDWA), or
  - A Home Care Agency provider.
- For Residential,
  - An adult family home (AFH), or
  - A licensed assisted living facility (ALF) which includes:
    - Assisted Living (AL),
    - Enhanced Adult Residential Care (EARC), or
    - Adult Residential Care (ARC).

If the client chooses an IP,

- The IP is an employee of the CDE,
- The client will work with the CDE and the IP on assignment of the client's authorized in-home hours,
- The client will be the one to select, schedule, supervise, direct, and dismiss the IP.
  - If a client is unable to provide supervision, an alternate supervisor must be identified in the CARE plan.

- The client is responsible for identifying back-up caregivers to cover sick or vacationing caregivers.
- If a client wants training on how to select, direct, or dismiss an in-home caregiver, they may request training materials at any time from their case manager or the CDE. See Caregiver Management Training for more information.

– See LTC Manual, Chapter 11 – Consumer Directed Employer for more information on CDE.

CDE contact numbers dedicated specifically to CM, Client, or IP:

For Case Managers *only*:	For Clients and IPs:
Phone number: 1-866-932-6468	Phone number: 1-866-214-9899
	Email: infocdwa@consumerdirectcare.com

In-Home Providers

– Individual Providers (IPs):
  - Meet the qualifications listed in WAC 388-115-0510;
  - Are hired and employed by the CDE;
  - Must have:
    - Successfully passed the appropriate criminal background check(s);
    - Met all training and certification requirements; ***and***
  - Must be:
    - Age 18 or older;
    - Able to legally work in the United States; ***and***
  - Are regulated under WAC 388-71-0500 through 388-71-1006, and Revised Code of Washington (RCW) 74.39A.250.

Use Carina or the CDE to help clients locate IPs.

– Home Care Agency providers:
  - Must have a current Department of Health (DOH) license;
  - Must have a current Contract with DSHS or AAA; ***and***
  - Are regulated under Chapter 70.127 RCW, and Chapter 246-335 WAC.

In-home providers can only be paid once for the same hour/unit of personal care service, even when providing services in a multi-client household.

Residential Providers

– See LTC Manual, Chapter 8 – Residential Services
– Assisted Living (AL), Adult Residential Care (ARC), and Enhanced Adult Residential Care (EARC) must have a current:
  - ALF License under Chapter 18.20 RCW, and Chapter 388-78A WAC; ***and***
  - Contract with DSHS under Chapter 388-110 WAC.
– Adult Family Homes (AFH) must have a current:
  - AFH License under Chapter 70.128 RCW and Chapter 388-76 WAC;
  - Contract with DSHS; ***and a***
  - Specialty designation, if needed, based on the needs of the client.

Requesting funding from the Managed Care Organization (MCO) for Behavioral Health Wraparound Support (BHWS) or Community Behavioral Health Support (CBHS) service

For Behavioral Health Wraparound Support (BHWS) information and eligibility criteria, please see Chapter 22a – Apple Health Managed Care and Apple Health Medicare Connect (D-SNP).
For Community Behavioral Health Support (CBHS) information and eligibility criteria, please see Chapter 22d – Community Behavioral Health Supports (CBHS).

In-Home Personal Care Services Outside Washington

Per WAC 388-106-0035, a client may receive personal care services from an Individual Provider (IP) employed through the CDE while temporarily traveling out of the state for **less than 30 days**.

All the following must be completed in order for out-of-state in-home personal care to be received and paid for:

1. Prior to the client leaving Washington, the case manager must:
    - Discuss with the client and/or client representative how the client's personal care needs will be met while the client is traveling out-of-state;
    - Obtain the temporary out-of-state address and phone contact;
    - Document in a SER note the conversation including the client's departure date and return date; and
    - Update the Client Details on the Contact Details screen in CARE to reflect the client's Washington address and phone contact **as well as** the temporary out-of-state address and phone contact(s);
2. Client's CARE plan must be in "current" status and services are authorized in the client's service plan prior to departure.
    - Out-of-state services are strictly for client's personal care and must not include provider's travel time or expenses.
    - The IP must be in good standing with the CDE and have met all required qualifications.
    - All other authorized services, except Wellness Education (if the client's CFC eligibility is through COPES), need to be closed while client is out-of-state.
3. Personal Care services must only be provided in the United States.
4. The client must also advise the CDE of the dates they will be out-of-state, and that the IP (employed through the CDE) will be with them. The IP should also notify the CDE.

Personal Care services are not allowed outside the United States.

If the client requests to receive personal care services out-of-state for **more than 30 days**, in addition to the above being completed, the following protocol must be followed:

5. The client must maintain Medicaid eligibility per Health Care Authority (HCA) WAC 182-503-0520 residency requirements;
6. The client must provide in writing to the case manager their intent to return to Washington once the purpose of their absence has been accomplished and provide adequate information of this intent. Written documentation from the client must be added to their case file (electronic case record for HCS/AAA or electronic file for DDA);
7. If the client is eligible for CFC through COPES, they must receive Wellness Education (their ongoing monthly waiver service) while out-of-state, which means the client needs to have their mail forwarded. Wellness Education is not delivered to a temporary address.
8. Advise the Public Benefits Specialist (PBS) via Barcode (HCS/AAA use form 14-443 and DDA use form 15-345) of the following:
    a. The dates the client will be out-of-state,
    b. The client's intention of returning to Washington and that a written document of such was received and placed in their file, and
    c. That the client will continue receiving personal care through CFC and if needed, the COPES ongoing monthly waiver service of Wellness Education.
9. Prior to the client leaving the state, an ETR must be reviewed and approved at the local, regional/AAA level.
    a. ETR Category and ETR Type will be "Other"
    b. Date Range: "Custom"
    c. Start date and End date boxes: will be the dates the client will be out of the state.
    d. Hours/Rate, Units, Quantity section: leave blank as the client will not be eligible for or able to use hours beyond their current CARE plan.
    e. WAC(s) referenced: add 388-106-0035 and 182-503-0520
    f. Request description section: indicate the ETR is for client to receive personal care out-of-state and to allow payment to the CDE (CDWA) for the IP that is also out-of-state beyond 30 days.
    g. Justification for request section: explain/notate the protocol steps listed above (in the less than 30-day section) that have been completed; and confirm that the written document from the client has been filed in the client's case record.
    h. ETR must go through your local office process for final review and approval.
10. During the time out of Washington, the client must not have been determined eligible for Medicaid or state funded health care coverage in another state (other than coverage in another state for incidental or emergency medical care); *and*
11. The client and/or their representative must contact the case manager:
    - *Every* 30 days the client is out of state to confirm that the CARE plan is meeting client's needs; *and*
    - Each contact must be documented in a Monitor Plan SER note.
    - Set a CARE tickler to remind the case manager of the next required check-in.

Note: Steps 5 – 11 are in addition to the four (4) steps noted above.

Relief Care

Relief Care is available only to CFC clients receiving in-home care services. It is a service that allows the client to use alternate providers for personal care when their regular provider of personal care is not available or needs a break.

- This service does not add any hours to the monthly hours generated by CARE. It is an alternate use of the CARE generated hours.
- Pre-planned use of relief care must be noted on the Service Summary by adding the paid relief care provider on the Supports screen under Care Planning in CARE – this will then print on the Service Summary.
- Use of Relief Care for un-planned absences, such as provider illness, does not need to be noted in the Service Summary, but must still be authorized using the correct Relief Care service code (T1019-U2) in ProviderOne (P1).
- Providers for Relief Care are IPs employed through the CDE and Home Care Agencies. For specific qualifications, see Personal Care Service Providers.
- If a relief care provider is in place:
  - Document a relief care provider on the Contact Details screen;
  - Add the relief care provider on the Providers screen; and
  - Assign tasks to the relief care provider on the Supports screen.

Relief Care is authorized separately from standard in-home personal care. On the provider's authorization, Relief Care is authorized using the service code T1019 – U2. See the Social Service Authorization Manual (SSAM) for more information.

Nurse Delegation

Nurse Delegation (ND) services allow Registered Nurses (RNs) to delegate specific nursing tasks to qualified Long-Term Care Workers (LTCW) when:

a) The client's personal care is provided by a registered or certified nursing assistant, or a Certified Home Care Aide who has completed nurse delegation core training; *and*
b) The client's medical condition is considered stable and predictable by the delegating nurse; *and*
c) The specific nursing tasks are provided in compliance with WAC 246-840-930.

See LTC Manual, Chapter 13 – Nurse Delegation for information on the Training and Credentialing Requirements/Responsibilities for LTCW and further specifics related to ND.

NOTE:

- Paid Nurse Delegation allowed for CFC clients receiving care in-home, at a contracted Adult Family Home (AFH), or at a contracted Adult Residential Care (ARC) facility.
- Nurse Delegation is not allowed at Assisted Living (AL) facilities or Enhanced Adult Residential Care (EARC) facilities as these residential facilities are already contracted and paid to provide intermittent nursing services.

ND Service Parameters

- A Registered Nurse Delegator (RND) assesses a client for program suitability and teaches, evaluates competency, and supervises the performance of a LTCW.
- The qualified LTCW performs the delegated nursing task(s) for a client as instructed by the RND.
- These ND tasks may include:
  - Administration of medications;
  - Blood glucose monitoring;
  - Insulin injections;
  - Ostomy care;
  - Simple wound care;
  - Straight catheterization; *or*
  - Other tasks determined appropriate by the delegating nurse.
- Services do not duplicate personal care.

ND Exclusions

- ND tasks may not include:
  - Sterile procedures;
  - Administration of medications by injections, except insulin injections;
  - Maintenance of central intravenous lines; *or*
  - Acts that require nursing judgement.

ND Providers

- Home Health Agency
  - Licensed under Chapter 70.127 RCW.
  - Individual RNs employed by the agency must be licensed under Chapter 18.79 RCW.
- Registered Nurse
  - Licensed under RCW 18.79.040.

Personal Emergency Response System (PERS)

A Personal Emergency Response System (PERS) is an electronic device (console) that enables clients to secure help in an emergency. The client wears an emergency response activator ("help" button), most clients choose a pendant or wrist bracelet "help" button. The console is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

PERS Eligibility

Standard/basic PERS

PERS standard/basic unit using a landline or using wireless technology

- If the service is necessary to enable the client to secure help in the event of an emergency and if the client:
  - Lives alone in their own home; *or*
  - Is alone, in their home, for significant parts of the day and has no regular provider for extended periods of time; *or*
  - No one in the client's home, including the client, can secure help in an emergency.
- See WAC 388-106-0270 subsection 4.

PERS Add-On Services in addition to PERS standard/basic unit

1. PERS add-on service of fall detection if the client:
   - Is eligible for a standard/basic PERS unit; *and*
   - Has a recent documented history of falls.
   - See WAC 388-106-0273 subsection 1.

2. PERS add-on service of Global Positioning System (GPS) tracking device with locator capabilities if the client:
   - Has a recent documented history of short-term memory loss and a recent documented history of wandering with exit seeking behavior; *or*
   - Has a recent documented history of getting lost in familiar surroundings and being unaware of the need or unable to ask for assistance.
   - PERS standard/basic with GPS add-on service is the only PERS service that may be provided in a residential setting.
     - The PERS standard/basic unit and all installation fees are covered by CFC services.
     - The GPS add-on service is paid for using the client's CFC SFY annual limit and is considered Assistive Technology.
     - Residential clients may not access a PERS standard/basic without GPS capabilities.
   - See WAC 388-106-0273 subsection 2.

> For PERS add-on service of GPS: If the client is **under the age of 12**, there must be information presented at the assessment that due to the client's disability, the support provided for memory or decision making is greater than is typical for a person of their age.

3. PERS add-on service of a medication reminder management system if the client:
   - Is eligible for a standard/basic PERS unit; *and*
   - Does not have a caregiver available to provide the medication management service; *and*
   - Is able to use the medication reminder system to independently take their medications.
   - See WAC 388-106-0273 subsection 3.

PERS Services

Standard/basic PERS

The standard/basic PERS unit is a covered service under CFC. It is not considered CFC Assistive Technology (AT), and its monthly fees are not considered when calculating how much of the client's CFC state fiscal year (SFY) annual limit is to be used.

- The standard/basic PERS unit includes the base device (console) that is connected through a landline or a cellular/wireless/mobile phone line and is programmed to signal a response center once the "help" button is activated by the client.
- Installation and maintenance of the standard/basic PERS unit is included in the PERS service under CFC and is not considered when calculating how much of the client's CFC SFY annual limit is to be used.

PERS Add-On Services

PERS add-on services to the standard/basic PERS unit are considered CFC AT and include:

- Fall detection units
- GPS units
- Medication Reminder Management systems

> If a client needs/wants and qualifies for a PERS add-on service, the PERS add-on service is an add-on to a PERS standard/basic unit which the client must also want. PERS add-on services are NOT standalone options. There are other one-time purchase CFC AT options for a medication reminder management system if the client does not want, will not use, or does not qualify for a PERS standard/basic unit but needs/wants a medication reminder management system.

The monthly fee for a PERS add-on service is paid with the client's CFC SFY annual limit of $550.

- If the PERS add-on service(s) monthly fees for the state fiscal year (July 1st through June 30th) exceed the CFC state fiscal year (SFY) annual limit of $550, an "Exceed CFC Annual Service Limit" ETR is needed.
- Only for PERS add-on services is the ETR reviewed/approved at the local level from the designated authority to cover the cost of the PERS add-on service for the full state fiscal year (July 1st through June 30th).
- If there are only a few months left in the state fiscal year, the service may be authorized for the remainder of the fiscal year and an ETR would need to be requested, in late June or early July, for the following SFY if the total cost of the PERS add-on service amount for twelve months (that fiscal year) exceeds $550.00.

Any installation fee for a PERS add-on service is included in the PERS service under CFC and is not considered when calculating how much of the client's CFC SFY annual limit is to be used.

PERS Equipment

- Emergency response activator ("help" button)
  - Must be able to be activated by breath, by touch, or some other means, and
  - Must be usable by persons who are visually or hearing impaired or physically disabled.
- PERS console unit
  - Must not interfere with normal telephone use and may include cordless equipment (cellular/wireless phone) that does not require a telephone landline.
  - Must be capable of operating without external power during a power failure at the participant's home in accordance with UL or ETL requirements for home health care signaling equipment with stand-by capability.
- The PERS provider, according to their contract, must install the PERS system within five (5) business days of the request for service.
- If/when a client is no longer eligible for PERS service,
  - Immediately contact the PERS provider so that they can retrieve their equipment, and
  - Terminate the authorized PERS service(s).

Lost or damaged PERS equipment:

Emergency response activator ("help" button)

- Per their contract, replacement or repair is the responsibility of the PERS provider when required.

PERS console unit

- PERS provider must report any loss to the case manager within two weeks.
- PERS provider must make a good faith effort to recover or repair a lost or damaged console unit.
- Case manager will also attempt to recover the console unit.
- If the console unit cannot be recovered or repaired, documentation of the wholesale cost must be provided by the PERS provider with the request for reimbursement.
- Only **one** replacement console unit is covered under CFC in a client's lifetime.
  - To authorize the **once-in-a-lifetime** replacement PERS console, use service code S5160 PERS Installation to pay for the replacement device.
    - Add an authorization comment indicating the service line is for a replacement device and what the wholesale cost of the console is.
    - Documentation/receipt of the wholesale cost must be submitted to the client's electronic case record (ECR) behind the Social Services Invoice/Receipt Packet Cover Sheet (DSHS 02-615).
- After termination of services
  - Reimbursement request from PERS provider must be submitted within 30 days of the termination notice.
  - Reimbursement must be paid using the last date of service on the PERS authorization.

- After death of client
  - Reimbursement for lost equipment is *not* permitted.

PERS Providers

- PERS providers are contracted by the AAA.
  - Each local AAA maintains a list of eligible contracted PERS providers.
  - The list of eligible contracted PERS providers is used by the local HCS, AAA and DDA staff members for the client's county of residence.
- PERS contracts must list the standard/basic PERS rate and the PERS add-on service rates separately.
  - The PERS provider must bill for these add-on services separately from the standard/basic PERS unit.
- PERS providers must provide equipment (console and "help" button) approved by the Federal Communications Commission (FCC) and the equipment must meet the Underwriters Laboratories, Inc. (UL) or Electrical Testing Laboratories (ETL) safety standard for home health care signaling equipment. The UL or ETL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard.

Authorizing PERS Services

- Installation fee for the PERS standard/basic unit or add-on service:
  - PERS installation fees are covered as a benefit under CFC and are not applied to the client's CFC SFY annual limit.
  - Use service code S5160.
  - Add a comment on the authorization indicating what the installation is for (i.e., standard/basic unit or which PERS add-on service).
  - The authorized start date for PERS service(s) should be aligned with the date the equipment was installed.
- PERS monthly service fee:
  - PERS standard/basic PERS unit is authorized on one service line.
    - Use service code S5161.
  - PERS add-on service(s) is authorized on a separate service line on the same authorization using the appropriate service code – see below:

Service	P1 Code
PERS Installation Fee	S5160
PERS standard/basic unit	S5161
– Fall Detection Add-on to PERS (Assistive Tech)	S5161 – U1
– GPS Add-on to PERS (Assistive Tech)	S5161 – U2
– Medication System Add-on to PERS (Assistive Tech)	S5161 – U3

  - Only the monthly fee for the PERS add-on service is considered Assistive Technology and is applied to the client's CFC SFY annual limit.

- Once authorized in P1, the PERS add-on service fees will be automatically added to the Budget Calculator screen under Client Details in CARE to help track the expenditures purchased from the SFY annual limit. The case manager will add comments to the Budget Details indicating what type of PERS add-on service was authorized along with any other helpful details.
  - The monthly cost of the PERS add-on service is multiplied by the number of months it will be used, and the total cost will be deducted from the client's CFC SFY annual limit.

    Example of authorization mid-SFY:

    The client received a PERS unit in *January 2026* and will have the unit indefinitely.
    - Standard/basic PERS unit and a GPS add-on service of $20 per month.
    - $20/month multiplied by the # of months left in the fiscal year (in this example, 6 months including January, the PERS unit start month) = $120 of the CFC SFY annual limit will be added to the Budget Calculator for the SFY July 1st, 2025 through June 30th, 2026.

- PERS authorizations do not automatically renew:
  - At the client's next face-to-face assessment, determine/confirm the client still meets eligibility for the PERS service(s) and still would like to receive the PERS service(s).
  - Having confirmed the client's continued need/want and eligibility for the PERS service(s), after the assessment is moved to current, the authorization to the PERS provider can be extended for the new CARE plan year.
- PERS replacement console unit:
  - Only one replacement is covered under CFC in a client's lifetime.
  - To authorize the **once-in-a-lifetime** replacement PERS console:
    - Use service code S5160 PERS Installation to pay for the replacement console,
    - Rate is the wholesale cost of the console,
      - See PERS Equipment section for more information about obtaining documentation of the wholesale cost of the console.
    - Add an authorization comment indicating the service line is for a replacement console.
  - Documentation/receipt of the wholesale cost of the console must be submitted to the client's file to justify payment of the replacement console.
    - For HCS/AAA, submit to the client's electronic case record (ECR) behind the Social Services Invoice/Receipt Packet Cover Sheet (DSHS 02-615).
    - For DDA, upload documents to client's electronic file in the RMT.

Note: When a client moves from an in-home setting to a residential setting (e.g., AFH, ALF, or Supported Living) and does not meet the requirements for a PERS unit in a residential facility, the case manager must contact the PERS provider, ensure all the PERS equipment is returned to the provider, and terminate the PERS payment authorization. If the equipment is lost or damaged, the case manager will need to follow the procedures for "Lost or damaged PERS equipment" as outlined in this chapter, under PERS Equipment section.

PERS Exclusions and Limits

- Authorization of a PERS add-on service (fall detection, GPS, or medication reminder management system) without a PERS standard/basic unit.
    - NOTE: A PERS add-on service of medication reminder management system by itself cannot be authorized when a client does not qualify for or does not need/want a PERS standard/basic unit
    - If the client only needs a medication reminder management system and NOT a PERS standard/basic unit, then make a one-time purchase of a medication reminder management system from an AT contracted provider.
    - There are many different medication reminder systems out there as one-time purchases that can meet a client's person-centered specific need.
      For example:
        - If they just need reminders to take insulin or have one pill to remember when the caregiver is gone, something like a Reminder Rosie 2.0 Voice Controlled Alarm Clock or single pill bottle reminder cap/lid may work;
        - If their need is for a locked medi-set with reminders.
- Authorization of a PERS add-on service when a client is not eligible for and/or does not want or need a standard/basic unit.
- A PERS standard/basic unit that does not include a GPS add-on service may not be paid for through CFC in a residential setting.
- Services not covered under the PERS service contract.
- 24-hour nurse triage call center/nurse hotline services are not covered.
- Electronic device or system enhancements that monitor blood pressure, blood glucose levels, weight, etc. (e.g., Tele Health, Well Being monitor) are not covered.

CFC State Fiscal Year (SFY) Annual AT/SAT Limit

Each client enrolled in CFC has a CFC state fiscal year (SFY) annual limit of $550 to purchase and receive eligible Assistive Technology (AT) and Skills Acquisition Training (SAT) hours.

- This is a combined total of all purchases for AT (Goods and/or Services) and/or SAT hours.
- This limit applies only to the SAT hours not obtained using the client's eligible personal care hours.

The annual limit follows the state's fiscal year (July 1st through June 30th). This limit:

- Does not coincide with the client's CARE plan year.
- Does not reset when clients have another assessment (i.e., significant change) during the year.
- Is not pro-rated based on when services start (e.g., CFC clients starting services in April 2026 have $550, the same amount as clients having started CFC services in July 2025).
- Resets once per state fiscal year for each client on July 1st.
  - In June of each year, case managers will receive **one** tickler on their Tickler list stating "Budget Calculator will start a new budget line for the new state fiscal year beginning July 1", as a reminder that **all** their CFC clients will begin a new budget line for the next following state fiscal year.

Unused funds from a client's CFC SFY annual limit do not carry over or accumulate from year to year; they cannot be combined with funds from previous state fiscal years.

A documented need exceeds CFC SFY annual limit

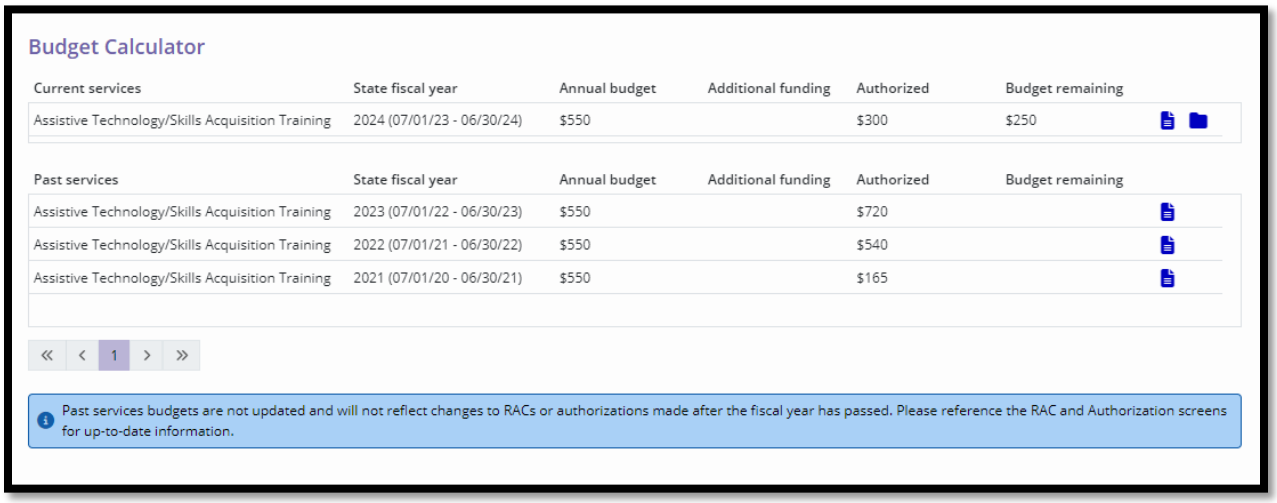
If the CFC client's need for an AT Good, AT Service, or SAT purchased hours, as documented on their individualized CARE plan, exceeds the CFC SFY annual limit (or remaining balance), the case manager may use the "Exceed CFC Annual Service Limit" ETR process to request the amount beyond the client's CFC SFY annual limit.

- ETR approval authority for "Exceed CFC Annual Service Limit" ETR request for an AT Good, AT Service, or SAT purchased hours:
  - For HCS/AAA, after the ETR goes through the initial review of your office, it will be sent to the CFC Program Manager at HCS Headquarters (HQ) for final review and decision making.
  - For DDA, the ETR is sent for review to the CFC Specialists in the regions, and then final decision making by the DDA CFC AT, ETR Committee at DDA HQ.
- As the CFC annual limit is based on the fiscal year, ETRs expire on June 30th every year. If your ETR is for an ongoing service (i.e., PERS add-on service), a new "Exceed CFC Annual Service Limit" ETR will need to be submitted and approved before July 1st.

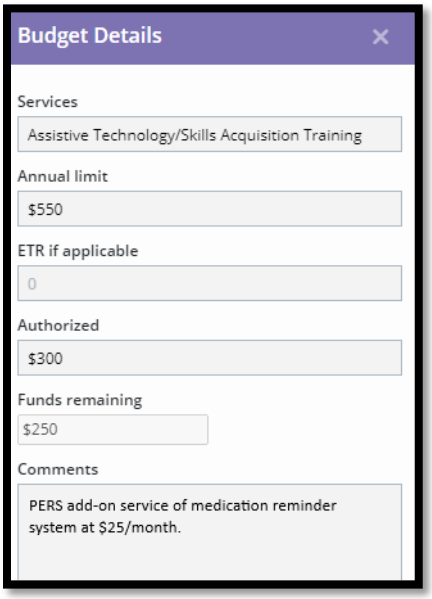
NOTE: For PERS add-on service fees that exceed a client's CFC SFY annual limit only, these "Exceed CFC Annual Service Limit" ETRs are **locally** reviewed and approved in your office.

Budget Calculator

The Budget Calculator is used to record AT Goods, AT Services, and SAT hours purchased/paid with the client's CFC SFY annual limit during that SFY. It also helps to monitor the amount that has been used for that SFY, what the client has purchased, and the remaining budget.



- Once AT Goods, AT Services, or SAT hours purchased are authorized in P1, the authorized amount will be automatically added to the SFY on the Budget Calculator.
- The case manager will make comments on the Budget Details indicating what AT Good, AT Service, or how many SAT hours were purchased along with any other helpful details.
    - Select the "Document" icon on the right side of the SFY line 
    - A Budget Details box will open where comments can be added

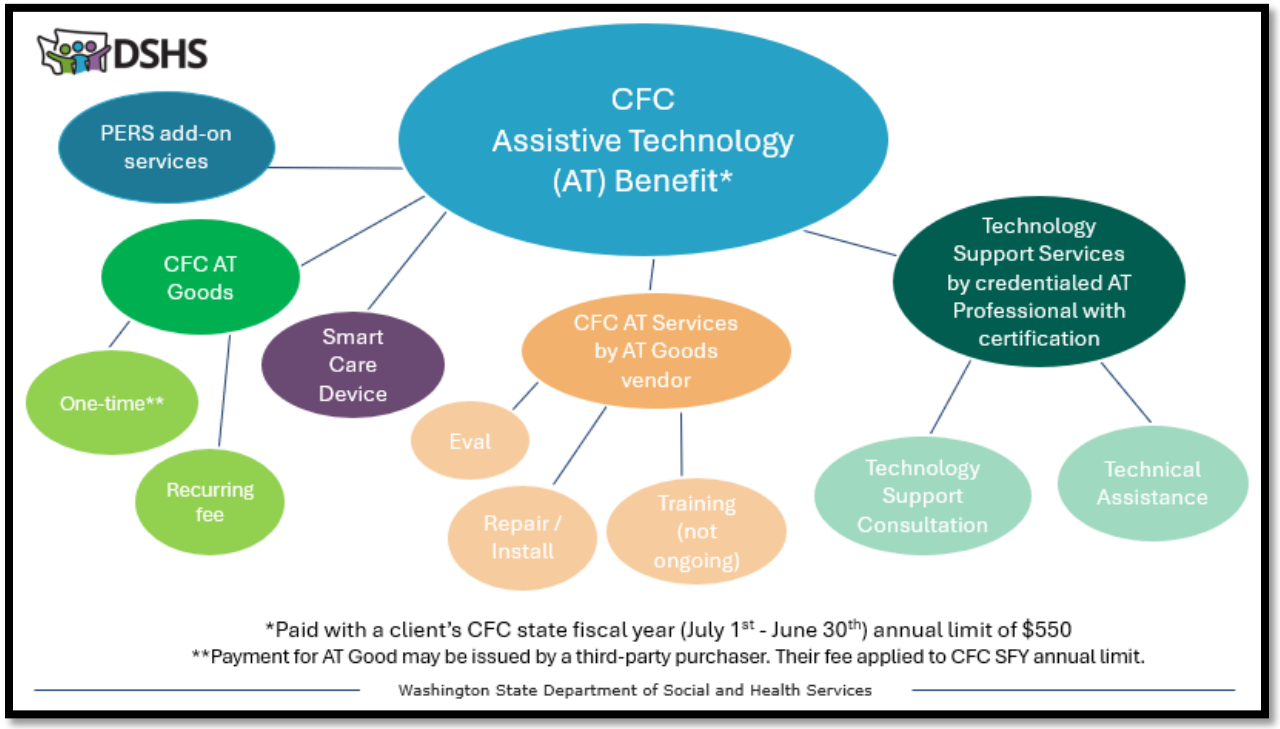


CFC SFY Annual Limit Exclusions and Limits

- Purchases must follow the guidelines provided for that benefit. See Assistive Technology (AT) and Skills Acquisition Training (SAT) benefit sections.
- Funding from the client's CFC SFY annual limit cannot be used to supplement the rate paid by Medicare or Medicaid for a purchase.
- If the AT Good or AT Service is covered by Medicare, Medicaid, or any other third-party payment source, a denial must be obtained for the item or service prior to payment from CFC or other social service program.
    - Exempted trust funds are not considered a third-party payment source, and clients must not be required to use these funds prior to using state or federal funding.

Assistive Technology (AT) benefit

CFC Assistive Technology (AT) benefit includes AT Goods and AT Services.



AT Goods and AT Services must be:

1. In response to an assessed and documented need in the client's assessment and agreed to by the Client;
2. Authorized by the case manager to be implemented as part of and in accordance with a client's service plan;

3. Within the coverage and any specific parameters of the client's eligible program; and
4. Not covered by Medicare, Apple Health, other insurances, or resources.

The cost of AT Goods and the fee for AT Services are both part of the client's CFC AT benefit and are applied to the client's CFC SFY annual limit of $550, which is based on the state fiscal year (July 1st through June 30th).

CFC AT Goods are adaptive/assistive items, devices, or equipment that increase a client's independence or substitutes for human assistance with an ADL, IADL, or health-related task. Exclusions and limitations of CFC AT Goods are listed below. CFC AT Goods may include a one-time purchase or an approved AT Good that has a recurring fee such as a Smart Care Device.

A *Smart Care Device* is an artificial-intelligence (AI) device that interacts and engages with a client to provide support through proactive suggestions, reminders for ADL and IADL tasks, health-related activities, and accessing their community. Smart Care Devices also provide onscreen instructions to interact in a way that makes it personalized and natural.

- For the Smart Care Device, an in-home client may be eligible if they:
  - Are 18 years old or older,
  - Are able to effectively use the Smart Care Device – able to hear and see the device, and speak and understand English (no other languages are currently available),
  - Have Wi-Fi internet service,
  - Choose to use and consent to this Smart Care Device, and
  - Have an unmet need for an ADL, IADL, or health-related task that can be met by a reminder set through the Smart Care Device.
    Some examples may include reminders for the client to:
    - Take medications
    - Attend a healthcare appointment
    - Brush teeth
    - Change clothes
    - Eat at a specified time
    - Take a shower

CFC AT Services may include:

- A written evaluation of what AT Good would best meet the client's need. The client's need must be determined and documented by the case manager in the service plan. The Contractor will evaluate what specific AT Good would best meet that need.
- Installation of a purchased AT Good (does not include any home modifications).
- Repair of an AT Good.
- Training for the client and their caregivers on how to use and maintain the purchased AT Good that is:
  - Expected to achieve outcomes documented in the client's service plan;
  - Competent and relevant to the client's culture;

- Delivered in a manner and format that is individually tailored to the client's abilities, strengths, and learning styles; and
- Designed to be outcome based and measurable.

– Technology Support Consultation and Technical Assistance provided by a contracted Assistive Technology Professional (ATP) who meets the specific training and certification requirements.
  - Technology Support Consultation is an evaluation of the client's environment and abilities to make recommendations of appropriate AT to help a client be more independent or substitute for human assistance with an ADL, IADL, or health-related task.
  - Technical Assistance is tailored training and/or technical support provided to the client to ensure they can use the AT Good to meet their needs. A client will receive skill building on how to use the AT Good and incorporate its use into their daily life to assist them to be more independent or to substitute for human assistance with an ADL, IADL, or health-related task.

NOTE: A client's Medicaid Apple Health must be used first or exhausted for any covered evaluation or training available, for example those services provided by a Physical Therapist (PT), Occupational Therapist (OT), or Speech Therapist/Speech-Language Pathologist (SLP).

CFC AT Goods and AT Services are based on the assessed needs of the client. Before authorizing AT Goods or AT Services:

– To help decide whether to authorize an AT Good and/or what AT Good would be most appropriate and cost-effective to meet the client's need, the client may need to obtain a recommendation from a professional.
  - The professional must:
    - Have knowledge of the client's functional level, either through knowledge of the client or an assessment of the client, *and*
    - Have knowledge that the client is functionally able to use the AT Good and would benefit from its use.
  - The professional could be:
    - The client's primary case manager who knows and has worked with the client; *or*
    - A treating healthcare professional familiar with the client who has examined the client and reviewed the client's medical/healthcare records.

– If the AT Good is something that may be covered by the client's medical benefits through Medicare, Medicaid (Apple Health), or a private insurance carrier, the client may also need a medical provider referral in order to have it covered by the client's medical benefits.

– The case manager will verify that the item is on the CFC Covered Items List and is within the $550 state fiscal year (SFY) annual limit. To determine whether an AT Good is a covered item:
  - Consult the "CFC AT Covered Item List"
    - If the item is on the list, it may be purchased from an AT contracted provider with subcode of AT Goods using CFC.
    - If the item is not on the list and it should be considered for addition to the list, contact your supervisor so that they may request consideration from the CFC Program Management team for HCS/AAA and DDA.

- For HCS/AAA case, an email can be sent to the HCS CFC Program Manager – contact information listed on page 1.
- For DDA case, an email can be sent to the Assistive Technology Program Manager - contact information listed on page 1.

- Confirm the AT Good meets CFC AT parameters:
  - Does it address the client's need; and
  - Is not on the Exclusions and Limits of CFC AT Goods list (described below).
- To help determine if the requested item meets CFC AT Goods parameters, ask yourself:
  - What is the need that is being addressed?
  - Is this item adaptive or assistive? Such as a speech app for a non-verbal client to communicate their needs to their caregiver.
  - Will this item be:
    - Helping the client be more independent with an ADL, IADL or health-related task? For example, use of a long-handled shoehorn so the client can put on their own shoes. **OR**
    - Substituting for a caregiver needing to do the task? For example, a CPAP cleaning machine where the caregiver can do other tasks instead of cleaning the CPAP mask/gear.

– For DDA – The case resource manager may use the CFC AT Covered Item list for ideas of what is approvable, and if there is a question about what can be approved for a particular client's need staff with your supervisor or CFC Specialist.

Examples of CFC AT Goods

– Devices that automatically turn off appliances if there is no motion detected within a specific timeframe.
– Devices that enhance sound or allow a non-verbal client to achieve communication.
– Speech to text software; communication apps.
– PERS add-on services:
  - Fall detection
  - GPS
  - Medication reminder management system.
    - Clients must be able to take their medications independently once they are reminded to take the medications and/or once the medications are dispensed.
– Devices that magnify or read and speak small print to enable the reader to read things such as medication labels and care instructions.
– Portable computing devices (tablet or laptop) – **base model level only** – that can increase an individual's independence or substitute for human assistance or allow a client to access tele-health appointments or remote services from a paid provider.

Exclusions and Limits of CFC AT Goods

– Any item that is covered under any other payment source, including but not limited to Medicare, Medicaid (Apple Health), and private insurance.

    - Medicare, Medicaid, or any other third-party payment source must deny payment for the item if the item is covered under one of these sources, prior to payment from CFC.
- Items provided without an assessed need or without an authorization by the case manager.
- Client choice of AT is limited to the most cost-effective option that meets the client's needs.
- Duplicate services to meet the same need are not allowed.
- Replacement of an AT Good or similar item with the same function is limited to once every two years.
- Any items that are solely for recreational purposes.
- Subscriptions, internet service, Wi-Fi internet service, phone service, or data plans are not covered.
- Portable computing device purchases are **base model level only**.
    - Additions to basic model portable computing devices such as added memory or storage, mobile wireless capabilities (cellular), data, and accessories such as decorative cases/covers/coatings are not covered.
    - Clients may use private funds to purchase additional memory or capabilities.
- Smart Care Devices are not available for clients in residential settings.
- Examples of items not covered under CFC AT:
    - Durable Medical Equipment (DME);
    - Specialized Medical Equipment (SME);
    - Specialized Equipment and Supplies (SES);
    - General use clothing or shoes that are not adaptive, such as slip-on shoes, and items which are considered medically necessary, including but not limited to compression socks/stockings and orthotics, that are covered by Medicaid Apple Health or another resource;
    - Environmental Modification;
    - Appliance locks that prevent access to food;
    - Hearing aids;
    - Prescription eyeglasses;
    - Reading glasses; or
    - Video surveillance or recording of client.

Exclusions and Limits of CFC AT Services

- Any service that is covered under any other payment source, including but not limited to Medicare, Medicaid (Apple Health), private insurance, waiver program, school, or other resources.

Process to obtain AT Goods and AT Services

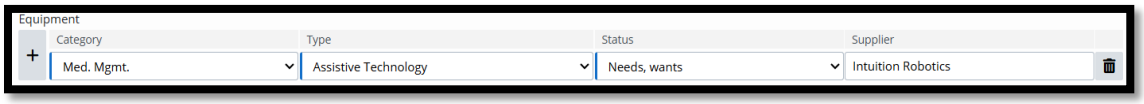
Documenting client's need for their CFC AT benefit

The Centers for Medicare and Medicaid Services (CMS) will only pay for CFC AT Goods and AT Services when there is a documented need that the benefit service will address in a client's current CARE assessment.

- AT Goods and Smart Care Device
  - For HCS/AAA, add the AT Good in the Equipment box on the most appropriate CARE screen. If necessary, complete an Interim assessment to add the client's need.

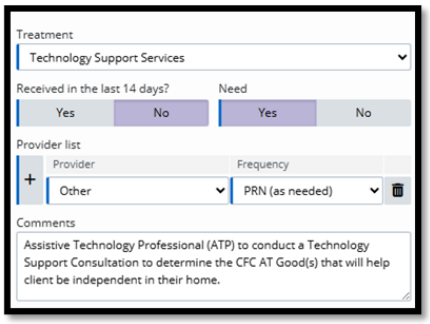
    Example: If the AT Good is to help a client be independent with putting on their shoes and needs/wants a long-handled shoehorn. Document the AT Good on the Dressing screen by selecting the "Assistive Technology" Type in the Equipment box with "needs/wants" as Status – this will pull the need to the Supports screen and can be assigned to the contracted AT provider. Add a comment on the Dressing screen specifying the AT Good is a long-handled shoehorn.

    Example for Smart Care Device reflecting need for medication reminders:

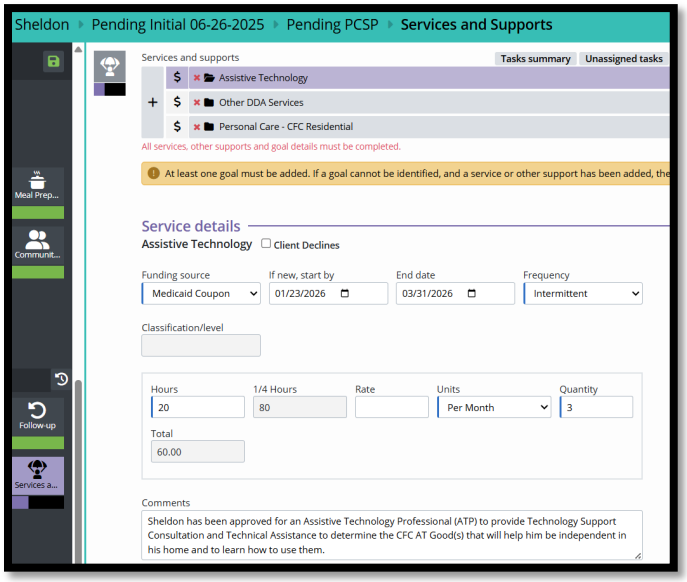
    

  - For DDA, provide a description and explanation of the AT Good and how it will increase the individual's independence or substitute for human assistance with specific ADLs and/or IADLs or health-related tasks in the Person-Centered Service Plan (PCSP) comment box.

- AT Services
  - AT Services by a contracted AT provider (who is likely the provider selling the AT Good):
    - Select "Programs: Other" on the Medical screen under the Treatments table.
    - Choose "Other" for the Provider field.
    - In the comments section, add what AT Service (an evaluation, installation, repair, or training) is being requested.
  - Technology Support Consultation and Technical Assistance by a contracted Assistive Technology Professional (ATP) who is credentialed and certified:
    - For HCS/AAA:
      - Select "Technology Support Services" on the Medical screen under the Treatments table.
      - In the Provider field, choose "Other".
      - Add a comment explaining the Technology Support Consultation and Technical Assistance needed, such as what the ATP will provide training and assistance with.
      - Example screenshot below:



- For DDA: On the Services and Supports screen of the Person-Centered Service Plan (PCSP), add "Assistive Technology", the specific details and comments explaining Technology Support Consultation and Technical Assistance is needed.
  - Example screenshot below:



Using a contracted Provider

AT Goods can be purchased from an AT contracted provider with the AT Goods subcode or a third-party purchaser may issue payment for an eligible AT Good.

Smart Care Device can be obtained from a contracted Smart Care Device Provider.

AT Services can be obtained by an AT contracted provider with the AT Services subcode.

Technology Support Consultation and Technical Assistance can be provided by a contracted, credentialed, and certified Assistive Technology Professional (ATP).

AT contracted providers and contract information

Providers for: **Assistive Technology Goods:**

- Assistive Technology Goods Provider
  - A legal manufacturer, retail establishment, or wholesale distributor of AT Goods.
  - List of AT Goods contracted providers with the appropriate subcode/provider type on the CFC AT Providers list.
  - Contract Information
    - Contract Name – Assistive Technology
    - Contract Code – 1811XP-12
    - Subcode – 1817SS: Assistive Technology Goods
    - Taxonomy – 225CA0ATPL: Assistive Technology
    - Headquarters contract
  - NOTES:
    - Not all items AT contracted providers sell are eligible AT Goods.
    - Please consult with the AT contracted provider to determine if they sell the AT Good you are seeking – for example, an AT contracted provider who sells non-medical or medical devices such as a long-handled shoehorn or hand-held shower head does not sell tablets.
    - Please do not ask the AT contracted provider to sell something they do not carry in their inventory.

- Third-party Purchaser to issue payment of an approved AT Good
  - For HCS/AAA:
    - A contracted CCG may be used to issue the payment to purchase the AT Good *only*, meaning without the client, and just for the purchase transaction.
    - Under CFC AT, a CCG cannot provide other services aside from issuing the payment to purchase the AT Good. They cannot "shop" for the item or deliver it.
    - The local AAA office in your area will have a list of CCG providers that serve your client's county of residence
      - Select a CCG who meets the qualifications and has chosen to be a purchaser as indicated by the Purchasing Subcode 1081SS [taxonomy: Non-medical Equipment and Supplies (33NM00000L)] on their Community Choice Guiding contract (1071XP).
    - When using a CCG to purchase an AT Good, please note the CCG will be reimbursed for the actual cost of the CFC AT Good (SA075-U1 – CFC AT) plus the fee to issue the payment (SA266 – 4 units at $10/unit). Both amounts will be applied to the client's CFC SFY annual limit of $550 and is subject to an approved "Exceed CFC Annual Service Limit" ETR if necessary.
  - For DDA:
    - A contracted Purchasing Goods and Services (PG&S) provider may be used to purchase the AT Good and/or coordinate an AT Service.

- The case resource manager (CRM) must review the Agency Contracts Database (ACD) to confirm the provider has a Purchasing Goods and Services contract in "signed" status.
- The PG&S provider can be reimbursed $10 per unit (15 minute increments), for a range of 1 unit to 4 units, for time spent purchasing the item(s), or coordinating services, or issuing payment (SA266-U1 – maximum of 4 units at $10/unit); and reimbursed for the actual amount spent on purchasing the CFC AT Good (SA075-U1 – CFC AT).
- A PG&S provider is the most cost-effective contracted provider to use.

– Smart Care Device
  - Current Contracted Provider
    - Provider Name – Intuition Robotics
    - P1 Provider ID: 231915701
  - Contract Information
    - Contract Name – Remote Assistive Technology Provider
    - Contract Code – 1085XS-12
    - Taxonomy – 246ZRATP0L: Remote Assistive Technology Provider
    - Headquarters contract

Providers for **Assistive Technology Services:**

– Assistive Technology Services Practitioner
  - These AT Services by an AT Service Practitioner provider, who is usually the provider who sold the AT Good from their retail establishment, are one-time services (evaluation, repair/install, or training).

    For example, a high-definition portable magnifier was purchased as CFC AT from the AT contracted provider Vision Matters. The magnifier breaks. Vision Matters is consulted; the break is something that can be repaired and the cost of a repair is more cost-effective. Vision Matters would be authorized for the AT Service of repair.
  - List of AT Services contracted providers with the appropriate subcode/provider type on the CFC AT Providers list.
  - Contract Information
    - Contract Name – Assistive Technology
    - Contract Code – 1811XP-12
    - Subcode – 1816SS: Assistive Technology Services
    - Taxonomy – 225CA2400X: AT Practitioner
    - Headquarters contract
  - Not all AT contracted practitioners are able to provide all AT Services (evaluation, installation, repair, or training).
    - Please consult with the AT Services provider to determine what services they provide.

        - They may only provide repair, installation, and training on the AT Goods they sell.

- Technology Support Consultation and Technical Assistance by an Assistive Technology Professional (ATP) who meets the specific training and certification requirements.
    - *Technology Support Consultation* is an evaluation of the client's environment and abilities to make recommendations of appropriate AT to help a client be more independent or substitute for human assistance with an ADL, IADL, or health-related task.
    - *Technical Assistance* is tailored training and/or technical support provided to the client to ensure they can use the AT Good to meet their needs. A client will receive skill building on how to use the AT Good and incorporate its use into their daily life to assist them to be more independent or to substitute for human assistance with an ADL, IADL, or health-related task.
    - List of contracted ATPs who can provide Technology Support Consultation and Technical Assistance are located on the Assistive Technology SharePoint site.
    - Contract Information
        - Contract Name – Assistive Tech, VM, and Tech Support Consult
        - Contract Code – 1053XP-12
        - Subcode – 1082SS: Technology Support Consultation
        - Taxonomy – 246Z00000X: Assistive Tech. Specialist

Authorizing CFC AT Goods

- Connect with a contracted provider.
    - When making the request from an AT contracted provider with the AT Goods subcode, please inform the Contractor that the request is for AT Goods. As many of our AT contractors have multiple contracts, this will help them utilize their correct contract.
- Request a written itemized quote:
    - HCS/AAA – If using a CCG, the quote may not reflect their fee to issue payment, but this fee will need to be included in the total cost of the AT Good applied to the limit.
    - DDA – If using a Purchasing Goods and Services provider, the quote should contain:
        - The most appropriate and cost-effective AT Good; and
        - The presumed total cost prior to the items and services being provided.
- After obtaining the written itemized quote, the case manager will review it to ensure it is the most appropriate and cost-effective AT Good to meet the client's documented need in the service plan.
    - The AT contracted provider cannot bill DSHS in excess of its "**usual and customary price"** per Federal regulations. "Usual and customary price" means the price/cost most commonly charged by the AT contracted provider for items sold to the general public.
    - If the quote received seems extraordinary or in excess of a "usual and customary price", the case manager can request a quote from a different AT contracted provider or a contracted third-party purchaser.

    - If you do not know what a "usual and customary price" is of the item, do an internet search for the item to determine a usual cost range.
- The case manager will contact the client:
    - To advise them of the quote and obtain their consent to proceed with the ordering of the AT Good; and
    - If the item is being shipped/delivered by the Contractor, verify the client's correct delivery address, including apartment numbers, etc. This is to help ensure the client receives the requested AT Good and to help prevent the item from being lost or stolen.
- If the quoted amount exceeds the client's CFC SFY annual limit of $550 or the balance the client has remaining, an "Exceed CFC Annual Service Limit" ETR will need to be created and approved before moving to the next step.
    - For HCS/AAA, after the ETR goes through the initial review of your office, it will be sent to the HCS CFC Program Manager at Headquarters (HQ) for final review and decision making.
    - For DDA, the ETR is sent for review to the CFC Specialists in the regions, and for final decision making by the DDA CFC AT, ETR Committee at DDA HQ.
- The case manager will notify the Contractor of the AT Good approval, and
    - If the AT Good is being delivered directly to the client by the Contractor, provide them with the client's correct delivery address; or
    - If allowed by your office/region, the AT Good can be shipped to the case manager who will deliver the AT Good to the client. Follow your office procedures/policy regarding receiving packages and delivery to client.
- Create the authorization to the contracted provider:
    - To pay for the CFC AT Good, use service code SA075-U1.
        - In the Comments section of the authorization, please note what the AT Good is.
    - If a third-party purchaser was used to issue payment of the approved AT Good, add a service line:
        - HCS/AAA: authorize service code SA266: Issuing Payment for AT Good, 4 units at $10/unit for the purchasing transaction to a contracted CCG with a contract subcode of purchasing.
        - DDA: authorize service code SA266-U1 to pay for the Purchasing Goods and Services provider's time spent making the purchase.
    - Place authorization in "Reviewing" status.
    - Once it is confirmed the client received the AT Good and a receipt was received, update the authorization to "Approved" status.
    - Notify the contracted provider that the AT Good can be claimed via ProviderOne.
- Once authorized in P1, the total AT Good purchase amount (with the third-party purchaser fees if used) will be automatically added to the Budget Calculator. The case manager will add comments to the Budget Details indicating what AT Good was purchased along with any other helpful details, and
- To document and justify authorized payments made,
    - For HCS/AAA:

- Submit a Social Services Invoice/Receipt Packet Cover Sheet (DSHS 02-615) to DMS Hotmail with:
  - The receipt/invoice for the AT Good, and
  - Any other supporting documents (i.e., written recommendation or denial letter if one was needed).

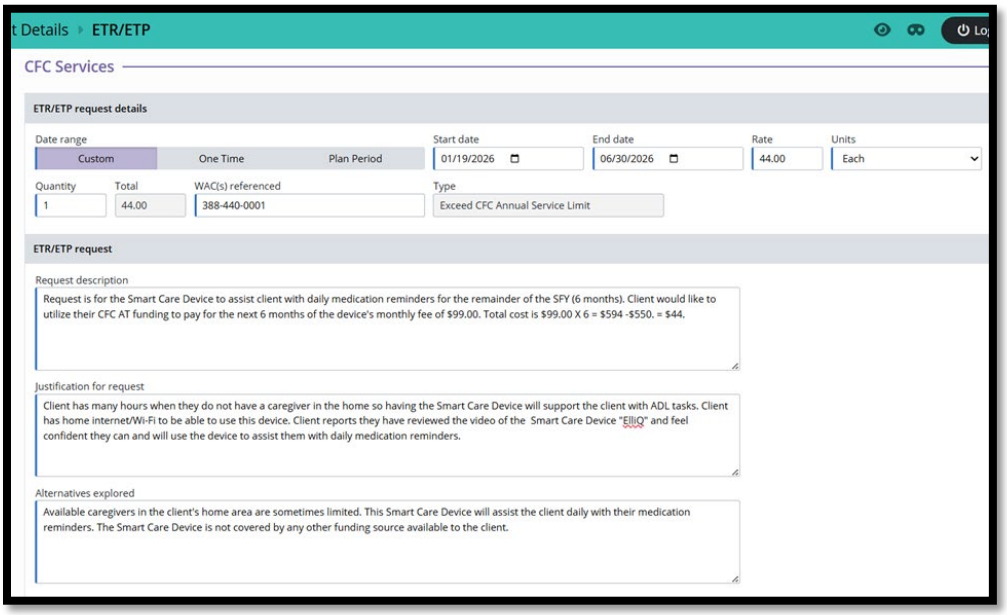
- For DDA:
  - Upload the following in the client's electronic file in RMT:
    - The receipt/invoice for the AT Good, and
    - Any other supporting documents (i.e., written recommendation or denial letter if one was needed).

Authorizing a Smart Care Device

- Create an "Exceed CFC Annual Service Limit" ETR for the Smart Care Device.
  - ETR Category: CFC Services
  - ETR Type: Exceed CFC Annual Service Limit
  - Date Range: Custom, use state fiscal year dates
  - Rate: This is the total amount of the number of months within the state fiscal year (SFY) the Smart Care Device is being authorized multiplied by $99.00/month minus $550 or the balance remaining of the client's CFC SFY annual limit.

    Example: For the entire SFY: 12 months (7/1-6/30) x $99/month = $1188 - $550 = $638 for the ETR amount

    Example screenshot below is for an ETR request for six (6) months of the Smart Care Device beginning 01/19/2026.



- Review and approval process of the "Exceed CFC Annual Service Limit" ETR:
  - Go through your internal office review process.

        - Then the final review and approval will be by Headquarters (HQ).
          The Processing Status of the ETR will be changed to "Pending HQ Approval" and the ETR will be assigned to:
            - For HCS/AAA clients, the HCS CFC Program Manager.
            - For DDA clients, the DDA CFC AT, ETR Committee.
- Make a referral for the Smart Care Device ElliQ by going to the Washington State DSHS ElliQ Form page to complete the referral form.
    - A confirmation email from Intuition Robotics (the contracted provider who made ElliQ) will be sent to the case manager, prompting the case manager to enter the ProviderOne (P1) authorization.
    - Please ensure the ElliQ device is shipped either to the client's residence or to the case manager's office, addressed to the attention of the case manager for delivery to the client.
- Contact the client to confirm they received the Smart Care Device, that it is connected to their Wi-Fi, and is working for them. Document conversation in a SER, confirming client's receipt of the Smart Care Device.
- Create the authorization to the contracted provider:
    - Provider Name: Intuition Robotics
    - P1 Provider ID: 231915701
    - Service Code: SA077-U2
    - Rate: $99.00 per month
    - **Note**: Authorizations for monthly services, like the Smart Care Device, do not require going into "reviewing" status.
- Once authorized in P1, the amount for the Smart Care Device will be automatically added to the Budget Calculator according to the associated state fiscal year.
    - The case manager will add:
        - The ETR amount in the "additional funding" column of the Budget Calculator which will reflect $0.00 (and not a red negative amount) in the budget remaining column; and
        - Comments to the Budget Details indicating this is for the Smart Care Device.

Authorizing CFC AT Services

- Connect with an AT contracted provider with the subcode of AT Services and request the AT Service.
    - Please inform the Contractor that the request is for AT Services. As many of our AT contractors have multiple contracts, this will help them utilize their correct contract.
    - Please confirm the Contractor can perform the needed AT Service (i.e., maybe they only do evaluations and cannot do installation or repairs).
- After obtaining the written itemized quote for the most appropriate and cost-effective AT Service(s) to meet the client's need, the case manager will review the quote to ensure the scope of the request is appropriate for the AT Service based on the client's individualized assessed need.

- The case manager will contact the client to advise them of the quote and obtain their consent to proceed with the requested AT Service.
- If the quoted amount exceeds the client's CFC SFY annual limit of $550 or the balance the client has remaining, an "Exceed CFC Annual Service Limit" ETR will need to be created and approved before moving to the next step.
    - For HCS/AAA, after the ETR goes through the initial review of your office, it will be sent to the HCS CFC Program Manager at Headquarters (HQ) for final review and decision making.
    - For DDA, the ETR is sent for review to the CFC Specialists in the regions, and then final decision making by the DDA CFC AT, ETR Committee at DDA HQ.
- The case manager will notify the Contractor of the AT Service approval, inquire as to when the AT Service will be done, and remind them of any documents they may need to send you, i.e., written evaluation.
- Create the authorization to the contracted provider using the applicable service code:
    - SA636-U1 – Assistive Technology Services Evaluation
    - SA636-U2 – Assistive Technology Services Installation/Repair

      Note: For the AT Service of Repairs to an AT Good, the AT Contractor must have both subcodes (AT Goods and AT Services) in their contract because the fee for coordination and arrangement of the repair is authorized with SA636-U2, and the reimbursement for the repair is authorized with SA075-U1. Reimbursement can only occur after confirmation that the client received the repaired AT Good and the case manager receives the original receipt for repairs made.
    - SA636-U3 – Assistive Technology Services Training
    - The rate is $60 per AT Service.
- Upon delivery of the AT Service, the Contractor must submit a final invoice/receipt and any applicable documents (i.e., written evaluation or training plan).
- After the final invoice/receipt is received, the case manager will contact the client to verify the AT Service(s) were received as authorized.
    - For AT evaluation, the AT Contractor will have also sent a written evaluation of what AT Good would best meet the client's need.
        - If this AT contracted provider has an AT Goods subcode and will be the provider of the AT Good, please obtain that written itemized quote as well.
        - If another contracted provider is used, go through the process of obtaining the AT Good.
    - For AT training, the AT Contractor may have sent a written document of the training with expected and achieved outcomes.
- After receiving confirmation that the client received the AT Service, the case manager changes the authorization from "Reviewing" to "Approved" status.
- Once authorized in P1, the total AT Service amount will be automatically added to the Budget Calculator. The case manager will add comments to the Budget Details indicating what AT Service was purchased along with any other helpful details, and
- To document and justify authorized payments made,

- For HCS/AAA:
  - Submit a Social Services Invoice/Receipt Packet Cover Sheet (DSHS 02-615) to DMS Hotmail with:
    - The receipt/invoice for the AT Service, and:
    - Tor an AT evaluation, include the written evaluation of what AT Good would best meet the client's need;
    - For an AT installation, any supporting documents;
    - For an AT repair, include the original receipt for repairs made to the AT Good;
    - For AT training, any supporting documents regarding the training expectations and achieved outcomes.
- For DDA:
  - Upload the following in the client's electronic file in RMT:
    - The receipt/invoice for the AT Service, and:
    - For an AT evaluation, include the written evaluation of what AT Good would best meet the client's need;
    - For an AT installation, any supporting documents;
    - For an AT repair, include the original receipt for repairs made to the AT Good;
    - For AT training, any supporting documents regarding the training expectations and achieved outcomes.

Authorizing Technology Support Consultation and Technical Assistance

After documenting the client's need in CARE and obtaining client consent for this service, the case manager will:

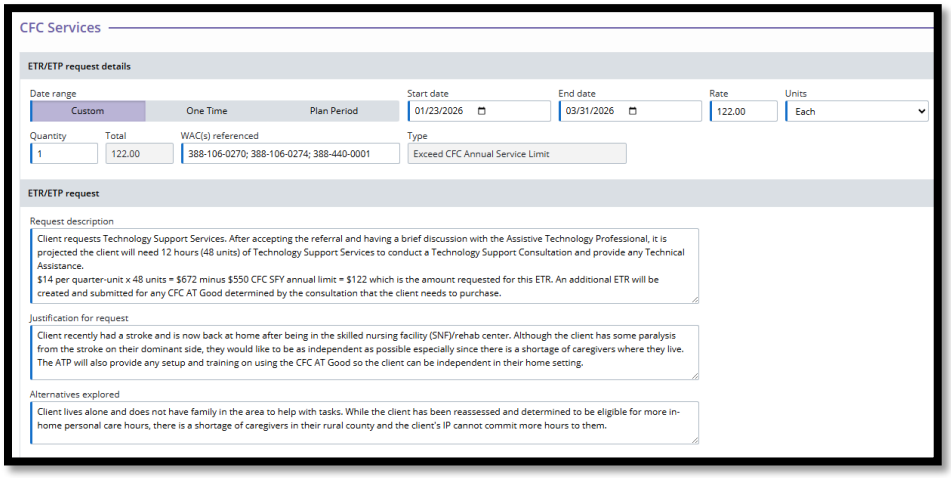
- Connect with a contracted Assistive Technology Professional (ATP) and provide the following information:
  - Client's name
  - Client's ProviderOne (P1) ID
  - Client's confirmed current residence address
  - Client's phone number, and
  - Description of the request and the client's need:
    - What is being asked of the ATP – a Technology Support Consultation or Technical Assistance.
    - What is the intended result, some examples are:
      - Training on the use of an AT Good already purchased
      - Evaluate what items would help the client be more independent with the ADL of dressing.
- Once the ATP accepts the referral, create the P1 payment authorization in CARE.
  - Service Code: H2014, U9
  - **NOTES:**

- Maximum of 80 units/per calendar month for 3 calendar months (not 90 days).
- The total units for the Technology Support Consultation and Technical Assistance and the cost of any CFC AT Good are applied to the client's CFC SFY annual limit or the client's remaining balance for the SFY.

– For a Technology Support Consultation,
  - The ATP will send written recommendations to the referring case manager after the ATP has the consultation with the client. These recommendations will be on the Technology Support Consultation & Technical Assistance (TSCTA) Recommendations form.
  - The case manager will:
    - Review the written recommendation,
      Please note, not all suggested items by the ATP will be eligible for purchase with CFC or Medicaid Long-Term Services and Supports (LTSS) programs funding.
    - Determine if the recommended AT is an approved CFC AT Good,
    - Have a discussion with the client to ensure they will use the proposed CFC AT Good to be more independent with the ADL, IADL, or health-related task, and
    - Reflect the need for the AT Good in the CARE assessment. See section on Documenting client's need for their CFC AT benefit.
      NOTE: Documentation of the client's need for services in their Person-Centered Service Plan is a requirement by the Centers for Medicare and Medicaid Services (CMS) and is necessary to allow our Medicaid LTSS programs to pay for any needed service or good.
  - Once the assessment reflects the need, proceed with purchasing the CFC AT Good(s) from a contracted AT provider or a contracted third-party purchaser. See section on Authorizing CFC AT Goods for balance of process for the approved AT Good.

– For Technical Assistance, the client will receive training and technical assistance from the contracted ATP to support the use of the CFC AT Good. A client will receive skill building from the ATP on how to use the device and incorporate its use into their daily life to assist with the designated ADL, IADL, or health-related task.

– If the Technology Support Consultation and Technical Assistance fees exceed the CFC AT benefit limit, an "Exceed CFC Annual Service Limit" ETR needs to be created.
  - ETR Category: CFC Services
  - ETR Type: Exceed CFC Annual Service Limit
  - Date Range: Custom, use actual dates of service
  - Rate: This is the total amount of the Technology Support Consultation and Technical Assistance units, minus $550 or the balance remaining of the client's CFC state fiscal year (SFY) annual limit.
  - Request description, Justification for request, Alternatives explored – add the justification and support for the client's request to access the Technology Support Consultation and Technical Assistance.



- Review and approval process of the "Exceed CFC Annual Service Limit" ETR:
  - Go through your internal office review process.
  - Then the final review and approval will be by Headquarters (HQ).
    The Processing Status of the ETR will be changed to "Pending HQ Approval" and the ETR will be assigned to:
    - For HCS/AAA clients, the HCS CFC Program Manager.
    - For DDA clients, the DDA CFC AT, ETR Committee.

– Once authorized in P1, the amount for the Technology Support Consultation and Technical Assistance will be automatically added to the Budget Calculator.
  - The case manager will add comments to the Budget Details indicating what AT Service was purchased along with any other helpful details.
  - If an ETR was necessary, the case manager will add the ETR amount in the "additional funding" column of the Budget Calculator which will reflect $0.00 (and not a red negative amount) in the budget remaining column.

– To document and justify authorized payments made for the Technology Support Consultation and Technical Assistance,
  - For HCS/AAA:
    - Submit a Social Services Invoice/Receipt Packet Cover Sheet (DSHS 02-615) to DMS Hotmail with:
      - The invoice from the ATP, and the TSCTA Recommendations form.
  - For DDA:
    - Upload the following in the client's electronic file in RMT:
      - The invoice from the ATP, and the TSCTA Recommendations form.

Skills Acquisition Training (SAT)

Skills Acquisition Training (SAT) services include functional skills training to accomplish, maintain, or enhance ADLs, IADLs, or Health Related tasks. Health related tasks are specific tasks related to the needs of an individual that under state law licensed health professionals can delegate or assign to a qualified health care practitioner.

1. SAT is provided at the same time as client's other personal care (ADLs, IADLs, and/or health-related) tasks and must be provided directly to the client receiving CFC personal care services.
2. SAT is for the sole benefit of the client.
    - Formal and informal care providers may participate in the training in order to continue to support the client's goal outside of the training environment.
    - Use of this service should be determined and approved based on the client's direction.
3. Services may complement therapy or nursing goals when coordinated through the CARE plan.

SAT Qualified Providers:

- Individual Providers (IPs)
    - Must be an employee of the CDE; and
    - Must meet all other IP qualifications listed under Personal Care Services; and
    - May only provide ADLs that are in their scope of practice listed in WAC 246-980-140(5) and IADL tasks listed below.
- Home Care Agency providers
    - Must have a current Department of Health (DOH) license, as defined in Chapter 70.127 RCW and Chapter 246-335 WAC; and
    - A current contract with DSHS or AAA; and
    - May only provide ADL and IADL tasks listed below.

SAT provided by these providers is limited to training on ONLY the following tasks:

- Cooking and meal preparation
- Shopping
- Housekeeping tasks
- Laundry
- Limited Personal Hygiene tasks including only:
    - Application of deodorant
    - Application of make-up
    - Bathing (excludes any transfer activities)
    - Brushing teeth/denture care
    - Dressing
    - Menses care
    - Shaving with an electric razor
    - Washing hands and face
    - Washing, combing, styling hair

Documenting need for SAT in CARE:

1. On Medical screen, Treatment(s) section, select "Programs: Skills Acquisition Training".
    a. Add Comment indicating the tasks the client requests SAT to learn.

For example, if a client wanted to learn how to shave, a suggested comment may be "client wants SAT to learn how to shave with an electric razor with non-dominant hand due to stroke affecting dominant side."

b. Select the provider and frequency.

2. On the Supports screen, assign "Programs: Skills Acquisition Training" to the paid provider.

For DDA clients, instructions for documenting a client's need may differ. CRM, please see your CFC Specialist for procedural instructions.

Authorizing SAT:

1. One-to-one even exchange of one personal care hour to one hour of SAT:
    - In-Home CFC clients may choose this option.
    - Authorized with service code T1019-U3.

    or

2. Purchase SAT hours from a client's CFC SFY annual limit:
    - In-Home and Residential clients may choose this option.
    - Authorized with service code T1019-U4.
        - The rate authorized and paid to the provider (the CDE for an IP or the Home Care Agency) will auto-populate in P1.
        - The authorized hourly rate is deducted from the client's CFC SFY annual limit.
        - Once authorized in P1, the total amount of purchased SAT hours authorized will be automatically added to the Budget Calculator.
        - The case manager will add comments to the Budget Details to add details of the SAT hours such as total number of hours, frequency of use, duration, what task is being learned, etc.
    - If the client's need, as documented on the individualized care plan, for SAT purchased hours exceeds the client's CFC SFY annual limit, the case manager may use the "Exceed CFC Annual Service Limit" ETR process.
        - For HCS/AAA, after the ETR goes through the initial review of your office, it will be sent to the HCS CFC Program Manager at Headquarters (HQ) for final review and decision making.
        - For DDA, the ETR is sent for review to the CFC Specialists in the regions, and then final decision making by the DDA CFC AT, ETR Committee at DDA HQ.

SAT Exclusions

- SAT does not include therapy such as Occupational Therapy, Physical Therapy, or Speech/Communication Therapy.
- SAT does not include nursing services or therapies that must be performed by a licensed Therapist or Registered Nurse.

Community Transition Services (CTS)

Community Transition Services (CTS) are one-time, set-up expenses necessary to help a client discharging from a qualified institutional setting: a skilled nursing facility (SNF), an institution for mental disease (IMD) or an intermediate care facility for individuals with intellectual disabilities (ICF/IID) to set up their own home in the community. When CTS are furnished to clients, the service is not considered complete and cannot be authorized until the client discharges from the qualified institution AND is enrolled in the CFC program – determined functionally and financially CFC eligible.

CTS Definition

- Non-recurring set-up expenses for clients transitioning from a qualified institutional setting to a home and community-based setting.
- Are usually a one-time package of services, a grouping of items and services at the time of discharge, getting the client into their community home.
- Are completed within 30 days of discharge from a qualified institutional setting.
- Allowable expenses are those necessary to enable a client to establish a basic household that do not constitute room and board and may include:
  - Security deposits required to obtain a lease on an apartment or home, including first month's rent;
  - Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, bed/bath linens, and basic items essential for living outside the institution;
  - Set-up fees or deposits for utilities, including telephone, electricity, heating, water, and garbage;
  - Services necessary for the client's health and safety such as pest eradication and one-time cleaning prior to occupancy;
  - Moving fees/expenses; and
  - Activities to assess need, arrange for, and procure needed resources.
- This service includes the training to the client and their caregivers in the maintenance or upkeep of equipment purchased only under this service and does not duplicate training provided under other waiver services.
- Community Transition Services are furnished only to the extent that the:
  - Services are reasonable and necessary as determined through the CARE plan development process, and
  - Services are clearly identified in the CARE plan, and
  - The client is unable to meet such expense, and
  - Services cannot be obtained from other sources.
- CFC CTS funds may not exceed $2500 per discharge for items and services.
  - If reasonable and necessary services and items are determined as needed and exceed $2500, the Case Manager may use the ETR process to request a higher amount.
  - The CFC "Community Transition Services" ETR would be sent to the CFC Program Manager at HQ for approval after field review.

NOTE: Community Transition Services – Items (SA296) does not permit payment of tips. With online orders/pickups, some companies have added an automatic tip to the overall total of the transaction. This cannot be reimbursed using Community Transition Services-Items. If the automatic tip cannot be removed from the transaction total, shopping at these companies should be avoided altogether.

Paying a money order/cashier's check fee as part of a move-in cost (payment of first month's rent/deposit) is allowable.

Qualified Institutional Settings

- Skilled Nursing Facilities (SNF)
- Institution for Mental Disease (IMD)
  - Most common are Eastern and Western state hospitals
  - Department of Health (DOH) licensed psychiatric hospitals with more than 16 beds
    - To confirm the facility is a qualified institutional setting, do a Provider Credential Search.
    - Select the "Facility and Services Search" tab.
    - Select the Facility Type "Hospital Psychiatric License"; press "search".
    - A list will be created, select "view" for the facility to confirm their license is still valid (has not expired).
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

See LTC Manual, Chapter 10 – Nurse Facility Case Management and Relocation for more information on the use of CTS for clients discharging from a nursing facility.

CTS Providers

- Providers of CTS vary based on the needs of the client, for example, movers or pest eradicators.
- Providers of CTS are contracted with local AAA or DDA offices for the client's county of residence. These CTS providers hold a valid Community Transition and Sustainability Services (CTSS) contract and are paid directly via ProviderOne.
- Providers must meet any licensing or certification required by state statute or regulation to provide their services.
- Additionally, if the service needed is not one that is regulated, the State will ensure that such services are delivered as specified by the waiver beneficiary and detailed in the client's CARE plan.

NOTE: CTS service providers such as pest eradicators, janitorial services, and movers must be contracted with the Community Transition and Sustainability Services (CTSS) contract and paid directly via ProviderOne. No other purchasing option is available for these services (including using a purchaser – a PG&S provider for DDA).

Documenting client's need for CTS

A requirement of the Centers for Medicare and Medicaid Services (CMS) is that a client's need for any service we pay for be documented in the CARE assessment, to reflect a client's need for CTS goods and/or services:

1. For CTS goods, on Medical screen, Treatment(s) section, select "Community Transition Goods or Items".
    a. Add a comment indicating what CTS goods/items are needed, an example is: "Essential household furnishing goods (a bed, dresser, chair, and linens for bed and bathroom) for client to transition from ESH into their own apartment in the community."
    b. Select the provider and frequency.
    c. On the Supports screen, assign "Community Transition Goods or Items" to the paid provider.
2. For CTS services, on Medical screen, Treatment(s) section, select "Community Transition Services".
    a. Add a comment indicating what CTS services are needed, an example is: "Client transitioning from ESH into their own apartment in the community. This is to move the client's belongings from their friend's home to their own apartment."
    b. Select the provider and frequency.
    c. On the Supports screen, assign "Community Transition Services" to the paid provider.

For DDA clients, instructions for documenting a client's needs may differ. CRM, please see your CFC Specialist for procedural instructions.

CTS Exclusions and Limits

- Community Transition Services (CTS) may not be used for items that an AFH, ARC, EARC or AL facility are required to provide per WAC 388-76-10685 (AFH settings) and WAC 388-78A-3011 (AL settings).
- Community Transition Services do not include:
    - Ongoing monthly rental expense;
    - Mortgage expense;
    - Room and board;
    - Regular utility charges;
    - Home modifications or adaptations; and/or
    - Household appliances or items that are intended for purely diversion/recreational purposes, such as a television, cable service, or DVD/DVR/VCR players.
- CTS funds do not pay for items or services that would otherwise be covered under other payment sources, including but not limited to Medicare, Medicaid, private insurance, and other resources.
- CTS funding is not available for clients discharging from an Evaluation & Treatment (E&T) center or a "step-down" facility.
- See WAC 388-106-0275 which reviews the limits to CFC CTS.

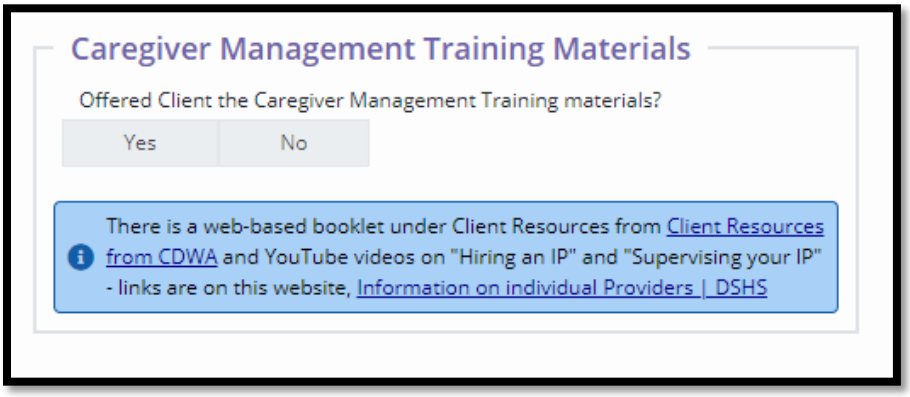
Caregiver Management Training

Caregiver Management Training is a service that the Centers for Medicare and Medicaid Services (CMS) require when a state offers Community First Choice (CFC) as one of their Long-Term Services and Supports (LTSS). As Washington state has chosen to provide CFC as one of their Medicaid LTSS programs, Caregiver Management Training materials are available to any client and/or legal representative who would like to receive it. A client may request this Caregiving Management Training material at any time.

The Caregiver Management Training is designed as a self-study training course to help clients understand how to select, manage, and dismiss a personal care provider. There is a web-based booklet and also two videos on YouTube.

Clients are offered the training by the case manager during service planning such as their assessment or when they are changing to an IP. A section in CARE Web has been created to easily document the Caregiver Management Training material was offered to the client and/or their legal representative. Having this information in CARE Web allows us to be able to pull a report and supply it to CMS when asked.

Indicate on the Profile screen under the Client Details section in CARE if the client and/or their legal representative was offered the Caregiver Management Training materials.



1. The web-based self-study training booklet, "Managing Employer Handbook", which is downloadable from the CDWA website, Client Resources section. This booklet as well as the "Managing Employer Quick Start Guide" which has general information to help a client and their IP, can be found under the General Information section of the Client Resources page.

   There are also two online videos available on YouTube:
   - How to Hire the Right Individual Provider - YouTube
   - Supervising Your Individual Provider - YouTube

   Topics include:
   - Understanding the CARE plan;
   - Creating job descriptions;

- Locating caregivers;
- Pre-screening, interviewing, and completing reference checks;
- Training, supervising, and communicating effectively with caregivers;
- Tracking authorized hours worked;
- Recognizing, discussing, and attempting to correct any caregiver performance deficiencies;
- Discharging unsatisfactory caregivers; and
- Developing a back-up plan for coverage of personal care services when the regular caregiver is not available or requires relief.

2. Through individualized training from a qualified Caregiver Management Training provider. Clients who have and manage multiple care providers will be offered the opportunity to receive individualized training on how to select, manage, and dismiss their caregivers.

Caregiver Management Training Providers

Community Choice Guides (CCG)

- CCGs can be used by HCS/AAA clients.
- The CCG must contract with DSHS through an AAA before being paid to provide services and must meet any licensing or certification required by State statutes or regulations. Prior to contracting, the AAA must verify that the CCG:
  - Has a valid current photo identification and Social Security card; *and*
  - Has cleared the initial and ongoing background checks as required by state law and remain free of disqualifying crimes and/or negative actions; *and*
  - Is age 18 or older.
- The CCG must also demonstrate by relevant successful experience, training, license, or credential that they have the skills and abilities to provide Caregiver Management Training services that are:
  - Expected to achieve outcomes identified by the client; *and*
  - Competent and relevant to the client's culture; *and*
  - Delivered in a manner and format that is individually tailored to the client's abilities, strengths, and learning styles.

Peer Support Specialist

- Peer Support Specialist must contract with the Department before being paid to provide peer support services for caregiver management training.
- Prior to contracting, the Department must verify that the Peer Support Specialist:
  - Has a valid current photo identification and Social Security card; *and*
  - Has cleared the initial and ongoing background checks as required by state law and remain free of disqualifying crimes and/or negative actions; *and*
  - Is age 18 or older.

- The Peer Support Specialist must also demonstrate by relevant successful experience, training, license, or credential that they have the skills and abilities to provide Caregiver Management Training services that are:
  - Expected to achieve outcomes identified by the client; *and*
  - Competent and relevant to the client's culture; *and*
  - Delivered in a manner and format that is individually tailored to the client's abilities, strengths, and learning styles.

SERVICE NEEDS BEYOND CFC-ONLY

CFC clients that need other services beyond those available under CFC, may access and enroll in a waiver program when they meet the criteria.

- For HCS/AAA clients, they may also receive services through CFC and the COPES waiver if they meet criteria for the COPES service.
- For DDA clients,
  - May also receive services through CFC and either the Basic Plus, Core, Children's Intensive In-Home Behavioral Support (CIIBS), or Individual and Family Service (IFS) waivers.
  - Must receive prior approval from DDA Headquarters to enroll on a waiver program.

Home Delivered Meals (HDM) is a service paid under the COPES waiver program to a contracted HDM provider. A CFC client who needs/wants HDM and meets the criteria listed below should enroll in COPES (see next section for more information) to receive this COPES service. The client would then be a CFC+COPES client. Please see LTC Chapter 7d – COPES for more information about HDM.
To receive HDM, a client must meet all the criteria below:

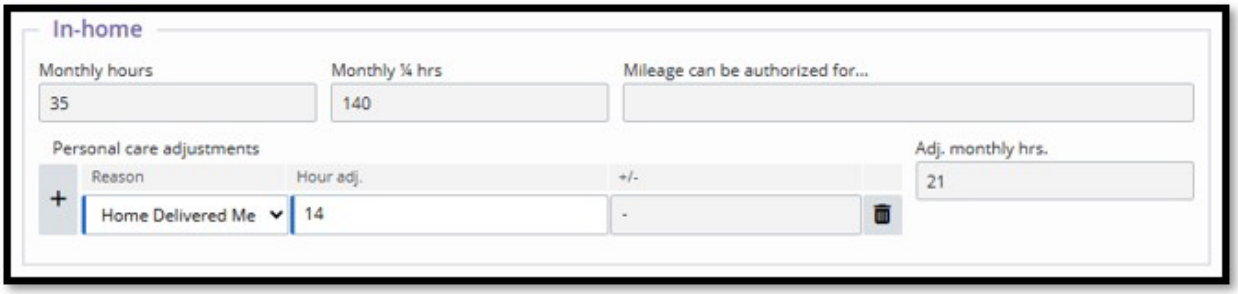
- Is homebound and lives in their own private residence;
  - Homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, intermittent absences for non-medical reasons, such as a trip to the barber or to attend religious services.
- Is unable to prepare the meal;
- Doesn't have a caregiver (paid or unpaid) available to prepare the meal; and
- Receiving the meal is more cost-effective than having a paid caregiver.

If, however, a CFC-only client is not determined eligible to enroll in COPES and needs/wants home-delivered meals/nutrition services, they must receive the meals from a different funding source such as a church, or a community center, or the Older Americans Act (OAA). Regardless of the funding source for the home-delivered meals/nutrition services, a 0.5 hour (30 minutes) deduction from the client's eligible CARE-generated monthly personal care hours will be made for each meal up to a 15 hour maximum deduction per month.

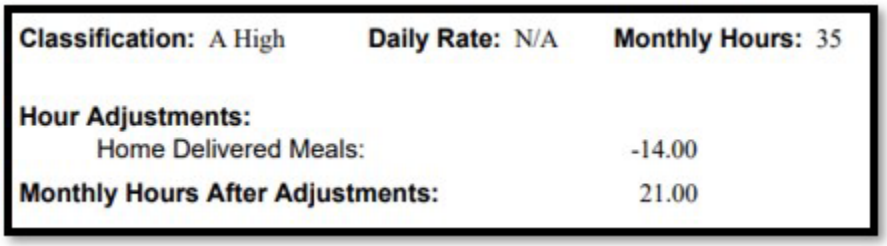
To reflect the hour adjustment for the home-delivered meals/nutrition services, in the CARE assessment, on the Care Plan screen, in the In-home section, under Personal care adjustments, select

"Home Delivered Meals" and add the number of hours (not meals) to be deducted. The example below shows the client has chosen to receive 28 meals per month at 0.5 hours = 14 hours deducted from their CARE-generated monthly personal care hours.

Deduct HDM from the Care Plan section:



The Service Summary will reflect the deduction:



MOVING BETWEEN CFC AND CFC+COPES

1. If a CFC client has needs beyond the amount, duration, and scope of the CFC program, consider enrolling the client into the COPES waiver and choosing the program option CFC+COPES on the Care Plan screen in CARE.

Clients who are financially eligible for CFC can ONLY be authorized under CFC+COPES if:

- Documentation in CARE indicates why the client's needs are beyond the amount, duration, or scope of CFC; and
- The Public Benefits Specialist (PBS) has verified eligibility for COPES waiver services. You must work with your PBS even if the client is on Supplemental Security Income (SSI).

To be eligible for waiver or institutional services, a recipient must not have:

1. Transferred an asset for less than fair market value.
2. Ownership of a home that has equity greater than the current Home Equity Limit found on the Washington Apple Health Income & Resources Standards chart (April 2026 changes).
3. Ownership of an annuity that does not meet the requirements in Chapter 182-516 WAC.

2. When authorizing HCBS waiver services (COPES) for SSI recipients, inform the SSI recipient of the requirement to submit an "*Eligibility Review for Long-Term Services and Supports"* form, DSHS 14-416. This form will need to be submitted to the PBS for processing.

   a) The CFC+COPES option may be used when the client requires frequent COPES services.
      - If the client is enrolled in CFC+COPES, they are enrolled in **both** the CFC state plan *and* the COPES waiver.
      - The client will not need to switch between programs to access the services as they are already eligible for these two programs.
      - When a client is enrolled in CFC+COPES, they **must access at least one ongoing COPES service every month** (such as Wellness Education or Home Delivered Meals) in order to continue to be eligible for the COPES waiver. See LTC Manual, Chapter 7d – COPES for more information.

   b) If the client is only enrolled in CFC and wishes to access a waiver service on a short-term basis (for example: the client is eligible for and needs a piece of SME),
      - The client may enroll in CFC+COPES temporarily to access the waiver service.
      - Once the service has been completed, the client then disenrolls from the COPES waiver and returns to only the CFC program.
      - No change needed on the Care Plan screen in CARE – client's program selection will remain "CFC" only.

   If the client's need for a COPES waiver service is **short-term** ask the client to complete and sign DSHS 14-416 at the time of assessment (when the COPES service need is requested by the client and documented in CARE). This will ensure that the PBS is notified of the change before the short-term use of COPES waiver service ends.

3. Use the Financial/Social Services Communication form (DSHS 14-443) in Barcode to notify the PBS of an SSI recipient applying for waiver services.

a) The client must be financially approved and converted to CFC+COPES before a COPES waiver service can be authorized and paid.
b) Complete an Acknowledgement of Services (DSHS 14-225) form if this was not done at the time of the assessment to meet both CFC and COPES waiver enrollment requirements.
c) Verify financial eligibility has been completed and there is a communication in Barcode from the PBS showing that the client is financially eligible for waiver program services.

4. Authorize COPES Services:
   a) If this is an **ongoing** COPES service (e.g., Home Delivered Meals or Adult Day Care):
      i) Enter the RAC for COPES into CARE;
      ii) Select the CFC+COPES dropdown selection on the Care Plan screen in CARE;
      iii) The authorization Start Date will be the first day the COPES service begins, and the End Date will be the CARE plan end date; *and*
      iv) Notify PBS on Barcode form DSHS 14-443 of the COPES program addition for the CARE plan period. Advise the PBS of the start date for the COPES waiver service(s).

> Examples of ongoing monthly COPES services:
> - Wellness Education (WE)
> - Adult Day Services
>   - Adult Day Health (ADH)
>   - Adult Day Care (ADC)
> - Home Delivered Meals (HDM)
> - Skilled Nursing Services

   b) If this is a **short-term** waiver service use (e.g., environmental modification service of a wheelchair ramp):
      i) Enter the RAC for COPES into CARE;
      ii) The authorization Start Date must be the 1st day of the month for the month that the needed short-term service will be paid;
      iii) Notify PBS on Barcode form DSHS 14-443 of the COPES program addition – advise that this is short-term for 30 days; *and*
      iv) Once the service is paid,
         (1) Close all COPES service lines/authorizations; *and*
         (2) Terminate the COPES RAC effective the last day of the month; *and*
         (3) Notify PBS on Barcode form DSHS 14-443 of the COPES termination date.

> **Note:** If the client is also on Medicare and has high prescription co-payments, you may go through the process above (client completes and signs DSHS 14-416 and DSHS 14-225 with CFC and COPES selected and you notify the PBS) and authorize CFC+COPES for the entire CARE plan period with client receiving at least one ongoing monthly waiver service (i.e. Wellness Education).

SWITCHING BETWEEN PROGRAMS

Functional eligibility for MPC clients wishing to enroll in CFC **or** CFC+COPES:

- MPC eligible clients were determined not to meet institutional level of care criteria and do not qualify functionally for CFC services.
  - They can no longer do a "one month flip" to COPES waiver when their needs are beyond the amount, duration, and scope of MPC services. This is because MPC clients do not meet institutional level of care (NFLOC for HCS/AAA and ICF/IID for DDA).
- If they are re-assessed in CARE and found to meet institutional level of care criteria, they *must* change programs from MPC to CFC as they are no longer functionally eligible for MPC.
- Require a functional eligibility determination in CARE before enrolling in CFC.
- The institutional level of care criteria applies to both CFC and to COPES.

COPES Financial Eligibility

- Financial criteria for the COPES waiver are different than for the CFC program.
- A PBS must approve eligibility before enrolling any client into COPES, which may require a financial eligibility review.
- Contact PBS through Barcode form 14-443 as soon as you are aware the client wishes to enroll in COPES.

MPC to CFC	A functional eligibility determination in CARE that determines NFLOC is required.
MPC to CFC+COPES	• A functional eligibility determination in CARE that determines NFLOC is required. • Financial eligibility review and determination through financial.
MAGI on ABP MPC to CFC+COPES	MAGI-based ABP MPC (N-track) clients are not part of the Aged, Blind, Disabled population that is required to be eligible for waiver services, therefore the client: • must complete a Social Security Disability Determination (or the Non-Grant Medical Assistance (NGMA) process – see Appendix IV in LTC Manual Chapter 7h – Appendices for information on NGMA) before being considered for COPES or any other waiver service. • must also apply for SSI related medical using HCA form 18-005. Information about the form and the process to fill out the application can be found here. Clients who have completed the above-mentioned disability determination process, will then need to have a functional and financial determination as noted in the "MPC to CFC+COPES" row above.
CFC to CFC+COPES	CFC clients enrolled in COPES are required to continue to receive a service from COPES *every month* in order to maintain waiver eligibility. Clients who need a one-time service from COPES, such as SME, may only remain on the waiver if they receive a monthly, ongoing COPES waiver service.

	Examples of COPES services that may occur monthly include: – Wellness Education – Home Delivered Meals – Adult Day Services – Skilled Nursing services

ACKNOWLEDGEMENT OF SERVICES FORM

By federal rules, clients who are functionally and financially eligible for CFC or both CFC and a waiver program can choose to receive their care in an institution or in the community. The Acknowledgment of Services form (DSHS 14-225) is the documentation that the program choices have been explained to the client, and the client has acknowledged their choice of CFC state plan services and/or waiver services over nursing home or institutional care. For DDA, this acknowledgement of services form is entitled Voluntary Participation form (DSHS 10-424).

- This Acknowledgement of Services form is mandatory as it provides documentation that the federal requirement has been met.
  - CFC services and waiver services cannot be authorized without the client's dated signature on this form.

- If the CFC and/or waiver client enters the nursing facility, services are terminated on that date.
  - A new Acknowledgment of Services form is required if the client wants to return to the community on CFC and/or on waiver services. The DSHS 14-225 is documentation of the client's choice to receive services outside of the nursing facility.
  - A new DSHS 14-225 is not required if the nursing facility stay is short-term, less than 30 days (i.e. client is attending post-surgery rehabilitation and will be returning to place of residence.).

- Two copies are required – one copy is given to the client and a correctly completed dated/signed copy is placed in the client's file:
  - For HCS/AAA, send completed DSHS 14-225 to DMS Hotmail to be included in the client's electronic case record.
  - For DDA, upload completed DSHS 10-424 in the client's electronic file in RMT.

RESOURCES

Related Washington Administrative Codes (WAC)

WAC 388-106-0270	Services available under CFC
WAC 388-106-0271	Limits to Skills Acquisition Training
WAC 388-106-0272	Qualified providers for Skills Acquisition Training

WAC 388-106-0273	PERS add-on services
WAC 388-106-0274	Limits to Assistive Technology
WAC 388-106-0275	Limits to Community Transition Services
WAC 388-115-0510	Qualifications of an individual provider (IP)

Forms

DSHS 02-615	Social Services Invoice/Receipt Packet Cover Sheet
DSHS 10-424	Voluntary Participation (DDA)
DSHS 13-712	Behavioral Health Wraparound Support (BHWS) Request for MCO Funding
DSHS 14-225	Acknowledgement of Services
DSHS 14-416	Eligibility Review for Long Term Services and Supports
DSHS 14-443	Financial/Social Services Communication (use form in Barcode)
HCA 18-005	Health Care Authority Washington Apple Health Application for Aged, Blind, Disabled / Long-Term Care Coverage

Exception to Rule (ETR) Reference Grid for CFC Services

Here is a link to an ETR reference grid for CFC services.

What Program to Use: Transition and Sustainability Goods and Services

Here is a link to a chart that reflects which HCS LTSS program to use for transition and sustainability goods and services.

Acronyms

AAA	Area Agency on Aging
ABP	Alternative Benefit Plan
ACD	Agency Contracts Database
ADC	Adult Day Care
ADH	Adult Day Health
ADL	Activities of Daily Living
AFH	Adult Family Home
ALF	Assisted Living Facility
ARC	Adult Residential Care
AT	Assistive Technology
ATP	Assistive Technology Professional
BHWS	Behavioral Health Wraparound Support
CARE	Comprehensive Assessment and Reporting Evaluation
CBHS	Community Behavioral Health Support
CCG	Community Choice Guide
CDE	Consumer Directed Employer
CDWA	Consumer Direct Care Network of Washington

CFC	Community First Choice
CIIBS	Children's Intensive In-Home Behavioral Support
CM	Case Manager, also refers to DDA Case Resource Manager
CMS	Centers for Medicare and Medicaid Services
CN	Categorically Needy
COPES	Community Options Program Entry System
CRM	Case Resource Manager with DDA
CTS	Community Transition Services
CTSS	Community Transition and Sustainability Services
DDA	Developmental Disabilities Administration
DME	Durable Medical Equipment
DMS	Document Management Services
DOH	Department of Health
DSHS	Department of Social and Health Services
EARC	Enhanced Adult Residential Care
ECR	Electronic Case Record
ETL	Electrical Testing Laboratories
ETR	Exception to Rule
FCC	Federal Communications Commission
GPS	Global Positioning System
HCA	Health Care Authority
HCBS	Home- and Community-Based Services
HCLA	Home and Community Living Administration
HCS	Home and Community Services
HIU	Hub Imaging Unit
HQ	Headquarters
IADL	Instrumental Activities of Daily Living
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IFS	Individual and Family Service
IMD	Institute for Mental Disease
IP	Individual Provider
JRP	Joint Relations Procurement
LTC	Long-Term Care
LTCW	Long-Term Care Worker
LTSS	Long-Term Services and Supports
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MPC	Medicaid Personal Care
ND	Nurse Delegation
NFLOC	Nursing Facility Level of Care
NGMA	Non-Grant Medical Assistance
P1	ProviderOne
PBS	Public Benefits Specialist – HCS financial worker
PCSP	Person-Centered Service Plan

PERS	Personal Emergency Response System
PG&S	Purchasing Goods and Services – a DDA contracted provider
RAC	Recipient Aid Category
RCW	Revised Code of Washington
RMT	Records Management Tool – an electronic file system for DDA
RN	Registered Nurse
RND	Registered Nurse Delegator
SAT	Skills Acquisition Training
SCDS	Service Code Data Sheet
SER	Service Episode Record
SES	Specialized Equipment and Supplies
SFY	State Fiscal Year
SME	Specialized Medical Equipment
SNF	Skilled Nursing Facility
SSAM	Social Service Authorization Manual
SSI	Supplemental Security Income
TSCTA	Technology Support Consultation and Technical Assistance
UL	Underwriters Laboratories, Inc.
WAC	Washington Administrative Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
07/2026	Victoria Nuesca	• Updated policy and provider type for Community Transition Services to align with MB H25-051. • Updated name related to the Treatment selection to represent goods or services needed for CFC Community Transition Services. • Updated reference information for BHWS and CBHS. • Fixed broken links.	

04/2026	Victoria Nuesca	• Added AT policy and procedures from MB H26-003
		• Reorganized “AT benefit” section to flow better with the additions
		• Updated DDA information:
		  • added AT Program Manager contact
		  • electronic file in the Records Management Tool
		  • ETR Committee
		• Fixed formatting and links, and added/updated acronyms
			H26-019

11/2025	Victoria Nuesca	• Updated language to reflect HCS and DDCS divisions versus Aging & Long-Term Support Administration (ALTSA) and Developmental Disabilities Administration (DDA). • Fixed color to align with template. • Made minor grammatical corrections for better flow. • Reorganized "CFC Services" section to clarify examples of receiving services without a current CFC personal care. • Mirrored Community Choice Guide (CCG) information to align with what is located in the Roads to Community Living (RCL) chapter regarding issuing of payment for AT Good purchase and the note that tipping is not allowed. • Reorganized "Service Needs Beyond CFC-Only" section to clarify receiving home-delivered meals/nutrition services for CFC-only clients. Added snapshots of how to reflect deduction from CARE-generated monthly personal care hours.	H25-057
08/2024	Victoria Nuesca	• revised MCO-funded behavioral health section to align with the services of BHWS and CBHS • moved the CBHS / BHWS section into the Personal Care section to align with the MPC chapter	H24-044
04/2024	Victoria Nuesca	• Added information about home delivered meals reduction in in-home hours • Revised eligibility section for better flow • Added clarification for CFC Services introduction section • Aligned words with CARE Web terms/screens • Fixed formatting, links, and acronyms	H24-018
08/2023	Victoria Nuesca and Sue Halle	• Added clarification to sections on Personal Care, Nurse Delegation, and the CFC state fiscal year annual limit • Added procedure tasks/assistance to Skills Acquisition Training (SAT) and Community Transition Services (CTS)	H23-071

		• Updated info to reflect the Budget Calculator	
05/2023	Victoria Nuesca	• Update DDA CFC Program Manager contact info • Corrected links • Added authorization information for a client's once-in-a-lifetime PERS console replacement • Skills Acquisition Training (SAT) – amount deducted when SAT hours are purchased from CFC SFY annual limit will be the authorized provider rate	H23-039
11/2022	Victoria Nuesca and Pon Manivanh	• Fixed grammatical errors • Removed reference to rescinded Chapter 11 – Individual Providers • Added clarification to the following: ▪ Out-of-State Personal Care ▪ Personal Emergency Response System (PERS) add-on service of Global Positioning System (GPS) ▪ Caregiver Management Training material	H22-064
08/2022	Victoria Nuesca and Pon Manivanh	• Updated info to correctly reflect the changes that are now in place due to the Consumer Directed Employer (CDE). • Clarified policy language for better understanding and consistency. • Added Community Transition Services (CTS) provider information to align with other program chapters. • Updated the CFC Assistive Technology (AT) Covered Item list. • Added an Exception to Rule (ETR) Reference Grid for CFC Services • Corrected links.	H22-042
03/2022	Victoria Nuesca and Pon Manivanh	• Updated info to reflect that Individual Providers are now employees of the Consumer Directed Employer (CDE) and made the appropriate changes, i.e., removing the Home Care Referral Registry which will now be a function of the CDE. • Aligned the "In-Home Personal Care Services Outside Washington" section with the policy for Medicaid Personal Care (MPC). • Clarified the Assistive Technology (AT) Benefit section to provide more descriptive information and instruction.	H22-020

		• Reorganized process steps for further clarity and simplicity. • Corrected links.	
12/2021	Victoria Nuesca and Pon Manivanh	Clarified policy related to PERS, AT and CTS. Added the service codes for AT Services. Added the new CTS limit for items and services per discharge. Made minor grammatical word changes. Updated links.	H22-005
05/2021	Victoria Nuesca with Pon Manivanh	Fixed formatting; changed order of sections. Clarified policy related to AT, SAT, and CTS; added some clarifications for DDA staff.	H21-050
11/2020	Victoria Nuesca	Updated section related to BHWS Wraparound Support services funded by MCO	H20-104
03/2019	Victoria Nuesca	Placed chapter into the new template. Fixed hyperlinks and form numbers. Clarified policy for CFC services.	H19-015
10/2017	Jacqueine Cobbs	Changes based on the CFC State Plan Amendment	H17-078
03/2017	Jacqueine Cobbs	Information related to RSN funding of personal care services was updated and moved into new section, 7h – Appendices	H17-021
12/2015	Tracey Rollins	Review the chapter for clarification of policy and procedure as it relates to CFC	H16-002