

Community Options Program Entry System (COPES)

Chapter 7d defines the Community Options Program Entry System (COPES) waiver and the services available to enrolled clients. This waiver provides services to over 51,000 clients who live in their own homes, adult family homes or assisted living facilities. The purpose of the waiver is to develop and implement supports and services to successfully enable individuals to live in their chosen community setting.

Ask the Expert

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WHAT IS COPES?

COPES is one of the 1915(c) Medicaid waivers operated by Home and Community Living Administration's (HCLA) Home and Community Services (HCS). This waiver provides the opportunity for individuals who, in the absence of the home and community-based services and supports provided under COPES, would otherwise require the level of care furnished in a nursing facility. The COPES waiver was first established in 1982 and is one of the oldest waivers in the nation!

Services in the COPES waiver act as a wraparound to services available to the Community First Choice (CFC) State Plan program. Since July 1, 2015, it would be highly unusual for a person to be enrolled in COPES and not also be enrolled in CFC because personal care is no longer available in COPES. Rules governing the COPES waiver can be found in [WAC 388-106-0300 through 0335](#).

WHO IS ELIGIBLE FOR COPES?

To be eligible for the COPES program, and before services can be authorized, the client must meet **ALL** the following eligibility criteria:

- Age:
 - Age 18 or older & blind or has a disability as outlined in [WAC 182-512-0050](#); or is
 - Age 65 or older
- Functional Eligibility:
 - CARE algorithm determines that the individual meets nursing facility level of care as outlined in [WAC 388-106-0355\(1\)](#), [WAC 182-515-1506](#); or
 - Will likely need the level of care within 30 days unless waiver services are provided; and
 - Client chooses community services under the waiver instead of nursing facility services.
- Financial Eligibility:
 - Meet the Supplemental Security Income (SSI) disability criteria; and
 - Be eligible for institutional categorically needy (CN) medical coverage group.
 - See [Chapter 7a](#) of the LTC manual for more information regarding financial eligibility for LTC programs.
- Individuals must have needs that exceed what is available in CFC.

Use ACES On-line to verify financial eligibility at initial, annual, or significant change assessments.

Clients who are functionally and financially eligible for the COPES 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 waiver services or nursing facility care. This form is a federal requirement and waiver services cannot be authorized without the client's signature on it. Have the client sign the form, submit the original to DMS and provide the client with a copy of the form for their records.

If a waiver client enters a nursing facility for less than 30 days, waiver services cannot be provided during the time the client is in the nursing facility. The end date for all waiver service authorizations must be changed to match the admission date into the nursing facility. However, enrollment on the

waiver is not terminated and eligibility does not have to be re-determined when returning to the community. A new [DSHS 14-225](#) is not required if the stay is short term (less than 30 days).

If a waiver client enters a nursing facility for 30 days or longer, waiver services are terminated, and the client is dis-enrolled from the waiver. The client must have his/her eligibility reestablished if he/she reenters the community on waiver services. A new [DSHS 14-225](#) is required when the client returns to the community after a stay of 30 days or more in the nursing facility.

When a MAGI-based client on CFC is enrolling in the COPES waiver or a MAGI-based client is leaving MPC and enrolling in the COPES waiver, the start date for the waiver needs to be the 1st day of the following month. Start dates should not be mid-month.

WHERE CAN INDIVIDUALS RECEIVE COPES SERVICES?

COPES services can be received by clients living in a private residence or a licensed residential setting. See the chart below for a summary of services and location.

Waiver Services by Setting

Service	In-Home COPES	Residential COPES
Adult Day Care	◆	
Adult Day Health	◆	◆
Client Support Training/Wellness Education	◆	◆
Community Choice Guide	◆	◆
Community Supports: Goods and Services	◆	Available to assist with transitioning to in-home setting
Environmental Modifications	◆	
Home Delivered Meals	◆	
Nursing Services	◆	◆
Skilled Nursing	◆	◆
Specialized Medical Equipment & Supplies	◆	◆
Transportation	◆	◆

SERVICES AVAILABLE THROUGH COPES WITH PROVIDER QUALIFICATIONS

Clients may receive any combination of waiver services if they meet the secondary eligibility criteria for each of these services. Waiver services cannot be duplicative of each other.

Federal rule requires that waiver services not replace other services that can be accessed under Medicaid, Medicare, health insurance, Long Term Care (LTC) insurance, and other community or informal resources available to them.

- If a client has other insurances or resources, case managers must document the denial of benefits before the client can access waiver services. This documentation must be in the client's file.
- Waiver services may not be used when the vendor refuses the reimbursement or considers the payment inadequate from the other resources.
- Waiver services may not supplement the reimbursement rate from other resources.
- ETRs are not allowed for the above circumstances.

Providers of waiver services must meet certain qualifications and be contracted through the local AAA prior to services being authorized. Each local AAA maintains a list of contracted, eligible providers for HCS and AAA.

Note: All services must be indicated in a client's plan of care and assigned to a paid provider prior to authorization. Clients must have also approved their plan of care.

The services available through the COPES waiver are described below (defined in [WAC 388-106-0300](#) and [388-106-0305](#)).

Adult Day Care (ADC)

ADC is a supervised daytime, in-person or remotely through telephonic or other technology media, program providing core services for adults with medical or disabling conditions that do not require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician or Advanced Registered Nurse Practitioner (ARNP). For more detailed information regarding how to make referrals, authorize and monitor this service, including details about the remote/hybrid program, see LTC Manual [Chapter 12 Adult Day Services](#).

Adjusting CARE generated hours for ADC:

For clients receiving adult day care services, there is no manual reduction of personal care hours generated by CARE. For all clients receiving ADC, **the assessor must include the ADC provider as informal support when coding status for each ADL and IADL task** that is provided by the ADC provider.

Add Adult Day Care program in CARE as a *Treatment* in the *Medical screen*, as required.

Adult Day Care Service Codes:

- **[S5102 UA](#) Adult Day Care intake** – authorize for intakes, both in-person and remote
 - Authorization for client intake is a onetime approval per attendance cycle
 - If the client discharges from services and at a later date is reauthorized, the authorization may be forced by the HQ Program Manager.
- **[S5100](#) Adult Day Care in-person services** – when the client is attending ADC for less than 4 hours in a day
 - 1 unit = 15 minutes
- **[S5100 U1](#) Adult Day Care remote services** – when the client is attending ADC remotely
 - 1 unit = 15 minutes
 - The provider will be able to claim a minimum of one (1) hour, or four (4) units, per visit.
- **[S5102 HQ](#) Adult Day Care day services** – when the client is attending for 4 or more hours in a day
 - 1 unit = 15 minutes

Provider Qualifications:

- Meet the requirements of [WAC 388-71-0702 through 388-71-0776](#); and
- Have a current contract with the Department.

Adult Day Health (ADH)

ADH is a supervised daytime program, in-person or remotely through telephonic or other technology media, providing skilled nursing and rehabilitative therapy services in addition to the core services of Adult Day Care. Adult Day Health services are appropriate for adults with medical or disabling conditions that require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician or ARNP. For more detailed information regarding how to make referrals, authorize and monitor this service, including the details about the remote/hybrid program, see LTC Manual [Chapter 12 Adult Day Services](#).

Adjusting CARE generated hours for ADH

For clients receiving adult day health services, there is no reduction of personal care hours generated by CARE. For all clients receiving ADH, ***the assessor must include the ADH provider as informal support when coding status for each ADL and IADL task*** that is provided by the ADH provider.

Adult Day Health Service Codes:

- **[S5102 CG](#) Adult Day Health intake** – authorize for intakes, both in-person and remote
 - Authorization for client intake is a one-time approval per attendance cycle.
 - If the client discharges from services and at a later date is reauthorized, the authorization may be forced by the HQ Program Manager.
- **[S5102 TG](#) Adult Day Health in-person day services** – when the client attends ADH four (4) hours or more per day
- **[S5100 U2](#) Adult Day Health remote services** – when the client is attending ADH remotely
 - 1 unit = 15 minutes
 - The provider will be able to claim a minimum of one (1) hour or four (4) units, per visit.

Adult Day Health Provider Qualifications:

- Meet the requirements of [WAC 388-71-0702 through 388-71-0839](#), and
- Have a current contract with the Department.

Client Support Training/Wellness Education (WE)

The Client Support Training/Wellness Education (WE) service is identified in the client's CARE assessment and if needed, specific training needs can be identified in a professional evaluation. This service is provided in accordance with a therapeutic goal outlined in the plan of care and includes but is not limited to:

- Adjustment to a serious impairment,
- Maintenance or restoration of physical functioning,
- Self-management of chronic disease,
- Acquisition of skills to address minor depression,
- Development of skills to work with care providers including behavior management, and
- Self-management of health and well-being through use of actionable education materials

Note: In a residential setting, the training must be in addition to and not a replacement of the services required by the department's contract with the residential facility.

Please note regarding Client Training Support services offered by an occupational therapist or physical therapist: These services must exceed the scope of services offered through the Medicaid State Plan (Apple Health). Per [WAC 182-501-0060](#), occupational and physical therapy are services offered through home health and outpatient rehabilitation services, and these services, available as a benefit from the client's medical plan, should be exhausted first. For example, a client may need a home safety evaluation for fall prevention. This is a service offered through the State Plan and this benefit should be used before authorizing client training for a home safety evaluation.

Prior to authorizing Client Training by these provider types, the client should coordinate with their healthcare provider and request a prescription for services through the Apple Health benefit and be referred to a Medicaid contracted home health agency. If the service is denied or the client has exhausted their State Plan benefit, document this in the Service Episode Record (SER) prior to authorizing Client Training by an occupational or physical therapist. The OT or PT contracted to provide Client Training must also have a prescription from the healthcare professional to provide this service to ensure it is not a duplication of existing services offered through the State Plan.

The Client Training Contract (1073XP) is used for Client Support Training services provided by medical and non-medical providers as well as providers like Chronic Disease Self-Management (CDSM), PEARLS workshops, and Evidence-Based Trainings (EBT).

Provider qualifications are based on provider type:

- Chronic Disease Self-Management Training – Individual:

- Certification in an evidence-based, chronic disease, self-management training program such as the Stanford University Chronic Disease Self-Management Program (CDSMP).
- Chronic Disease Self-Management Training – Agency:
 - Each employee/trainer must have certification in an evidence-based, chronic disease, self-management training program such as the Stanford University Chronic Disease Self-Management Program (CDSMP).
- Community Mental Health Agency:
 - Licensed under WAC 182-538
- Home Health Agency:
 - Licensed under [Chapter 70.127 RCW](#) and [Chapter 246-335 WAC](#)
 - Have core provider agreement with Health Care Authority
- Home Care Agency:
 - Licensed under [Chapter 70.127 RCW](#) and [Chapter 246-335 WAC](#)
- Certified Dietician/Nutritionist:
 - Certified under [Chapter 18.138 RCW](#) as dietician/nutritionist
 - Have core provider agreement with Health Care Authority
- Independent Living Provider meeting one of the following qualifications:
 - Bachelor's degree in social work or psychology with two years of experience in the coordination or provision of Independent Living Services (ILS); or
 - Two years of experience in the coordination or provision of ILS in a social service setting under qualified supervision; or
 - Has had a personal disability for four years and experience providing independent living skills training.
- Physical Therapist
 - PT license under [Chapter 18.74 RCW](#)
 - Have core provider agreement with Health Care Authority
 - Have site visit as required by federal regulations
- Registered Nurse
 - RN license under [Chapter 18.79 RWC](#) and [Chapter 246-840 WAC](#)
 - Have core provider agreement with Health Care Authority
- Licensed Practical Nurse
 - LPN license under [Chapter 18.79 RWC](#) and [Chapter 246-840 WAC](#)
 - Have core provider agreement with Health Care Authority
- Community College
 - Community-based, non-profit organizations in Washington State which provide services by, and for, people with disabilities. Centers for Independent Living receive funding through the Federal Department of Education/Rehabilitation Services Administration and are contracted in the state of Washington through the Department's Division of Vocational Rehabilitation.
- Pharmacist
 - Licensed per [Chapter 18.64 RCW](#) and [Chapter 246.863 WAC](#)
 - Have core provider agreement with Health Care Authority
- Human Service Professional

- Bachelor's degree or higher in Psychology, Social Work or a related field with a minimum of two years of experience providing services to aging or disabled populations.
- Occupational Therapist
 - OT license under [Chapter 18.59 RCW](#)
 - Have core provider agreement with Health Care Authority
- Centers for Independent Living (CIL)
 - Community based non-profit organizations in Washington State which provide services by and for people with disabilities. CILs receive funding through the Federal Dept. of Education/Rehabilitation Services Administration and are contracted in the State of Washington through the Department's Division of Vocational Rehabilitation.
- Board-Certified Music Therapist
- Evidence-Based Training (EBT) – Enhance®Fitness
 - Certification in the evidence-based training program, Enhance®Fitness

Client Support Training Examples:

Music Therapy:

Music therapy is the use of musical interventions to promote the accomplishment of individualized goals within a therapeutic relationship. Services may include music improvisation, listening to receptive music, song writing, lyric discussion, music and imagery, music performance, or other expressive musical forms.

Contracted providers are required to conduct an intake and review documentation regarding the waiver participant to determine the most effective course of music therapy intervention, develop and implement a plan, provide progress reports to the case manager every 90 days, at a minimum, and participate in and/or consult with the client's case managers as needed.

Chronic Disease Self-Management:

The Chronic Disease Self-Management Program (CDSM) is a workshop for adults with at least one chronic health condition, which may include arthritis. It focuses on disease management skills including decision making, problem-solving, and action planning. This interactive program aims to increase confidence, physical and psychological well-being, knowledge of ways to manage chronic conditions, and motivation to manage challenges associated with chronic diseases. Key activities may include interactive educational activities like discussions, brainstorming, practice of action-planning and feedback, behavior modeling, problem-solving techniques, and decision making; as well as symptom management activities like exercise, relaxation, communication, healthy eating, medication management, and managing fatigue.

PEARLS (Program to Encourage Active, Rewarding Lives):

PEARLS is a treatment program designed to reduce symptoms of depression and improve quality of life among older adults and among all-age adults with epilepsy. The goals of the sessions include solving problems and becoming socially and physically active.

STAR-C:

STAR-C is an evidence-based behavioral intervention where the caregivers of clients with dementia are taught to monitor concerns, to identify environmental triggers for behavioral challenges, and to develop



effective methods to alter the environment to decrease disruption to a client. Caregivers are also taught to identify pleasurable activities for the client as a means of decreasing depression.

Evidence-Based Training (EBT) Enhance®Fitness:

Client Support Training Evidence-Based Training (EBT) Enhance®Fitness is an evidence-based group exercise and falls prevention program that helps individuals at all levels of fitness become more active, energized, and empowered. Participants' progress is tracked with evaluation checks completed at the time the individual joins EnhanceFitness, and again after four months, and then as often as needed. Each class session includes cardiovascular, strength training, balance and flexibility exercises and the fostering of strong social relationships between participants. Individuals with a chronic condition, such as arthritis, will never have to do anything that hurts and will be able to use chairs for support, if necessary.

CARE Assessment Documentation for EBT Enhance®Fitness:

- Identify in the "Treatment" screen
 - Include: "Client Training/Waiver"
 - "Comments" section: "Client is eligible for and has opted into the Evidence-Based Training Enhance®Fitness training service."
- Support Screen: add provider

Provider responsibilities:

- Evaluation completed at first session and again after four (4) months, then as needed
- Evaluation is provided to the case manager and should be added to the client's electronic case record.

NOTE: If a client experiences changes in their circumstances and is unable to safely participate in the scheduled session, notify the contracted provider as soon as possible to work out other arrangements or end the authorization timely.

Client Support Training Service Codes (for Client Training: Behavior Support, see next section):

- [H2014 UC](#) (Medical) and [H2014 UD](#) (Non-Medical) - The provider's credentials is the determinate for which code to use. For example, if a nurse is teaching a client how to use their diabetic medications, then using code H2014 UC would be appropriate.
- [T2025 U1](#) for Chronic Disease Self-Management workshops
- [T2025 U2](#) for PEARLS workshops
- [T2025 U6](#) for Star-C
- [T2025 UA](#) for EBT Enhance®Fitness
 - This service is for 16 weeks, up to 3 times a week for one-hour sessions. This service can be authorized again after the initial 16-week (112 day) period has ended with a reevaluation of need.
 - Clients must attend a minimum of one training session per month for the provider to claim the service

NOTE: There is a limit of 80 units (20 hours) in a six-month period for client support training services. This service can be authorized again after the initial six-month period has ended. In order to authorize the service for an additional 6 months, a staffing with a supervisor must occur and be captured in an SER.

Client Training-Behavior Support:

This waiver service provides *training* to the client and caregivers in an in-home, adult family home, or assisted living facility setting through the development of a client-centered behavior support plan. The goal of this plan is to develop positive interactions and outcomes which help facilitate a successful care plan.

Please note: Client Training-Behavior Support should not be authorized in place of a client's Medicaid health insurance benefits. If a client may benefit from additional behavioral health services offered through a client's insurance (also referred to as a client's Apple Health benefit), a referral should be made to the local mental health agency. Behavioral health services provided through insurance include but are not limited to individual therapy, family therapy, group therapy, medication management, crisis services, and the Program for Assertive Community Treatment (PACT).

For services related to the Residential Support Waiver (Expanded Community Services or Specialized Behavior Support), please refer to [Chapter 7f](#).

Provider responsibilities once the service is authorized:

- The behavior support provider will begin with an assessment of the client's behavior to determine the causes, triggers, and purposes behind the challenging behavior.
- The behavior support provider will **develop a behavior support plan** within 30 days of the client's assessment and provide this to the case manager. The behavior support plan will address things such as:
 - Factors that are associated with an individual's documented or identified behaviors.
 - Written strategy of behaviorally specific interventions designed to address those behaviors and promote optimal functioning with recommendations for improving the client's overall quality of life, teaching methods and environmental changes designed to decrease the behaviors that may be impacting the client remaining or transitioning to a community setting.
 - Direct interventions with the client to decrease the behavior that compromises their ability to remain in the community. This could include demonstrating and practicing new interventions and skills with formal and informal supports and significant others to support the individual in their community setting.
 - Case consultation regarding escalating situations.
 - Make recommendations for treatment and assisting with making referrals for community behavioral health services.

Examples of Client Training-Behavior Support:

Client #1 Example: Lisa has a traumatic brain injury and aphasia. She experiences anxiety daily and becomes easily irritable and agitated and has difficulty expressing herself. Lisa becomes frustrated when she is not understood by others and at times yells at the caregiver. Lisa and her Case Manager have a meeting and Lisa agrees to receive Client Training-Behavior Support.

The behavior support provider begins working with Lisa to develop new techniques when communicating with caregivers. The provider also works with Lisa's caregivers to develop successful interventions when Lisa becomes agitated and angry, as well as strategies to help prevent the behavior from occurring. A behavior support plan is developed.

In addition to Client Training-Behavior Support services, a referral is made to the local mental health agency for individual therapy. Lisa begins seeing a counselor and attending weekly therapy sessions to address her anxiety.

Client #2 Example: John has quadriplegia and depression and experiences crying/tearfulness daily, is easily irritable and agitated, and uses foul language with caregivers. As a result, John is having difficulty maintaining caregivers, jeopardizing his ability to remain in the community. During his annual assessment, John agrees to receive Client Training-Behavior Support services. In addition, a referral is made to the local mental health agency to address John's depression through individual therapy.

The behavior support provider begins working with John to develop communication skills and identify triggers when communicating with caregivers. In addition, the provider works with John's caregivers on successful interventions, as well as strategies to minimize the severity or duration of the behavior. A behavior support plan is developed.

Client #3 Example: Erin experiences delusional thoughts and is living at an adult family home (AFH). Erin is already receiving direct counseling services from her local mental health agency. Erin is often resistive to care and has been combative in the past with caregivers. The Case Manager received a phone call from the AFH explaining that providing care to Erin was increasingly difficult and recently she had begun cussing at caregivers and others living in the home.

The Case Manager visits Erin at the AFH, and she agrees to accept services through Client Training-Behavior Support. The behavior support provider begins working with Erin and staff at the AFH to identify the causes, triggers, and purpose behind the behaviors. A behavior support plan is developed.

CARE Assessment Documentation for Client Training-Behavior Support:

- On the Treatments screen in CARE: Select Client Training/Waiver under the Rehab Restorative Training header.
- On the Pre-Transition and Sustainability screen found below the Client Details section in CARE, select the Sustainability Goals tab. From the drop down, select the goal description, and describe the goal of behavior support in the comments. This section helps the provider understand the specific reasons for the development of a behavior support plan.

- On the Care Plan Supports screen, assign Client Training to the behavior support provider.
- Send the chosen behavior support provider a copy of the Assessment Details, Service Plan, and Sustainability Goals.

The Behavior Support Services Contract (1044XP) is used for Client Training-Behavior Support and the qualifications include:

- Master's Degree in Psychology, Education, Social Work, or related discipline, or a Doctoral Degree in Psychology, Education, or related field.

Client Training-Behavior Support Service Code:

- [H2019](#) Behavior Support – Individual

Note: there is a limit of 80 units (20 hours)/month in a three-month (92 day) period for client support training services. This service can be authorized for an additional three- months (92 days) once a staffing with a supervisor regarding the client's progress has occurred, which must be documented in an SER. If needed, the service can be authorized again after the initial 6-month (184 days) period with a local ETR. However, service cannot be expanded with an ETR past 80 units per month.

Wellness Education (WE) is a customized, monthly newsletter service available to clients enrolled in COPES to help manage health related issues, achieve goals on their service plan, and address topics of community living. Data from a client's assessment is used to target articles specific to the client. It is important that the client's address is correct on the Client Contact screen. NSAs receive a copy of the client's WE, so it is also important that the NSAs address is accurate on the Collateral Contact screen. See "Helpful Tips" in the [Appendix](#) to ensure delivery of this service.

WE is available in 27 languages, based on the client's preferred written language in CARE. Some clients indicate Braille in CARE but prefer to have WE read to them. If a client with visual impairment and wants WE in Braille, please contact the WE Program Manager to have the client added to the list for Braille transcription.

Wellness Education is offered in the following languages:

Albanian	English	Large Print	Somali
Arabic	Farsi/Persian/Dar	Moldavian/Romanian	Tagalog
Amharic	Hindi	Punjabi	Thai
Armenian	Ilocano	Russian	Tigrinya
Braille	Japanese	Samoan	Ukrainian
Cambodian/Khmer	Korean	Serbo-Croatian	Urdu
Chinese	Lao	Spanish	Vietnamese

If WE is not currently being provided in a client's preferred written language and English is not meeting the client's needs, please contact the WE Program Manager.

Wellness Education Service Code:

- [SA080](#)
- This service may be authorized for 1 unit per month.

Note: the start date for this service can be between the 1st and the 20th of each month. If the start date will be after 7:00pm on the 20th, the start date should be the first of the following month.

Community Choice Guide (CCG)

Community Choice Guide (CCG) services can be authorized to clients enrolled in COPES to establish or stabilize a person currently in a community living arrangement including a licensed residential setting, such as an adult family home or assisted living facility, or in a private residence. Individuals are eligible for CCG services when the person's community living situation is unstable and the person is at risk of institutionalization. Examples include if a client is experiencing:

- Frequent institutional contacts (ER visits, SNF stays, hospital admits, etc.).
- Frequent turnover of caregivers resulting in an inability to maintain consistency of care.
- Threat of imminent eviction or loss of current community setting.

CCG services in COPES assist the eligible COPES client to live in the community setting of their choice by:

- Identifying needs and locating necessary resources to establish and achieve successful integration into the client's community setting of choice.
- Coordinating, and linking the client to resources which will establish or stabilize their community setting, including arrangements with pharmacies, primary care physicians, financial institutions, utility companies, housing providers, social networks, local transportation options, household budgeting, and other needs identified in care plan.
- Supporting the establishment of networks of relevant client partners: nursing or institutional facility staff, case managers, community providers (including AFH and ALF providers), medical personnel, legal representatives, paid caregivers, family members, housing agencies and landlords, informal supports and other involved parties.
- Ensuring all necessary paperwork and documentation is identified and completed to obtain and maintain Public Benefits and other services necessary for community integration.
- Assisting the client in locating and arranging transportation to effectively connect with the community and community resources. An example would be a one-time purchase of a bus pass. Transportation for medical appointments should be provided by existing non-emergency medical transportation benefits if the client is eligible.
- Shopping for necessary household goods/items or paying for rental deposits (to include first month rent), utility hookup fees, or rent/emergency rental assistance service. This service assists clients transitioning out of institutions or when needed to stabilize a client's community setting.
 - The provider is also reimbursed for the authorized purchases after it is verified the client received the goods or service. Authorization for the item/service is under a separate service code and case managers will process the reimbursement(s) for these one-time

goods or services supports to the CCG as timely as possible. This reimbursement should not exceed 30 days after the CCG has provided an invoice/receipt as proof of the purchase.

- Locating and arranging appropriate, accessible housing, including working with HCS Housing Resources, local housing authorities and other community resource providers and landlords, when applicable and authorized (see Chapter 5b for more information).
 - If client needs more intensive, long-term support with housing than a CCG can assist with, see [Chapter 30d](#) for information on Foundational Community Supports-Supportive Housing.
- Assisting in finding a qualified caregiver (see **Note** below).

Below are specific tasks a CCG can be authorized to assist the case manager with that are not a duplication of services. This information can be found in Chapter 11 of the LTC Manual.

Note: CCGs do not have access to Carina but can assist clients with other tasks related to locating a potential IP and guiding the potential IP to CDWA for hiring, when authorized by the case manager. The case manager should follow the steps detailed in [MB H21-083](#).

1. The CM will send the Assessment Details and Service Summary to CDWA through the standard file transfer process (through CARE) or via email to InfoCDWA@consumerdirectcare.com.
2. The CCG should be listed as a Collateral Contact if a CCG will be authorized to assist in locating an IP and the CCG copied on the email.
3. Authorized CCG tasks that could expedite posting of an ad when directed by a CM and the hiring of an IP, could include:
 - a. *When directed by the CM*, email CDWA at InfoCDWA@consumerdirectcare.com.
 - **Note:** CCG should always copy the authorizing case manager when communicating with CDWA.
 - CDWA applies email filters based on the subject and key words to direct the email internally to CDWA's Client/IP Referral Support Team, so emails must use the exact subject lines below to communicate.
 - b. Subject lines for specialized needs:
 - For client's new to Medicaid Services use the subject line: "CDWA new client / new to Medicaid services".
 - For clients who are discharging from an acute care setting or skilled nursing facility, has left a facility AMA, has APS involvement, or nursing/ wound involvement, use subject line: "CDWA urgent hire required".
 - c. If the IP is already a CDWA employee, the CCG can include the IP name, phone number, email, and mailing address in the email, if known.
 - d. If the IP is a brand-new IP, the CCG can include the IP name, phone number, email, and mailing address in the email (if known). Refer the IP to the "[Careers](#)" tab on the CDWA website to begin the hiring process.

- e. The CCG can be authorized to assist the Client/AR with interviewing and hiring the IP, if authorized by the CM, including emailing the CDWA Client/IP Support Team of the client's IP choice, copying the CM.

Tasks outside of CCG scope of work:

- Activities that require specific training or licensure/certification (e.g. pest eradication, moving services)
- Anything that has to do with a client's personal finances (e.g. cashing personal check, loaning money to client, using client's money as down payment, etc.)
- Becoming a co-signer (e.g. rental applications, loans, etc.)
- Driving a client or representative's owned vehicle (even with insurance required to provide transportation).
- Enter a client's home without the client's/representative's expressed/written permission.
- Perform tasks or skill building which fall under the [Client Training](#) scope of work.

Community Choice Guide – Issuing a Payment for AT Goods ([SA266](#))

Assistive Technology (AT) Goods can be purchased from an AT contracted provider with the AT Goods subcode, or if needed, a third-party purchaser such as a Community Choice Guide (CCG) for HCS/AAA clients. See CFC Chapter 7b for more information.

Based on a client's eligibility:

- The case manager will supply the detailed information for the covered AT Good, which retailer it is to be purchased from, the amount it should cost, and where it should be delivered.
 - The provider is also reimbursed for the authorized purchase of AT after it is verified the client received the AT Good. Authorization for the AT Good is under a separate service code and the case manager will process the reimbursement(s) for AT Goods to the CCG as timely as possible. This reimbursement should not exceed 30 days after the CCG has provided an invoice/receipt as proof of purchase.

Community Choice Guide Service Codes:

- [SA263](#) CCG (includes the most recent Activity Tracking Form)
- [SA266](#) Issuing Payment for AT Goods

NOTE: Service providers, such as pest eradicators janitorial services, and packing/moving services must be performed by a contracted provider who hold the Community Transition and Sustainability Services (CTSS) contract and paid directly via ProviderOne. Authorizing a CCG to perform the CTSS scope of work is prohibited. HCS may consider using the HQ managed purchasing card when there is CTSS contracted provider capacity concerns. Further instructions on HCS use of the HQ purchasing card can be found in [Chapter 10: Nursing Facility Case Management and Relocation](#).

Clients residing in King County:

Agency CCGs may have negotiated a different rate when performing authorized tasks for clients who are residents of King County (SA263; see SCDS for more information). When authorizing services, confirm

the correct contracted CCG rate has been selected for a client who resides in King County. When the rate for an Agency CCG provider is county specific and a move has occurred that impacts rate (into or out of King County, for example), the service line should be modified prior to transferring the file following all instructions in the Social Service Authorization Manual (SSAM).

Community Choice Guide Provider Qualifications:

- Bachelor's degree in social work or psychology with two years' experience in the coordination of Independent Living Services (ILS). Examples of ILS include working as a supported employment or supported living staff, peer trainer or mentor, volunteer or staff of an ILS Center, or similar where you teach and support individuals to maintain or learn skills to increase independence.
- Two years' experience in the coordination of ILS in a social service setting under qualified supervision.
- Four years personal experience with a disability.

Steps to Authorize Community Choice Guide (CCG) Services:

1. Contact a contracted CCG provider to discuss the case. The provider will determine capacity to assist the client with the goals and tasks. CCG providers can decline referrals without providing a reason.
2. Add the CCG business name to the Contact Details screen under Client Details.
3. Add "Community Integration" and "Community Transition Services" and/or "Community Transition Goods and Items" in the Treatment section of the Medical Screen in CARE Web.
 - a. Enter a brief comment for each treatment. Examples include:
 - **Community Integration:** CCG to assist with transitioning a client to the community **OR** CCG to assist with stabilizing client in the community.
 - **Community Transition Services/Community Transition Goods and Items:** CCG to assist with purchasing goods or services as authorized.
4. Add the CCG Provider to the Providers screen within the CARE Planning section of assessment.
5. Assign Community Integration to the CCG on the Support Screen.
6. Complete the Sustainability Goals outlining the goals and tasks the CCG is assigned to assist the client with.
7. Send documents to CCG Provider:
 - a. Sustainability Goals
 - b. Signed DSHS Consent form
 - c. Assessment Details (if available)
 - d. Service Summary (if available) – CCG Providers are not required to sign the Service Summary
8. Ensure appropriate RAC is entered. CCG Services (SA263) are available through RCL, CFC (SA266 only), RSW, COPES, CTSS, or WA Roads.
9. Authorize [SA263](#) and/or [SA266](#) (only if purchasing an AT Good).
10. Create an approval Planned Action Notice (PAN) for all services the client is authorized to receive as outlined in CARE (except for any services provided through WA Roads).
11. CCG Providers may either fax the Activity Tracking Form directly to DMS or email it to the assigned case manager. The assigned case manager is responsible for reviewing this document and ensuring the Activity Tracking Form is uploaded to DMS. If the Activity Tracking Form is sent

directly to the case manager, they must submit the form to DMS. If the CCG sends the form directly to DMS, the assigned case manager will receive a notification on their Barcode To-Do list indicating that the Activity Tracking Form is ready for review.

For additional resources please see the [CCG Services SharePoint](#) site.

Community Supports: Goods and Services

Community Supports: Goods and Services are non-recurring set-up expenses for individuals that are not eligible for Community Transition Services provided under the 1915(k) Community First Choice program and who are transitioning from a provider operated living arrangement to an in-home setting.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens;
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating, and water;
- Services necessary for the individual's health and safety such as pest eradication and non-recurring cleaning prior to occupancy;
- Moving expenses;
- Necessary home accessibility adaptations; and,
- Activities to assess need, arrange for and procure needed/resources.
- Assisting the participant in arranging for transportation to effectively connect the participant with the community. Examples include a one-time purchase and reimbursement of a bus pass.

These services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

NOTE: 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. Authorizing a CCG to perform the CTSS scope of work is prohibited. HCS may consider using the HQ managed purchasing card when there is CTSS contracted provider capacity concerns. Further instructions on HCS use of the HQ purchasing card can be found in [Chapter 10: Nursing Facility Case Management and Relocation](#).

These services do not include monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes.

Community Supports service codes to authorize:

- [SA296](#) Community Transition and Sustainability Services: Items (Matched Funds)
- [SA297](#) Community Transition and Sustainability: Services (Matched Funds)

A case manager may authorize the CCG to purchase items, to pay for rental set up fees and/or pay for utility deposits and will process the reimbursement(s) for these Community Supports to the CCG as timely as possible. This reimbursement should not exceed 30 days after the CCG has provided an invoice/receipt as proof of the purchase.

See [Which Program to Use-Transition and Sustainability Goods and Services 03.2026](#) in the [Appendix](#) for reference guide.

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.

Environmental Modifications

Environmental modifications are those minor physical modifications to the private residence of the client (owned or rented) that are:

- Justified by the client's service plan,
- Necessary to ensure the health, welfare and safety of the client or enable the client to function with greater independence in the home, and
- Is the most cost-effective option to meet the client's identified need.

All authorized modifications must meet ADA specifications, including the slope of a ramp. Modifications may include:

- The installation of ramps and grab-bars,
- Widening of doorway(s),
- Modification of existing bathroom facilities,
- The installation of specialized electric and plumbing systems that are to accommodate the medical equipment and supplies that are necessary for the health and welfare of the client,
- Lift systems not covered by insurance (such as EWC-type lifts).

Excluded are:

- Modifications or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the client.
- Repairs or general maintenance needed prior to a modification being completed (or determined during the modification), including testing and removal or abatement of asbestos or mold or repairs required due to water or pest damage. Repair and general maintenance of a dwelling are the responsibility of the owner.
- Tile showers, walls, or floors as there are typically other, less costly options. If a contractor can demonstrate that a basic tile is the most cost-effective option, tile may be considered.

- Modifications that add to the total square footage of the home except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Modifications to licensed settings such as adult family homes or assisted living facilities.
- Modifications to more than one entrance/exit

Prior to pursuing an environmental modification, explore cost-effective alternatives that might meet the client's needs. Examples of considerations include:

- **Equipment:**
 - Is there specialized medical or non-medical equipment that can assist the client to address the barrier? Some examples: transfer bench, grab bars, toilet rails.
 - If a patient lift (such as a Hoyer) cannot be used, would a stationary lift system assist with transfers?
 - Is an inflatable bathtub or portable shower an option? If the client moves frequently or the home is not in a condition to complete an environmental modification, this may be an alternative.
 - Are there assistive devices that may help a client safely navigate stairs such as a stair cane? Or is there a room on the main floor that could be used as a bedroom?
 - How much does a doorway need to be widened? Can replacing existing door hinges with extended, swing-away hinges provide the additional width required?
- **Training:**
 - If the client already has equipment, is training needed to maximize effectiveness by client/caregiver?
- **Insurance covered benefits:**
 - If a patient lift (such as a Hoyer) is not working for the client, has the client's healthcare provider been contacted to see about possible solutions?
 - Could the client benefit from physical therapy or occupational therapy?
 - Should an OT evaluation be done to determine whether equipment can meet the need or if a modification is the most cost-effective alternative?
 - Is the client eligible for a different type of lift paid for by insurance?

Additional considerations when determining viable alternatives and the possibility of an environmental modification:

- How long has the client lived at their residence?
- Do they own or rent?
- Are they planning on staying at this residence?
- Are repairs or general maintenance needed prior to using waiver funds for the modification? Does the client/landlord have the resources necessary to complete them?
- What condition is the home in?
 - General repairs or necessary maintenance discovered during a modification cannot be paid for using waiver funds. An example would be mold or asbestos discovered during a modification. Repairs and maintenance are considered "general utility" and are the responsibility of the homeowner.
- Will the home accommodate the changes structurally?

- Does the client already have an accessible entrance/exit from the home?
 - Social services may not be used if there is a safe, accessible entrance/exit or for more than one entrance/exit.

Additional Information:

- For modifications that will require an Exception to Rule (ETR) request to exceed rate maximum limits, cost-effective alternatives explored to address the barrier must be documented in the ETR (this should include specific alternatives such as Specialized Medical Equipment, not simply that the client's wants to remain in the community setting).
- For high-cost modifications, consider staffing the unique client situation with a supervisor to ensure all alternatives have been explored.
- A stair lift requires an elevator installation permit. The installation permit can only be purchased by a licensed elevator contractor. Prior to considering a stair lift, explore all available options which may include converting a room or part of a room on the main floor into a bedroom, if there are adequate bathroom facilities on the main floor.

When a client is in a nursing facility:

- Modifications may be authorized up to 180 days in advance of the community transition of a resident of a nursing facility.
- Environmental modifications started while the client is institutionalized are not considered complete and may not be billed until the date the client leaves the institution and is enrolled in the waiver.
- If the project is started for a client residing in a nursing facility and the client does not transition due to changing their mind, a significant change in condition, or dies before completion, the authorization must be switched to state-only funds (SOAP RAC).
- If an in-home client dies or admits into a nursing facility or acute care hospital, and the client is not expected to return in a timely way, the authorization for environmental modification must be switched to the SOAP RAC.

When a client is renting their home:

- Under fair housing laws, landlords must *provide* reasonable accommodations, which could include things like providing a lease in large print, reading aloud the lease for someone who is blind, and providing a doorbell signaler for someone who is deaf. Reasonable accommodations are adjustments in rules, procedures, or services.
- Under fair housing laws, landlords must *allow* reasonable modifications, but they are not necessarily obligated to pay for the modifications. Reasonable modifications are a change in a dwelling that is needed to live safely. Some landlords may be willing to complete and pay for reasonable modifications, so that resource should always be explored first.
- Examples of "reasonable modifications" include widening doorways, installing grab bars in the bathroom, and adding ramps to make a primary entrance accessible.
- The landlord is responsible for general maintenance and repairs that may be required prior to the start or completion of the modification (such as mold or asbestos removal).



- Approval for a modification must be given in writing from the landlord/homeowner prior to an authorization being created. Use [DSHS form 27-147](#), Housing Modification Property Release Agreement to obtain written approval. This form is a legally binding form and cannot be altered in any way.
- If a landlord refuses to sign the form, a client may consider seeking legal advocacy.

NOTE: Use DSHS form 27-147A for RCL's Environmental Adaptations In-Home: General Utility or Repairs Allowance (service code [S5165 U3](#)). See [Chapter 29: Roads to Community Living](#) for more information about Environmental Adaptations In-Home General Utility or Repair Allowance.

Authorization of the Environmental Modification:

1. Best practice: obtain at least two bids for environmental modification, when possible, to allow client's choice of provider and to ensure paying a competitive rate.
2. Create the authorization in "Reviewing" status based on the approved bid.
3. Prior to authorizing payment, obtain a final invoice to verify actual costs and completion of the environmental modification. Confirm: 1) the project was completed as bid and authorized; and 2) document in an SER that the client is satisfied with the completed project.
4. If criteria described in #2 (above) is confirmed, change the authorization to "Approved" status and change the end date to the date the modification was completed. Payment will automatically be made to the provider.
5. Submit the final invoice with a completed [Social Service Packet Cover Sheet](#) to DMS.

Environmental Modification Service Code:

- [S5165 UA](#)
- Limit without ETR \$700.00 per occurrence.
- Limit of \$4000 without ETR for construction of ramps.

Provider Qualifications:

- Meet the standards of [Chapter 18.27 RCW](#) Registration of Contractors, and
- Have a current contract with the Department.
- If a stair lift is being authorized, the contracted environmental modification provider must hold an elevator license.

Volunteer Provider Qualifications:

- Sign Confidentiality Statement,
- Have knowledge of building codes as applicable to the task,
- Have costs less than \$500 per [Chapter 18.27.090\(9\) RCW](#) (Note: volunteers are reimbursed for costs of supplies and materials but are not reimbursed for labor), and
- Have a current contract with the Department.

See [Specialized Equipment and Supplies](#) section for information regarding portable ramps less than eight (8) feet in size. Ramps larger than eight (8) feet must be installed by a vendor with an Environmental Modification contract.

Home Delivered Meals (HDM)

HDM provide nutritionally balanced meals delivered to the client's home. Home delivered meals offer additional face-to-face contact to monitor the client's well-being and safety or a mail delivery option is available when the in-person delivery is not feasible.

To qualify for home delivered meals the client must meet all of the following criteria:

- 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.

NOTE: Clients currently receiving home delivered meals only from an Older Americans Act (OAA) HDM program should be transitioned to CFC + COPES at their next regularly scheduled assessment to access the in-home COPES waiver HDM service. For a CFC only client, an NGMA may need to be completed, see [Chapter 7h: Appendices](#).

These meals must not replace nor be a substitute for a full day's nutritional regimen but must provide at least one-third (1/3) of the current recommended dietary allowance as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council.

A unit of service equals one meal. No more than one meal per day will be reimbursed under the waiver. This is not subject to an Exception to Rule.

When a client's needs cannot be met by a Title III provider due to geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, or existing Title III provider waiting lists, a meal may be provided by:

- Restaurants,
- Cafeterias, or
- Caterers who comply with Washington State Department of Health and local board of health regulations for food service establishments.

Deductions from CARE generated hours for Home Delivered Meals:

- A deduction of 0.5 hour (30 minutes) must be taken at the end of the assessment for each home delivered meal regardless of the funding source. Through COPES funding, only one meal per day may be authorized. If 31 days are authorized, a maximum of 15 hours should be deducted from the CARE hours.

- If a client is on CFC or MPC, and not eligible for COPES, and is receiving home delivered meals, a deduction of 0.5 hour (30 minutes) must still be taken at the end of the assessment for each home delivered meal. See Chapter [7b](#) and [7c](#).
- If the client chooses to receive additional home delivered meals through another non-HCLA paid funding source, then a 0.5-hour (30 minutes) deduction will be made for each additional meal beyond the 15-hour COPES maximum deduction.

Clients must not be referred to the OAA HDM program unless the client:

- Is an in-home waiver client age 60 years or older,
- Still has an unmet need in meal preparation for other meals, and
- Chooses to get the need met with an additional HDM rather than having the in-home provider prepare the meal.

Home Delivered Meals Service Code:

- [S5170](#)
- There is a limit of one meal per day through COPES funding.
- An ETR for more than one meal per day is not available.

Provider Qualifications:

- Provider must have a staffing pattern that includes a Nutrition Program Director, Registered Dietician, or Individual with Comparable Expertise (ICE) certified under [RCW 18.138](#);
- Deliver meals in a manner that provides a face-to-face contact with the client to monitor general well-being and safety;
- Comply with the state Senior Nutrition Program Standards for home delivered meals;
- Meet Food Service Vendor rules – home delivered nutrition program standards and [Chapter 246-215 WAC](#) (food service); and
- Have a contract with DSHS or AAA.

Note: The service is considered completed when the meals are delivered to the client. If a client enters the hospital after the service has been completed the service line can be end dated with the date the client enters the hospital with no reduction of units and no overpayment referral for the provider.

Nursing Services

Nursing Services is not a specific waiver service but is available to COPES waiver clients. Nursing Services offer clients (e.g., COPES, CFC, MPC and DDCS Waiver Personal Care), providers, and case managers with health-related assessment and consultation to enhance the development and implementation of the client's plan of care.

A nursing services provider is not a direct care provider of intermittent or emergency nursing care, skills or services requiring physician orders and supervision.



The goal of nursing services is to help promote the client's maximum possible level of independence and contribute nursing expertise by performing the following activities:

- Comprehensive Assessment Reporting Evaluation (CARE) review, which includes Skin Observation Protocol (SOP) and the other triggered referrals;
- Nursing assessment/reassessment;
- Instruction to care providers and clients;
- Care and health resource coordination;
- Referral to other health care providers; and/or
- Evaluation of health-related care needs affecting service planning and delivery.

Skilled *treatment* is provided by Nurse Care Consultants (NCC) or Registered Nurse Case Managers (RNCM) only in an emergency. For example, the provisions of CPR or first aid until emergency responders arrive to provide care.

This service does not typically require an authorization in ProviderOne since HCS and AAA nursing staff are most commonly used for this service. For more information about Nursing Services, including referral process and resources, see LTC Manual [Chapter 24 Nursing Services](#).

Provider Qualifications:

- Registered nurse (RN) licensed under [Chapter 18.79 RCW](#) and [Chapter 246-840 WAC](#), and
- Contracted with the AAA, employed by the AAA, or employed by HCS.

Skilled Nursing

Skilled Nursing services must be included in the client's service plan and the skilled tasks must be within the scope of the State's Nurse Practice Act.

Skilled Nursing services under the waiver differ and are beyond the amount, duration or scope of Medicaid-reimbursed home health services as provided under [WAC 182-551-2100](#) in the State Plan:

- Under the State Plan, skilled nursing is intended for short-term, intermittent treatment of acute conditions or exacerbation of a chronic condition.
- Under the waiver, skilled nursing is used for treatment of chronic, stable, long-term conditions that cannot be delegated, self-directed or provided under State Plan skilled nursing.

Skilled Nursing visit authorizations:

- For all Skilled Nursing visits, the case manager will authorize the visits using 1 unit = 15 minutes.
- The case manager can authorize up to 100 units per month.
- The Skilled Nurse can bill for visit time, documentation, and travel time.
- When Skin Observation Protocol (SOP) is triggered, the case manager will authorize the visits using 1 unit = 15 minutes
 - The case manager can authorize up to 24 units for an SOP referral.
- Each Skilled Nurse will need to keep a "Time Sheet Log" and have it available upon request of the Area Agency on Aging (AAA) or the HCS Nursing Services Program Manager for the purpose of auditing and billing questions.

Skilled Nursing Service Codes:

- [T1002](#) for Skilled Nursing RN visits
- [T1003](#) for Skilled Nursing LPN visits
- [T1002 U2](#) for Skin Observation Protocol (SOP) visits
- For the most current Skilled Nursing rate, check the rate sheet online [here](#).
- Exception to Rule (ETR) instructions for additional units that exceed system parameters must be authorized through this process prior to approval or payment.
 - Submit an Exception to Rule (ETR) in CARE;
 - Upload all supporting documentation; and
 - Notify the Nursing Services (NS) Program Manager (PM) via email (nursingservices@dshs.wa.gov) once the ETR has been entered.
- Following approval, the NS PM will override the system error in CARE, if applicable.

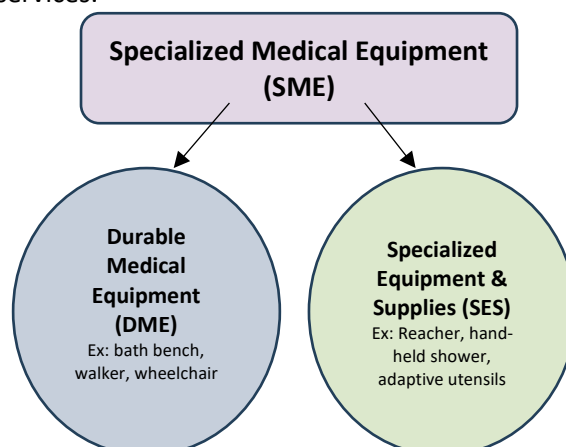
Note: COPES client support training cannot be used to authorize training a nurse to complete skilled nursing tasks.

Provider Qualifications:

- Registered Nurse licensed under [Chapter 18.79 RCW](#) and [Chapter 246-840 WAC](#), or
- Licensed Practical nurse licensed under [Chapter 18.79 RCW](#) and [Chapter 246-840 WAC](#), working under the supervision of a Registered Nurse per State law, or
- Home Health Agency licensed under [Chapter 70.127 RCW](#), and
- Have a Waiver Skilled Nursing Services contract with the AAA.

Specialized Medical Equipment and Supplies (SME)

SME, as defined in the waiver, includes items that may also be known as durable medical equipment (DME) and specialized equipment and supplies (SES). All items must meet applicable standards of manufacture, design, and installation. Once purchased, the item becomes the client's property. This service also includes maintenance and upkeep of items covered under the service and training for the client/caregivers in the operation and maintenance of the item. Training may not duplicate training provided in other waiver services.



DME, as defined under [WAC 182-543](#), include items which are necessary for:

- Life support;
- To increase the client's ability to perform ADLs;
- To perceive, control, or communicate with the environment in which he/she lives; or
- Are directly remedially beneficial to the client; and
- Do not replace, any medical equipment and/or supplies otherwise provided under Medicare and/or Medicaid.

Lift Chairs:

- See the SCDS for [SA419](#) for instructions and policy specific to authorizing purchase of lift chairs.
- An HCLA HQ ETR must be approved prior to creating the authorization for a lift chair when the client needs cannot be met within the rate range for the furniture portion of the chair:
 - After processing the ETR locally in CARE, email the quote and medical recommendation to [DME ETR Committee](#)
 - After reviewing locally, the ETR is sent Pending HQ Approval to "DME ETR Committee" in CARE.
 - If approved, case manager creates the authorization in CARE and request to have the rate forced by the DME ETR Committee staff.

Bathroom Equipment:

The Apple Health Medicaid benefit covers DME bathroom equipment. Per the [Health Care Authority's \(HCA's\) Washington Apple Health \(Medicaid\) Medical Equipment and Supplies Billing Guide](#) covered durable medical "bathroom safety equipment is considered medically necessary when, based on the client's medical condition, the client is at risk of falls or other injuries while performing activities of daily living (ADLs) necessary to maintain or improved their health, such as bathing and toileting."

Because Medicaid LTSS is the payor of last resort, if a case worker receives a request from a client for DME bathroom equipment or is aware of the client's need for DME bathroom equipment, the case worker will direct the client or the client's designated representative to the client's healthcare provider who will write a prescription for the DME bathroom equipment and will send the prescription to the client's chosen DME provider/supplier. DME bathroom equipment should be covered through the client's Apple Health medical benefit.

The DME provider/supplier will know the HCA billing process and what documentation is needed to process the DME bathroom equipment request. Here is the [step-by-step guide for prior authorization](#) that DME providers/suppliers have been given, but can be shared with them.

Bathroom equipment should never hold up a hospital or nursing facility discharge, the discharge planner and the DSHS/AAA case worker should connect and coordinate regarding equipment needs. If there is an urgent need or any issues, the case worker can reach out to the HCA DME inbox (DME@hca.wa.gov) with the client's name and their ProviderOne ID for assistance.

When Apple Health/HCA Denies the DME Bathroom Equipment Request (which should not be often)

If the client's Medicaid Apple Health medical benefit does not cover the needed/requested DME bathroom equipment and an HCA denial is received, which should be rare, the client should submit an appeal of the denial to HCA through an HCA administrative hearing.

If through the HCA administrative hearing process, the client does not get the DME bathroom item approved, the case worker may submit a Specialized Medical Equipment & Supplies ETR request to headquarters (HQ) for review. For DDCS, the request is a Prior Approval.

To inquire about the status of a DME bathroom equipment request, denial or appeal, the case worker can email the HCA DME inbox (DME@hca.wa.gov). In the email, provide the client's name, the client's ProviderOne ID number, and your inquiry.

If a Specialized Medical Equipment & Supplies ETR is required, case workers will complete the following:

1. **Assessment:** the need for the DME bathroom equipment must be documented as "Needs, wants" on the Bathing or Bladder/Bowel Activity of Daily Living (ADL) screen in CARE.
2. **ETR created in CARE:**
 - ETR Category: select "waiver services" for COPES clients
 - ETR Type: "Specialized Medical Equipment and Supplies"
 - Request description section: use the following template language:
 - Request is to purchase a [enter DME bathroom item] that has been denied by HCA. Client's request did not meet HCA's criteria for coverage of this bathroom equipment.
 - Justification for request section: add information to support the purchase and the reason the item was denied by HCA.
 - Alternatives explored section: n/a
 - Assign the DME ETR to HCLA HCS DME ETR Committee
3. Email the following **supporting documents** to dmeetr@dshs.wa.gov:
 - The DME provider/supplier quote with justification that the rate is 80% of the Manufacturer's Suggested Retail Price (MSRP) or 125% of the provider's invoice cost.
 - The healthcare professional's prescription/recommendation (signed by the healthcare professional with their printed name and credentials).
 - The denial documentation from HCA.
4. After the DME ETR is reviewed by the HQ DME ETR Committee and an approval is received, the case worker creates a social service payment authorization for the approved equipment using the DME blanket code [SA875](#), following all instructions, with the authorization in "Reviewing" status.
5. Upon confirmation that the client has received the equipment, and the case manager has received an invoice from the DME provider/supplier, the case manager will update the authorization status to "Approved" and the DME provider/supplier will be able to claim.
6. Submit to the client's electronic case record (ECR) a Social Services Packet Cover Sheet ([DSHS 02-615](#)) with the DME provider/supplier's invoice, their cost justification documented, the healthcare professional's prescription, and the denial from HCA.

Most commonly requested items in the SA875 blanket code include but are not limited to:

- Bath stools
- Bathtub wall rail (grab bars)
- Bedside commode chair
- Raised toilet seat
- Shower chair (not rolling)
- Shower/commode chair (not rolling)
- Standard and heavy-duty bath chairs
- Transfer bench for tub or toilet (not rolling)

See [Bathroom ETR Reference Tools](#) for more information.

Coverage of Other Durable Medical Equipment by Apple Health

[WAC 182-543-7200](#) allows for the Limitation Extension of services in cases when a provider can verify that it is medically necessary to provide more units of service (quantity, frequency, or duration) than are allowed in the State Plan. Case workers should assist clients in requesting the DME vendor to pursue an approval of limited extension from Apple Health (FFS or MCO) prior to authorizing additional units of service through the waiver. Examples include when a client needs more incontinence supplies than allowed in a month or a walker needs to be replaced sooner than allowed.

Some DME requires a **Prior Authorization** (PA) to be covered by Apple Health. [WAC 182-543-7100](#) details the prior authorization process that a vendor must follow for coverage. It is the responsibility of the DME vendor to be aware of the criteria and process necessary to pursue PA or LE per the published DME Billing Guide. Case workers can assist clients with the process, as necessary.

DME vendors must accept the Medicare and/or Medicaid DME rate as payment in full. The vendor cannot accept additional funds from the client, personal assistants, family, other Medicaid services (e.g., waivers) or any other organizations for services/items covered. However, the vendor can refuse to serve the client for any reason, including due to the rate. If a vendor refuses to serve a client, the case manager/social worker may use the [ProviderOne Find a Provider search tool](#) to assist the client to find a different vendor or look on the client's managed care organization's website.

Medicare and Apple Health publish their reimbursement rates for DME. Published reimbursement rates cannot be exceeded, including through a social service authorization or an ETR in CARE.

Waiver funds can only be used to pay for medical equipment and supplies that have been denied by, or are not covered by, Medicare and/or Medicaid. If the item is denied, documentation of the denial should be included in the client's electronic record (if not available to review in ProviderOne).

- Authorize DME services in "Reviewing" status using cost included in quote.
- Once it has been confirmed that the DME has been received by the client, update the authorization to the actual cost as reflected in the invoice.
- Change the status of the authorization to "Approved", allowing the provider to claim.
- The case worker should submit a [Social Services Packet Cover Sheet](#) to DMS with the invoice from the vendor and medical recommendation paperwork attached.

Durable Medical Equipment Service Codes:

- [SA875-SA887](#)
- If you are unsure what DME code should be used, ask the vendor what Health Care Procedure Code System (HCPCS) item code they will use to bill for the equipment in the ProviderOne billing system. Durable Medical Equipment codes (referred to as Group codes on the list) are “blanket” codes that cover multiple HCPCS codes. You can then search the HCPCS code (titled Proc/Svc code) in the link above to identify the corresponding DME code.

There is a limit of \$700 per occurrence without a local ETR (this ETR is not in regard to the rate of an item, it is solely to exceed the maximum service limit).

HQ DME ETRs are required for the following situations:

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

Specialized Equipment and Supplies (SES)

SES are non-medical equipment and supplies such as items that are never covered by Health Care Authority. Examples include waterproof mattress covers, handheld showers, reachers, urinals, adaptive utensils/plates/cups and portable ramps that don't involve any structural modifications to the client's home. To provide SES, a provider must hold the statewide SES contract, which is executed by HCS HQ.

SES are items that are:

- Necessary to increase the client's ability to perform activities of daily living; or
- Necessary for the client to perceive, control, or communicate with the environment in which the client lives; and
- Of direct remedial benefit to the client; and
- In addition to any medical equipment and supplies provided under the Medicaid State Plan, Medicare, or other insurance.

Notes:

- **Ramps:** When a portable, mini, or threshold ramp will meet the client's needs, a vendor with a Specialized Equipment and Supplies (SES) contract can provide the item when there is a single step with a maximum 7.75" rise:
 - The ramp must meet ADA specifications regarding slope.
 - The ramp cannot exceed 8 feet in length and cannot require installation other than to secure to the residence with a few screws.
 - The CM authorizes service code [SA421](#).
 - Reminder: for ramps necessary to cross more than one step, the vendor must have an environmental modification contract, and it is to be authorized as an environmental modification. This includes a ramp made of wood, a modular aluminum system (also

referred to as a semi-permanent ramp), or any other material. See the [Environmental Modification section](#) for more information.

- **Portable vehicle ramps:**
 - Not available through COPES due to concerns about the length of the ramp required to meet ADA slope requirements as well as potential risk of injury to the client and potential risk of damage to the wheelchair and vehicle if not set up and used correctly.
 - If a client has a bulky, motorized wheelchair, a lightweight manual chair may be available through Apple Health (AH). See [AH's Medical Equipment and Supplies Billing Guide](#) for additional information.
- **Grab bars:**
 - All grab bars should be authorized using [SA421](#) regardless of placement in the home (bathroom, hall, near doors/stairs, etc.).
 - All policies regarding SES apply.
 - A bathtub rail is considered a grab bar. **NOTE:** Toilet rails are NOT considered a grab bar and continue to be subject to the bathroom equipment ETR process because they may be covered by Apple Health.
 - Reminder: ensure that the most cost-effective item that will meet the client's needs is selected. At times, there can be a drastic difference in rate a grab bar depending on the selection of the finish (for example: nickel vs. white).
 - Current policy regarding installation is still valid:
 - Grab bars are to be included in a bid from a contracted environmental modification provider if installation is required. A separate authorization for the grab bar is not necessary if it is provided by the e-mod contractor.
 - If the only "modification" occurring is the installation of the grab bar(s), please make sure there are no other installation options available before authorizing an environmental modification. Consider: apartment maintenance staff (if applicable), family member, ADA compliant suction cup version (if appropriate), etc.
 - For CFC-only clients:
 - A client who needs a grab bar may be COPES eligible and a NGMA should be pursued. The client may benefit from other waiver services in addition to the grab bar.
 - If a client is not COPES eligible, other CFC benefits may be considered, including AT. If a client has used their annual AT budget, an ETR should be submitted to the HCS CFC Program Manager.
- **Incontinence Wipes ([SA421/U2](#) modifier):** Incontinence wipes are not approved as a complete replacement for toilet paper and cannot be requested to aid in menses care or for caregiver convenience.
 - Incontinence wipes are considered non-medical supplies that do not require Medicaid denial.
 - Incontinence wipes authorized for a client are the client's property and should not be stored or used communally in residential settings like adult family homes or assisted living facilities.
 - Before a case worker creates an authorization for incontinence wipes, the case worker must ensure the client's assessment:
 - Describes the client's support needs surrounding toileting and hygiene.
 - Identifies frequency and special considerations of toileting needs.

- Explains how incontinence wipes will increase independence with proper hygiene or prevent reoccurrence of a documented health condition.
- If a client requires a specialized kind of wipe (e.g., organic, all-natural, water-based, plant-based), the client must have an allergy or chronic skin condition documented in CARE and verified in a recent medical record.
 - The allergy must be to an ingredient in a standard wipe.
 - The chronic skin condition must be exacerbated by an ingredient in a standard wipe.
- [SA421/U2](#) is a monthly recurring payment type. The authorization is created based on the quote for a monthly supply (plus sales tax and shipping costs).
- Authorizations for monthly recurring payments are not subject to being created in Reviewing status. The provider will be able to claim monthly with no action required from the case worker on the authorization.
- To help determine appropriate monthly amount of wipes: a study by the NIH concluded that residents of nursing homes could be adequately cared for using 3-4 wipes per toileting session.

Specialized Equipment and Supplies:

- [SA421](#)
 - Limit of \$700 per occurrence without ETR.
 - Limit of \$4000 only for portable ramps per occurrence without ETR (see note above).
 - Authorize in “Reviewing” status.
 - Make a note of the item being authorized, sales tax and shipping costs per quote, in the comments section of the authorization.
 - Authorize SES services in “Reviewing” status using costs included in quote.
 - Once it has been confirmed that the SES has been received by the client, update the authorization to the actual cost as reflected in the final invoice.
 - Change the status of the authorization to “Approved”, allowing the provider to claim.
 - The case worker should submit a Social Services Packet Cover Sheet to DMS with the invoice from the vendor.
 - If the client did not receive the item and the vendor claimed, the vendor is at risk for an overpayment, as detailed in the provider’s contract.
- [SA421/U2](#) Modifier (incontinence wipes)
 - Create authorization for up to a six-month period.
 - A provider with a fully executed Specialized Equipment and Supplies contract must be authorized for incontinence wipes. Because SES contracts are statewide and these will be shipped, any vendor with the SES can provide wipes (not limited to local providers).
 - Create based on a quote for a one-month’s supply, including sales tax and shipping costs.
 - Sales tax and shipping costs should be documented in the Comments section of the authorization.
 - Need for incontinence wipes should be re-evaluated regularly and the authorization ended if client no longer has a documented need, or the need is being met in another way.
 - [SA421/U2](#) is a monthly recurring payment type, so the authorization is not subject to being placed in Reviewing status.



- Per current SES policy, the case worker must verify that the client received incontinence wipes as authorized each month.
- The case worker should submit a Social Services Packet Cover Sheet to DMS with the invoice from the vendor.
- If the client did not receive the item and the vendor claimed, the vendor is at risk for an overpayment, as detailed in the provider's contract.

Items that are not covered/allowed using COPES SME funding include, but are not limited to:

- Hearing aids
- Visual aids, including eyeglasses
- Computer software and accessories
- Nutritional supplements (prescribed or not)
- Heating pads and cold packs
- Foot massagers
- Thickeners
- TENS units
- Exercise equipment
- Dentures
- Furniture that is of general utility (e.g., tables, lamps, etc.)
- Household items that are of general utility (e.g., shampoo/soaps, air conditioners, shower capes, sharps containers, toileting stool aka "poop stool", etc.)
- Vehicle modifications including portable vehicle ramps, scooter/wheelchair racks, etc.
- Items HCA considers experimental (e.g., PureWick female catheter system, "stand-up" walkers, stair climbers, seat elevators, etc.)
- Home telemetry devices (home heart monitors for use with a smart device)

Provider Qualifications:

- DME vendors must have a Core Provider Agreement (CPA) with the Health Care Authority (HCA) as a Medicaid vendor and be Medicare certified.
- Specialized Equipment and Supplies (SES) vendors:
 - Must have a current SES contract.
 - May also have a CPA as a DME vendor, but it is not required.
 - Have provider taxonomy 33NM00000L.
 - SES contracts are statewide contracts (vendors not limited to a specific service area).

Transportation

Transportation is a service offered to enable clients enrolled in the waiver to gain access to waiver and other community services, activities and resources, as specified in the service plan. This service is offered in addition to medical transportation required under [42 CFR §431.53](#) and transportation services under the State Plan, defined at [42 CFR §440.170\(a\)](#) (if applicable), and **must not replace them**.



Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge should be utilized.

To authorize transportation services, the case manager must ensure the service:

- Provides access to community services and resources to meet the client's therapeutic goal; and
- Is not diverting in nature (such as traveling to recreational activities); and
- Is in addition to, and does not replace, the Medicaid-brokered transportation [42 CFR §440.170\(a\)](#) or transportation services available in the community; and
- Does not replace the transportation services required by the DSHS contract for clients living in licensed residential facilities.

This service does not replace Individual Provider (IP), or home care agency provided transportation to medical appointments and essential shopping as assessed and assigned in CARE.

In the CARE assessment "Supports" screen connect "Other Treatment" non-medical transportation as a **paid** task to **paid** transportation service provider.

To authorize transportation services:

1. Receive a bid from the contracted vendor(s). This bid should include mileage and any additional rates.
2. Authorize the transportation service with service code [T2003](#) for one (1) unit per trip for the period of time that the client will receive the service.
 - a. There should be a matching invoice per trip that is submitted to the case manager after the service is provided.
3. After the service is provided, the contracted vendor will then claim the unit in ProviderOne and the payment will be issued.

Transportation Service Code:

- [T2003](#) **Transportation Expense Reimbursement** to authorize non-medical transportation rates and mileage.

Provider Qualifications:

- Have Waiver Transportation Services contract with the AAA
- Meet the same standards as those applied to vendors who provide access to State Plan medical services
- May include:
 - Agencies
 - Sole Proprietors
 - Volunteers
 - Taxis
 - Public transit

RESOURCES

Related WACs and RCWs

WAC 182-501-0060	Health care coverage—Program benefit packages—Scope of service categories.
WAC 182-512-0050	SSI-related medical—General information.
WAC 182-515-1506	Home and community based (HCB) waiver services authorized by home and community services
WAC 182-543-7100	Prior authorization
WAC 388-71-0701 through 0839	Adult Day Services
WAC 388-106	Long-term Care Services
WAC 388-106-0300 through 0335	Community Options Program Entry System (COPES)

Acronyms

AAA	Area Agency on Aging
ADA	Americans with Disabilities Act
ADC	Adult Day Care
ADH	Adult Day Health
ADL	Activity of Daily Living
AFH	Adult Family Home
ARNP	Advanced Registered Nurse Professional
CARE	Comprehensive Assessment Reporting Evaluation
CCG	Community Choice Guide
CDSMP	Chronic Disease Self-Management Program
CFC	Community First Choice
CIL	Centers for Independent Living
CM	Case Manager
CN	Categorically Needy
COPES	Community Options Program Entry System
DDCS	Developmental Disabilities Community Services
DME	Durable Medical Equipment
DMS	Document Management Services
DSHS	Department of Social and Health Services
ETR	Exception to Rule
FFS	Fee For Service
HCA	Health Care Authority
HCLA	Home and Community Living Administration
HCS	Home and Community Services
HDM	Home Delivered Meals
HQ	Headquarters
IADL	Instrumental Activity of Daily Living

ILS	Independent Living Services
LPN	Licensed Registered Nurse
LTC	Long Term Care
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MPC	Medicaid Personal Care
OAA	Older Americans Act
OT	Occupational Therapist
PA	Prior Authorization
PACT	Program for Assertive Community Treatment
PT	Physical Therapist
RN	Registered Nurse
SER	Service Episode Record
SES	Specialized Equipment and Supplies
SLA	Service level agreement
SME	Specialized Medical Equipment
SOP	Skin Observation Protocol
SSAM	Social Service Authorization Manual
SSI	Supplemental Security Income
WAC	Washington Administration Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
4/2026	Becca Howard	- Updated contact information - Updated Skilled Nursing Services ETR process - Updated steps to authorize a CCG - Updated language for authorization extensions related to Client Training service	
11/2025	Annie Moua	- Updated to SA266 – Issuing Payment for AT Goods - Updated CCG language to reflect changes to the contract language	TBD
8/2025	Annie Moua	- Update Skilled Nursing – SOP service code and instructions - Add Client Training – EBT Enhance® Fitness - Update Appendix document links - Update AL TSA to HCLA and DDA to DDCS	H25-039
4/2025	Annie Moua	- Update chapter template - Minor formatting and grammar updates - Update to DME bathroom equipment process to follow process outlined in MB H24-067 - Updated CCG guides and added a clarifying note	H25-010

7/2024	Annie Moua	• Update Adult Day Services to include information about the remote/hybrid service delivery option • Update CCG services to align with the RCL Chapter and include: ○ Additional information regarding tasks outside of CCG scope of work ○ Details under the SA266 service code to clarify its use. ○ Steps to authorize CCG Services	H24-044
5/2024	Annie Moua	• Include Spanish in list of translation options for Wellness Education • Clarification on personal care hour deduction for clients not eligible for COPES but receiving HDM through another funding source. • Added descriptions examples of client support trainings • Added reference to DSHS form 27-147A, RCL's Environmental Adaptations In-Home General Utility or Repair Allowance Property Release Agreement.	H24-018
1/1/2024	Annie Moua	• Update Adult Day Care to include the ADC provider as informal support when coding status for each ADL and IADL task that is provided by the ADC provider • Update Transportation service codes and authorization process • Clarification added in CCG and Community Supports: Goods and Services	H23-090
10/1/2023	Annie Moua	• Corrected eligibility for services authorized by DDCS.	H23-071
6/1/2023	Debbie Blackner	• Added contact information for Medicaid Waiver Program Manager • Clarification regarding storage of incontinence supplies in AFH, ALF • Clarification regarding CCGs and 1) housing search, 2) driving a client's car, and 3) going into a client's home without the client or representative present. • Details that SME is the property of the client once purchased.	

		In Appendix: removed some attachments and inserted link	
12/30/2022	Debbie Blackner	- Clarifications and corrections regarding Client Training - Information on which tasks a CCG can complete when a client needs assistance hiring an IP. - Updates to the Environmental Modification section. - Removed the local review/approval requirement for bathroom equipment ETRs.	H22-064
9/13/2022	Grace Brower	- Update Consumer Directed Employer of WA relating to Community Choice Guide services - Home Delivered Meals service note	H22-042
6/9/2022	Debbie Blackner	- Updated the Nursing Service Program Manager information - Clarified transportation options under Community Supports: Goods and Services - Added a section regarding incontinence wipes authorized using SA421/U2. - Provided clarifications regarding Environmental Modifications - Added a section on SA421/U2 for authorizations of incontinence wipes.	H22-028
4/12/2022	Grace Brower	Updated Transportation service codes	H22-020
8/4/2021	Debbie Blackner	- Added information regarding Wellness Education. - Clarified contracting requirements for pest eradication, janitorial services and movers. - Added updated information regarding vehicle ramps, rolling shower equipment, and grab bars. - Added examples of items HCA considers experimental - Added additional reference tools to the Appendix.	H21-080
1/3/2020	Debbie Blackner	Added information regarding CCG rate revision	H19-051
10/1/2019	Debbie Blackner	Reworded the DME definition to align with current WAC	
10/1/2019	Debbie Blackner	Provided process to request an increase to the rate on the furniture portion of a lift chair	NA

APPENDIX

[Wellness Education: Helpful Tips for Addresses](#)

[Wellness Education Claims Span Single Date Range Desk Aid](#)

[Wellness Education Claim Span Multiple Dates Desk Aid](#)

[Purchasing Desk Aid – DME SES AT CTSS](#)

[Which Program to Use-Transition and Sustainability Goods and Services 03.2026](#)

[Transition Resources Guide](#)

DME Links:

- [HCA Equipment and Supplies Billing Guide](#)
- [Detailed DME Trainings, including environmental modifications, bathroom equipment ETR process and reference tools](#)