



The Long-Term Care Policy Manual: Roles and Responsibilities

This chapter defines the roles and responsibilities of the Long-Term Care (LTC) manual coordinator, management bulletin (MB) coordinator, and LTC chapter owners. This chapter provides policy guidance on writing and formatting chapters, submitting requests for policy clarification and drafting and coordinating management bulletins.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Jovi Sanchez Rules and Legislative Coordinator
360.915.4167 jovi.sanchez@dshs.wa.gov

Juliann Christoffersen Management Bulletin Coordinator
360.725.2312 juliann.christoffersen1@dshs.wa.gov

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BACKGROUND

The Long-Term Care (LTC) Manual is a set of standard operating procedures that guides line staff in partnering with clients and offering choice in accessing support, care, and resources. It provides up-to-date, clear, and concise policy language, which is critical for carrying out the duties of the department. Headquarters staff are responsible for coordinating and performing regular timely updates to this Long-Term Care Manual.

LONG-TERM CARE MANUAL—ROLES AND RESPONSIBILITIES

Policy owners, LTC Manual coordinators, chapter owners, regional and Area Agencies on Aging (AAA) partners, and the Home and Community Living Administration (HCLA) subject matter experts collaborate through a regular, standard process to update and maintain accurate and up-to-date policy in the LTC Manual chapters. This coordination also ensures a shared understanding and consistency in messaging to the regions. Throughout this chapter, the roles and responsibilities for those involved in the various LTC Manual processes will be defined and clarified.

What is the difference between policy owners and chapter owners?

Chapter owners are the person(s) responsible for the maintenance of a specific chapter of the LTC Manual. There may be multiple policy owners within a given chapter. It is the responsibility of the chapter owner to include all policy owners for their chapter in the revision/update process. An example of this is that Chapter 9 has chapter owners, but within that chapter, guardianship policy is referenced. Chapter 9 owner would need to include the guardianship policy owner at each revision/update cycle.

COORDINATING UPDATES TO THE LONG-TERM CARE MANUAL

What Is the Role of the LTC Manual Policy Owners for Maintaining Chapters and Chapter Updates?

Long-Term Care Manual policy owners are responsible for making timely updates to the chapter and act as subject-matter experts on the content of the chapters they are responsible for. Policy owners must collaborate regularly and frequently with regional, AAA, headquarters staff, Developmental Disabilities Administration (DDA), and community partners to ensure timely and accurate updates.

Special Note for Change of Chapter Ownership:

It is the responsibility of the out-going chapter owner or their supervisor to notify the LTC Manual Coordinator whenever there is a change in chapter ownership. The LTC Manual Coordinator needs to know the incoming or interim chapter owner's name and contact information prior to the transition taking place because access needs to be granted through a Service Now request.

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Policy owners are to collaborate with regional/AAA partners by responding to any requests made for policy update or clarification within **seven business days** and resolving the matter within **ten business days** of receiving the request. If a response requires multiple policy or program managers input and exceeds ten business days, policy owners need to communicate this delay and expected date of resolution to the requesting party. Policy owners also are required to collaborate on the development of or update to policy. This involves having discussions and providing adequate time to receive responses from regional/AAA teams and other policy owners at Home and Community Services (HCS) and AAA. HCS partners, including the AAA/Washington Association of Area Agencies on Aging (W4A) group, should be involved early in discussions on matters that may impact their work.

What is the Role of the LTC Manual Coordinator?

The LTC manual coordinator manages the updates and posting of the LTC Manual. In this role the LTC manual coordinator will create and set the triannual dates for updating chapters or establishing management bulletins to update chapters. This schedule will be sent to the chapter owners on an annual basis.

Schedule A draft of this schedule is as follows (please note the image below is an example of the schedule. Chapter and policy owners can refer to the [Long-Term Care Manual SharePoint site](#) for a current schedule:

LTC Manual Coordinator e-mails chapter owners to begin draft updates	Chapter draft due dates -- back to LTC Manual Coordinator	MB created by LTC Manual Coordinator and sent to the MB Coordinator	MB Coordinator routes MB to Office Chiefs	MB Coordinator routes MB to staff and stakeholders for review	Final steps to post updated chapters and release MB's
First week of March	First week of April	125-Jul	Third week of April	Last week of April	First week of May
First week of June	First week of July	15-Jul	Third week of July	Last week of July	First week of August
First week of September	Last week of September	28-Oct	First week of November	Mid-November	Third week of November
December to March are dedicated to the Legislative Session					

What is the Process for Coordinators and Policy Owners When Completing Chapter Updates During the Triannual Update Cycle?

1. LTC manual coordinator will notify chapter owners of each triannual chapter review and update period.
2. Policy/chapter owners will collaborate with subject matter experts (SMEs), joint policy owners, regional & AAA partners, and DDA staff on draft.
3. Obtain the owning office chief or unit manager's approval on the draft changes.
4. Policy/chapter owners will make edits to their chapter, ensuring all necessary edits are made prior to the scheduled due date. Leave track changes on this draft.



5. LTC Manual policy/chapter owners will notify the LTC manual coordinator that the draft version of chapter in track changes is available and ready for review in the LTC Manual Drafts folder on SharePoint and provide them with 3-5 bullets summarizing the key changes or updates made to the chapter by sending an email to the LTC manual coordinator of the bullet points. This is the information that the LTC manual coordinator will use in the management bulletin.
 - It is crucial that policy owners adhere strictly to the schedule/timelines provided for submissions of drafts to be published.
 - Policy owners will no longer need to email the LTC manual coordinator with the attached draft of their chapter, as all drafts will be maintained in the [LTC Manual Chapter Drafts](#) folder.
 - These revised chapters should have advanced approval from the author's office chief or unit manager. LTC chapter owners should discuss the process for their specific team with their immediate supervisor.
 - When saving these drafts, policy owners should utilize the naming convention of "Chapter #_short title_date_draft" (e.g. **Chapter1_LTCPolicyManual_May2025_draft**) to streamline the collaborative policy implementation process.
 - If you are late with your chapter, please let the LTC Manual Coordinator know prior to the due date of the draft submissions.

The timely submission of chapter drafts is critical to the LTC Manual update process.

6. LTC Manual Coordinator drafts LTC Manual Update Draft MB and sends it to the MB coordinator.
7. MB coordinator sends LTC Manual Update Draft MB out to Staff, AAA, and Community Partners to Review and Comment on Draft MB. (Note: On the draft submittal date to MB coordinator, revised chapters and bulleted information are sent by the LTC manual coordinator to the Management bulletin coordinator who notifies the appropriate regional/AAA and headquarters staff that the draft is open for their review and comments.)
 - The timeframe allotted for comments is approximately one week.
8. MB Coordinator collects comments from Staff, AAA, Community Partners and sends them to the LTC Manual Coordinator to distribute comments and feedback to LTC Chapter Owners.
9. The LTC manual coordinator forwards the submitted comments to the policy/ chapter owners, to which the policy owners can either agree or disagree, integrating the information or edits that the policy owner agrees with.
 - The chapter owner must respond to the LTC Manual Coordinator within **seven business days**.
 - **If edits are needed:** The policy owner will make the necessary adjustments and obtain the office chief or unit manager's approval before the finished document is placed in the [Finalized LTC Manual Chapters](#) folder on SharePoint.
 - **If no edits are needed:** The policy owner will finalize the draft and place the file into the [Finalized LTC Manual Chapters](#) folder on the LTC Manual SharePoint.



- When saving these final drafts to the [Finalized LTC Manual Chapters](#) folder on the LTC Manual SharePoint site, program managers should utilize the naming convention of “Chapter #_short title_date_final” (e.g. **Chapter1_LTCPolicyManual_June2025_final**) to streamline the collaborative policy implementation process.

9. Once final, the LTC manual coordinator verifies that the chapter is complete with track changes removed and is ready to be put in the final MB.

10. The final MB and finalized chapters are sent back to the MB Coordinator for the MB coordinator to send to HCS Director and DDA Director for review and approval.

11. The HCS Director and DDA Director review final MB. If there are any changes, the MB coordinator will communicate this back to the LTC manual coordinator. The HCS Director and DDA Director have a week for their review.

12. The MB coordinator publishes the finalized MB and the LTC manual coordinator creates the single PDF of the compiled LTC Manual. The LTC manual coordinator ensures the final chapters are ready to be published and requests the webmaster team post the finalized files on the [LTC Manual website](#).

When FINAL chapters are placed into the [Finalized LTC Manual Chapters](#) folder, they should be complete and ready for posting. This means all comments are removed and all track changes accepted or declined.

Prior to acceptance, the LTC manual coordinator will conduct a quality review to ensure the document meets all formatting standards and is complete, requiring no additional revisions.

How Often Must the Policy Owner Review Their Chapter(s) and Management Bulletin(s)?

Each chapter owner is responsible for updating their assigned chapter(s) upon entering their position and no less than tri-annually after that--meaning it must be reviewed for any necessary edits/corrections, and the last review or revision date should be updated to reflect this action on the chapter document itself. Chapters must be updated timely based on clarification requested from regional/AAA and headquarters staff or when new guidance is received. It is the expectation that chapter owners will respond to any requests for LTC updates or clarification received from regional/AAA or headquarters staff in a timely fashion, confirming receipt of the request within **seven business days** and offering a resolution within **ten business days**, as noted in the [“How Regions Can Request A Policy Update or Clarification” section](#).

During reviews, it is the responsibility of the chapter owner to adhere to the formatting outlined in the [Chapter Template and Style Guide 2025](#). This template and style guide is also available in the [Appendix](#) of this chapter.



Chapter owners are responsible for reviewing and making edits to draft chapter or management bulletins (MBs) after open comments are returned within **seven business days**. These are returned to the LTC manual coordinator via the LTC Manual SharePoint site so that they can continue the revision process without delay.

On a triannual basis, chapter owners will determine if management bulletins (MBs) that have been released for quick policy/procedure updates need to be added to the chapter and rescinded. [See MB process for more information.](#)

It is the responsibility of the chapter owner to learn and understand any programs or policies impacted by their chapter/policy. When policy changes affect other chapters, contact the other policy owner(s) to update their chapters accordingly. This ensures that consistent information will be provided across all chapters of the LTC Manual.

What Ongoing Work is Required for Policy Owners?

During off-cycle times, chapter owners should work with regions, other offices, AAA staff and subject matter experts (SMEs) to determine what changes, if any, need to be made to their chapters. If updates are needed, take the time to determine the potential impacts of these changes and vet your chapter updates before finalizing them. The best practice for doing this is by including others who may be impacted by the change (i.e. regional units, other Headquarters teams, AAA, and/or by presenting the change at the state-wide joint relations procurement (JRP)/social and health program consultant (SHPC) meeting). Lastly, coordinate any changes with the budget team, the Provider One team, and any other programs or entities that may be impacted, allowing enough time for their review and input.

It is the responsibility of the chapter owner listed within the chapter to properly maintain the chapter.

Chapter owners are responsible for responding to SharePoint requests about policy within **ten business days**, acknowledging receipt of the request within **seven business days**. If the policy is not clear, it should be updated to clarify appropriately. Delayed responses to these requests result in service delivery delays for our clients and increases the workload for our case management teams. These changes and/or clarifications, if adopted, can be communicated in a Management Bulletin or a formal update to the appropriate chapter. [See How Regions Can Request a Policy Update or Clarification section.](#)

WHAT MUST BE INCLUDED IN CHAPTER

The following are rules for what must be included in chapters, including the style guide that must be used for each chapter, which can be found here: [Chapter Template and Style Guide 2025](#). This document is also available in the [Appendix](#) section.

Please also follow the following guidelines to ensure policy can be operationalized at the regional/AAA level.



When a Chapter Identifies a Service

When a chapter identifies a service, include the following to assist case managers in navigating:

- a) List items to include when making a referral, how to refer, and the timeline for responses.
- b) Is there a requirement to try other services first?
- c) Are there other programs/services/options to consider? If so, when there are multiple choices that have differing eligibility criteria, spell out the differences between the choices. When able, provide a chart (flow chart, table, giving a visual diagram of the differences).
- d) What needs to be documented by a case manager and where (service episode record (SER) notes, treatment screen, forms, etc.)?
- e) What documentation, if any, must be submitted to Document Management Services (DMS)?
- f) What is the approval process and timeline?
- g) List what recipient aid categories (RACs) are eligible for this service?
- h) Provide authorization details—service code(s) and modifier(s), units allowed (link to [service code data sheet](#)).
- i) What client notices must be issued (i.e. Planned Action Notice (PAN)).

When a Chapter Covers a Program

When a chapter covers a program, include the following to assist case managers in navigating:

- a) Identify what makes a client eligible for the program including if other resources should be considered prior to accessing.
- b) What needs to be documented by a case manager and where (service episode record (SER) notes, treatment screen, forms, etc.)?

Many Chapters may include both programmatic and service eligibility information. For these LTC Manual chapters, ensure that service details and eligibility details follow the guidelines listed above.

TIPS FOR WRITING CHAPTERS

Think about the way the regions do their work. Your policy will be used to implement programs and services to the clients we serve. Using the following tips will help the case managers gain access to necessary information in an expedited fashion.

- Keep like topics grouped together. This allows the case manager to be able to find all the information pertaining to that topic in one place (e.g. put all bed hold information together in one section).
- Add links to other chapters if you are referencing that chapter. Try to link rather than replicate information in multiple chapters.
- Involve parties in discussions early when they will be impacted by the chapter creation or update. Seek feedback and allow adequate time for thoughtful responses.

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- Use the [Chapter Template and Style Guide 2025](#). Having familiar and consistent formatting across the LTC Manual makes individual chapters easier for our case management team to navigate.
- Prior to submitting final drafts of chapter, double check to ensure that all links work and that visual aids are correct.

How do Policy Owners Successfully Upload Documents & Attachments to the Designated LTC Manual Folder to Create Accessible Hyperlinks for Documents?

The Process

- **Step1:** Copy attachments to the designated folder: [\\dshswboly2411c\LTCAttachments](#). Please know that access to this folder is limited to policy and chapter owners.
- **Step 2:** Go to the website that allows you to view and search for the attachments and retrieve the public facing link to each attachment:
- **Step 3:** Use links in the LTC manual chapters. The link to an attachment can then be added to LTC chapter. Clicking on that link in the chapter will open the attachment for all public facing users to view

Naming Conventions for Attachments

Use a standardized naming convention for attachment of **Chapter # – Attachment Name.docx**. This will make it easier to identify and search for manual attachments for colleagues outside of the DSHS firewall or the public on the attachment web site.

For **documents referenced in multiple chapters**, please use the link that references the chapter that the attachment originates from. For example, to use an attachment from Chapter 3 on How to Identify a Guardian in Chapter 9 for inpatient assessing, you would find the attachment on the web site (<https://fortress.wa.gov/dshs/adsaapps/LTCAttachments/Default.aspx>) and utilizing the available link to the document by clicking the Copy Link option. There is no need to add the document again and re-name the documents to align with your chapter.

Chapter 3 HCLA - How to Identify a Guardian.pdf

06/04/2026

<https://fortress.wa.gov/dshs/adsaapps/LTCAttachments/documents/Chapter%203%20HCLA%20-%20How%20to%20Identify%20a%20Guardian.pdf>

[Copy Link](#)

Expanded Steps for this Process

Note: You must have authorized access to the folder before proceeding. If you do not have access to the folder, please contact Jovi Sanchez directly.

- **Start by clicking on this link to open the folder:** [\\dshswboly2411c\LTCAttachments](#)
- **To view or search attachments and links:** Go to the following web site: <https://fortress.wa.gov/dshs/adsaapps/LTCAttachments/Default.aspx>

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This web page will display all the uploaded attachments along with the date they were modified, and the link for each attachment to include in the desired LTC Manual chapter. You can copy that link manually or click the “Copy Link” option which will automatically save the link to your clipboard.

Home > Professionals & Providers > LTC Manual > **LTC Attachments**

LTC Manual Attachments

Search Attachments

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Name	Last Modified	Link	
Chapter 1 Chapter Template and Style Guide 2025.docx	06/03/2026	https://fortress.wa.gov/dshs/adsaapps/LTCAttachments/documents/Chapter%201%20Chapter%20Template%20and%20Style%20Guide%202025.docx	Copy Link
Chapter 1 Management Bulletin Blank.docx	06/04/2026	https://fortress.wa.gov/dshs/adsaapps/LTCAttachments/documents/Chapter%201%20Management%20Bulletin%20Blank.docx	Copy Link

Use the **Search** feature to quickly find attachments by name or chapter number.

LTC Manual Attachments

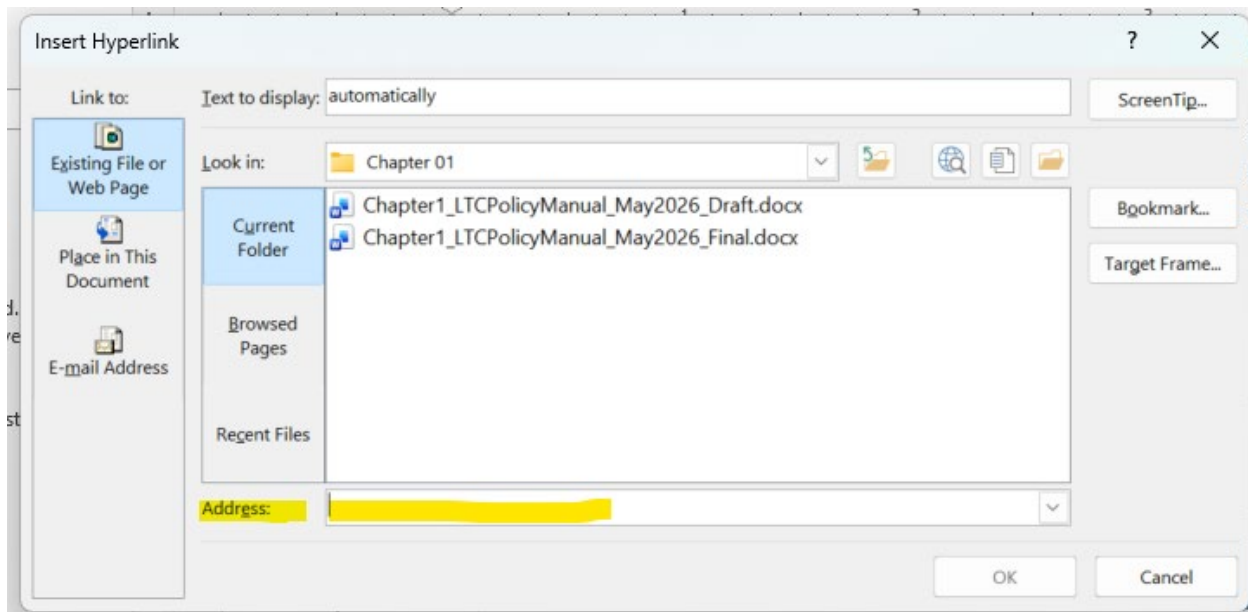
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Chapter 9 - Complex Case Staffing Referral Form.docx	05/18/2026	https://fortress.wa.gov/dshs/adsaapps/LTCAttachments/documents/Chapter%209%20-%20Complex%20Case%20Staffing%20Referral%20Form.docx	Copy Link
Chapter xx - attachment 1.docx	06/02/2026	https://fortress.wa.gov/dshs/adsaapps/LTCAttachments/documents/Chapter%20xx%20-%20attachment%201.docx	Copy Link
Desk Aid for Amazon Business .pdf	07/17/2025	https://fortress.wa.gov/dshs/adsaapps/LTCAttachments/documents/Desk%20Aid%20for%20Amazon%20Business%20.pdf	Copy Link
Financial Services Monitoring - Chapter 23b.docx	05/20/2026	https://fortress.wa.gov/dshs/adsaapps/LTCAttachments/documents/Financial%20Services%20Monitoring%20-%20Chapter%2023b.docx	Copy Link

- **Include links to attachments in LTC Manual chapters:**

To include the link in chapter, simply paste the copied link into the document by highlighting the text naming the document, right click and click on the word “Link” from the drop-down menu. Ensure you have selected to link to Existing File or Web Page, then paste the copied link into the address bar (see below image).



HOW TO CREATE A NEW CHAPTER

When the need is identified to create a new chapter the policy owner should consult with their supervisor or office chief prior to drafting that chapter. In the creation of the new chapter, it would be ideal to lay out the information that must be conveyed and any questions that could be asked and answered to assist in the operationalization of any processes. Once the draft is completed, it should be vetted with each office chief's teams and the W4A with a point person for each team to collect and share back any feedback. When comments and corrections are returned, the author should carefully work through this information looking for themes and how or if comments will be accepted. A response on what is and is not accepted should be provided to the point person(s) that comments were received from.

If the chapter is created outside of the triannual chapter update cycle, please follow the MB process for release. In this process, an MB would be submitted to the MB Coordinator and once approved, it would be posted to the MB intranet page. *It will NOT be posted on the LTC Manual webpage at this point.* At the next triannual cycle, the chapter can be integrated into the LTC Manual by following the process in the [What is the Process for Coordinators and Policy Owners When Completing Chapter Updates During the Triannual Cycle?](#) section for next steps. The draft of any new chapter would be the equivalent of the "draft updates" referenced in the flow chart and section.

When and How Should a Chapter be Dissolved?

Any policy owner or program manager may petition for the dissolution of a chapter. The process to dissolve a chapter should be enacted when a program or service has been suspended permanently or when legislative actions or administrative/departmental changes necessitate it.



Once the decision has been made it is necessary to dissolve a chapter, identify who needs to know (office chiefs, program managers, directors, etc.) and how you will communicate this change to that group. This can be worked on while the request navigates through the review and approval process. Much like the process to create a chapter, the request to dissolve a chapter should be submitted to the requestor's office chief for review first. After the requestor's office chief gives approval, that office chief should then submit the request to the office chief team for review. If the office chief team deems that request necessary, they would then submit this request to the division director to review and approve. If approval is received, notify the LTC manual coordinator of the dissolution of the chapter. It would then be appropriate to communicate this change thoroughly to the regions/AAAs and all policy owners/invested parties whose work will be impacted by the change. The last step of the chapter dissolution process is for the LTC manual coordinator to contact the webmaster team to have the chapter removed from the [LTC Manual website](#) at the next chapter update cycle.

HOW TO MAKE CHAPTERS ACCESSIBLE

The Department of Social and Health Services (DSHS) policy requires staff to make documents easy to access and read not only for our clients, but also for our staff. Accessibility in chapters encompasses everything from creating the appropriate size of text and contrast to using plain language. Each element of accessibility in chapters or management bulletins is crucial for inclusiveness and ensures that every staff member, including those with disabilities, can access and understand the information. One way to ensure the accessibility of a document is by utilizing Microsoft Word's Accessibility Checker from the beginning.

DSHS has created guides to assist in making Word or Portable Document format (PDF) documents accessible. These can be found by clicking the following hyperlink: [Accessibility Resources and Training](#). Additionally, free courses on using plain language in writing, creating more accessible PowerPoints, Word documents and Excel spreadsheets are available at the [Washington State Department of Enterprise Services](#). Training Professional Accessibility Resources are also offered [here](#).

To use the Accessibility Checker, navigate to the Review tab at the top of the Word document, then click Check Accessibility. The Accessibility Checker will then open on the side of the document, identifying any errors, warnings and tips that it finds. You can then address these issues and rerun the checker.

It is also possible to enable the Accessibility Checker to run while working on a Word document, which will provide real-time feedback on accessibility issues. To do this, go to File > Options > Ease of Access and check the box next to "Keep accessibility checker running while I work".

For more information, resources, and to identify training opportunities related to accessibility, please see the [Resources](#) section of this chapter.



ROLES AND RESPONSIBILITIES FOR THE CREATION AND MAINTENANCE OF MANAGEMENT BULLETINS

Management bulletins are how the Home and Community Living Administration (HCLA), formerly the Aging and Long-Term Support Administration (AL TSA), communicates and disseminates information to staff, community partners, tribal governments, and others about changes to information, procedures and policies.

What is the Role of the Management Bulletin Coordinator?

The role of the management bulletin (MB) coordinator is to assist in moving MBs through the review and approval process. In the [How and When to Write a Management Bulletin \(MB\)](#) section, the management bulletin process is explained in greater detail. It is the management bulletin coordinator that works behind the scenes to ensure that the workflow progression and necessary approvals and signatures are received for all MBs before they are released. It is important that policy owners draft MBs to be responsive to any requests or timeframes provided by the management bulletin coordinator to ensure the timely release of information.

The MB Coordinator is responsible for tracking, storing and archiving management bulletins.

- The MB coordinator enters status data on all MBs into a spreadsheet and tracks this data for the life of the MB from creation to either integration into chapter or rescission. This spreadsheet is used solely for the MB coordinator's internal workflow process.
- When an MB is signed during the final stages of the approval process, the MB coordinator enters the appropriate information into the MB log and assigns the MB number. The MB coordinator then renames the MB according to its newly assigned number and enters the heading and date of posting to the MB.
- The MB coordinator posts the final MB to the [HCS Management Bulletin site](#), notifying community partners, tribes and staff of its implementation.

How and When Does a Policy Owner Write a Management Bulletin (MB)?

Ideally, a management bulletin would be utilized as a short-term (1-year or less) update with the goal of placing the information into chapter at the next chapter update. Not all management bulletins need to be integrated into chapters, but all management bulletins do need to be reviewed tri-annually for relevance and to determine the best path forward for the MB, whether that be rescinding, integrating into chapter or maintaining the MB as is.

Be mindful that the Management Bulletin process can take 4 or more weeks to complete.

In creating an MB, it is important to be very clear on the following:

- What information needs to be communicated and to whom;
- What the impact/change will be;
- If other programs will be impacted; and
- For how long the change will be in place.

It is also important to determine what type of MB is needed.



For assistance drafting MBs, utilize the [Management Bulletin Writing Instructions](#). It can be located on the *HCS/AAA Intranet site* > *Management Bulletins* > *Tutorials* > *MB Writing Instructions*. These instructions will assist in the formulation and execution of the management bulletin.

Another helpful link on the [HCS Management Bulletin intranet site](#) is the [Guide to the MB Process](#). This can be found on the *HCS/AAA Intranet* > *Management Bulletins* > *Tutorials* > [Guide to the MB Process](#). In this document, you can review the MB Process and receive step-by-step instructions for completing the MB cover sheet entitled the [Management Bulletin Initial Draft Guide](#).

What are the Three Types of Management Bulletins?

There are three basic categories of MBs: informational, procedural and policy/policy and procedure.

- A **Policy/Policy and Procedure Management Bulletin** would be warranted if policy and/or procedure were created or need to be updated/clarified as quickly as possible and communicated to all staff. This is information that cannot wait until the next triannual chapter update to be disseminated.
- An **Informational Management Bulletin** would be appropriate if there is a situation where information needs to be disseminated quickly, but it is not related to implementing or clarifying policy or procedure (e.g. training schedules).
- A **Procedural Management Bulletin** would be selected if the change is temporary and only impacts internal processes, but not the greater policy.

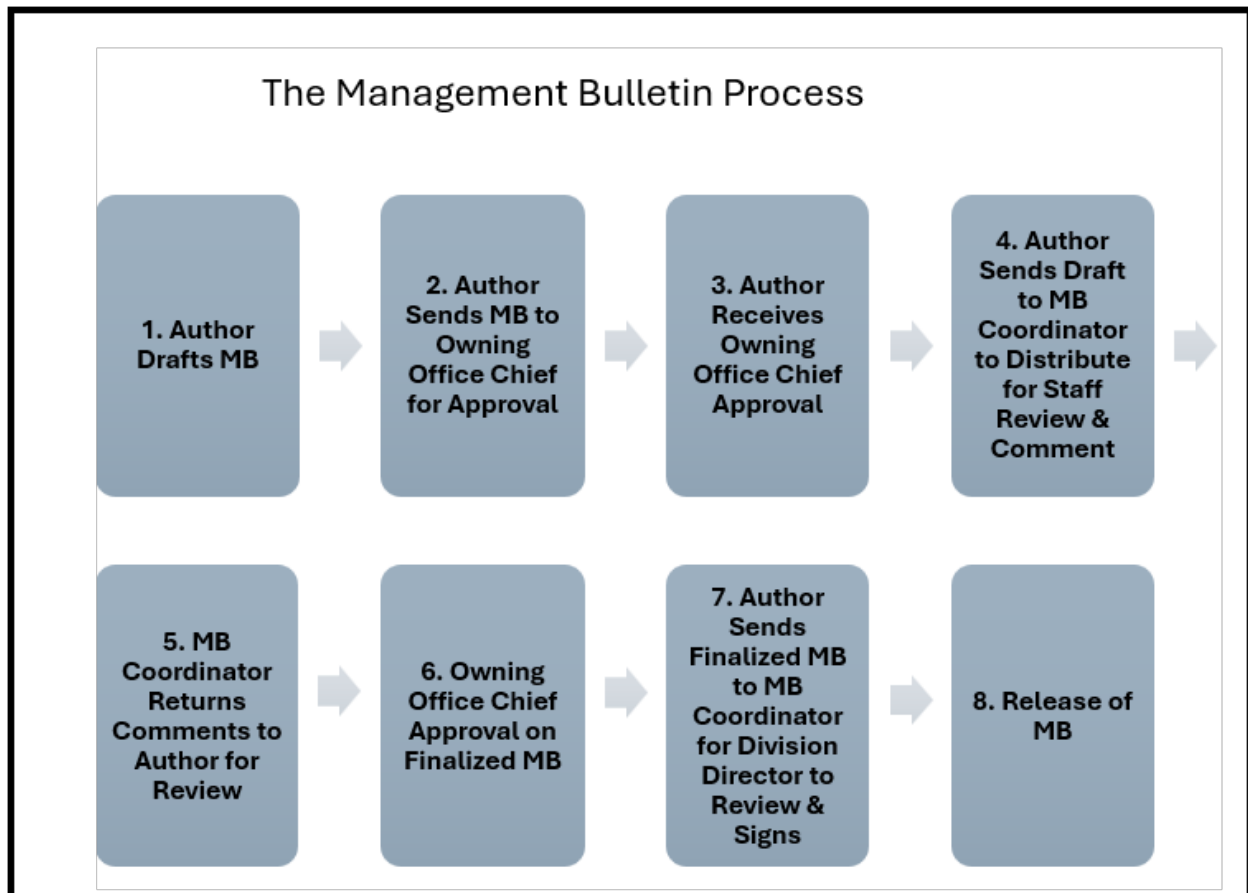
If the identified content is good information to share, but ultimately won't affect policy or procedure, a Management Bulletin would NOT be warranted. In this scenario, it is best practice to wait for the next chapter update to integrate this information into chapter.

What Review Process is Needed for Management Bulletins?

Once a management bulletin is in place, timely reviews are needed. Examine if the information in the management bulletin is a temporary or permanent update to policy. Set a reminder to add the information that is permanent policy into chapter at the next scheduled update. Once updated in chapter and mentioned in the chapter update, the MB can be rescinded stating that it has been moved into chapter and to point all regional/AAA policies to that section of chapter. Please see the [Role of Policy Owner in Transitioning Management Bulletins to Chapter](#) section for more detail.

If an informational management bulletin is temporary and does not need to go into chapter, set a timed reminder on your calendar to revisit the information. If the MB has been extended, amend the MB to reflect the new extension date. If it was not updated AND won't become permanent policy, rescind the MB and this would indicate the information has not been extended.

How Do Policy Owners Engage in the Management Bulletin Process and Collaborate with the Management Bulletin Coordinator?



As the above graphic shows, it will take eight steps to go from the drafting of an MB to its release.

1. The work begins with drafting the MB. At this stage, the author should include all necessary collaborators, such as subject matter experts (SMEs), DDA, AAA partners, program managers and/or other policy owners.
2. When the draft of the MB is completed, the author sends it to their office chief for approval.
3. Once approval is received by the owning office chief, the author will send the draft to the MB coordinator via email.
4. Next, the MB coordinator sends the draft out for regional/AAA and headquarters staff on the MB distribution list to review and comment via posting on the intranet at <http://intra.altsa.dshs.wa.gov/hcs/review/admin/>. Five days are allowed for these comments.



5. The comments are then collected and returned to the author of the MB. It will be the author's choice to make edits based upon the comments received.
 - If an **Informational MB** is being submitted, it will not need to be posted for staff to review and comment.
6. After reviewing all the comments, the author will send the finalized document to the author's office chief for final approval.
7. Once the owning office chief's approval is received, the finalized document will be sent to the MB coordinator. The MB coordinator will be forwarded to the HCS director's or their designee for review:
 - If it is approved, the MB will be signed.
 - If edits are requested, the MB will be returned to the author with comments once again.
 - For joint MBs, the MB will be forwarded on to the other division directors or their designees for approval and signature, as well.
8. Once all the steps have been completed, the MB will be released.
 - It is important to note that the effective date of the MB should align with the date of release or posting on the intranet site.

What is the Role of the Policy Owner in Transitioning Management Bulletins to Chapter?

Review management bulletins (MBs) and determine which MBs are temporary policy, and which are permanent policy. If an MB is permanent policy, this needs to be provided as a chapter update. It is at the discretion of the chapter owner whether this additional information will be a new chapter or subchapter or if the MB will be added to an existing chapter or subchapter.

When an MB is transitioned to a new section of a chapter and other areas of HCS collaborated on the work to develop the MB, those other entities should be informed of the transition of the MB into the chapter. This will allow the other entities to make any updates needed on their chapters in conjunction.

Chapter owners will not request off-cycle updates to their chapter unless it is either emergent or immediately effects how case managers perform their jobs. Follow the MB process and integrate changes at the next update cycle.

Once the MB has been incorporated into the chapter, the MB should then be rescinded by following the MB rescind process. Chapter owners should rescind MBs if they contain conflicting or outdated policy. For example, if chapter says one thing because it's been updated, but the MB gives different direction, that MB should be rescinded. Unless it is an emergency that immediately affects how case managers perform their jobs, chapter owners are not supposed to request off-cycle chapter updates.



How do Policy Owners Collaborate with the LTC Manual Coordinator on Chapter Update Management Bulletins (MBs)?

The best practice for policy owners is to both complete the appropriate documentation (i.e. The [MB Initial Draft Guide Form](#) and cover sheet) and respond promptly to any requests the author receives from the LTC manual coordinator. Through the completion of these two steps, completing chapter updates from management bulletins will be simplified.

How to Rescind a Management Bulletin

Rescinding (also referred to as sunseting) is the process to remove an MB from the Management Bulletin page when the process, procedure, or information has either been incorporated into an LTC Manual chapter or is no longer relevant for case managers. It is important to rescind MBs that are out of date to ensure consistent policy information is provided. For all MBs that are NOT being replaced with a new MB, please send an email to the MB coordinator that includes: the appropriate MB number with the request to rescind, the date for rescission and where this information can be found now. An example of this is:

"In reference to MBxx-xxx, please rescind this management bulletin effective 6/1/2026 as it was incorporated into the LTC Manual Chapter at the last chapter revision cycle."

	Target date for MB release: Click here to enter a date.
<i>If there is no rescind date, leave blank.</i>	Rescind date: Click here to enter a date.
<i>If there is no sunset review, leave blank.</i>	Sunset review date: Click here to enter a date.
<i>Default date is one year from MB release date.</i>	
<i>At sunset review, MB authors will be asked to review and determine if MB should remain or be amended, superseded, or rescinded.</i>	

Once the steps above have been completed, this form is to be sent to the MB coordinator via email for processing along with any additional information or attachments needed.

Tips for Successfully Drafting Management Bulletins

- Start drafting content as early as possible.
- Get input from other SMEs, AAA and community partners.
- If you are drafting a joint MB (with DDA A, Residential Care Services [RCS], or Management Services Division [MSD]), share your draft with your counterparts and other appropriate staff, allowing enough time for their input.
- If content of the MB impacts multiple programs, services, or units, share the MB with the other office chiefs and/or the division director for early input.
- Share the final draft with your office chief for approval. If you get their approval on the draft, you can save time in processing the MB.
- Complete the [MB Initial Draft Guide Form](#) and cover sheet thoroughly and completely.



- Create a tracking mechanism for the MBs that you manage to ensure that they are maintained properly.

ROLES AND RESPONSIBILITIES FOR REGIONAL AND AAA TEAMS IN COLLABORATING ON POLICY

Effective communication and collaboration between those creating and those implementing policies are critical for functional service delivery. When questions or concerns about the implementation of policy arise, and the [LTC Manual](#) cannot provide a clear answer, each region should enact their chain of command—depending upon the region and topic in question. Once regional/AAA resources are exhausted and no resolution has been found, the assigned JRP/SHPC or program manager should utilize the [LTC Manual SharePoint site](#) form to request policy update or clarification from the policy owner. Please see the “[How Regions Can Request a Policy Update or Clarification](#)” section for more details on escalating questions or concerns.

Policy is in constant review due to adaptation to legislative or programmatic changes and modifications to policy or procedures. It is through the collaborative efforts of regional and headquarters staff that consistency is achieved, especially regarding the creation and maintenance of training materials.

Responsibility of Regional/AAA Staff in Training Material Development

Before creating any one-off training or desktop aid, it is essential to follow these best practices:

1. Review the [LTC Manual](#) – Always reference existing guidance to ensure alignment with current policies and procedures.
2. Engage subject matter experts – Collaborate with those responsible for the relevant policy area to ensure accuracy.
3. Partner with headquarters program or policy staff – Work together to develop guides, desk aides, publications, and resources that can serve statewide and be incorporated into future chapter updates.
4. All desk aides and training materials must be dated and the chapter it belongs to referenced to ensure that the most up-to-date version is being used and that there is a point of contact for any discrepancies found.
5. Additionally, printed or saved/downloaded to desktop versions of the [LTC Manual](#) are not recommended, as accessing digital formats ensures access to the most up-to-date information.



By following these steps, we can maintain consistency, accuracy, and statewide alignment in our training materials.

Information received—whether in email, phone, or TEAMS discussion—by regions from policy owners clarifying policy does not negate or override the policy within the chapters of the LTC Manual. Continue to reference the [current LTC Manual](#) for all policy and procedure information. Regional resources like OneNote or SharePoint should be utilized as a notebook with regional processes rather than a policy source/document.

If regions are considering the development of training materials due to a need to clarify policy, please submit a [request for policy clarification or chapter update](#) first. These requests enable policy owners to understand the needs of the regions with more clarity.

HOW REGIONS CAN REQUEST A POLICY UPDATE OR CLARIFICATION

When regional/AAA staff find discrepancies, have questions that result in the need for policy clarification, or want to make suggestions for updates, staff should follow this process:

1. Review the matter with your JRP/SHPC or regional/AAA program manager. If the JRP/SHPC or program manager agrees that clarification or update to chapter is needed, the JRP/SHPC or program manager will escalate this request.
2. To escalate the request to the chapter owner, navigate to the “Chapter Revision Requests” tile on the [LTC Manual SharePoint site](#), which will take you to the [Request for Policy Update or Clarification](#) form. Please complete each section thoroughly. You will be asked to provide the requestor’s information/contact, the chapter title and number, the section of that chapter of concern, and either include an attachment with proposed edits in track changes to the request or complete the sections requesting information on the chapter situation and proposed change, along with a description of why this change or clarification is being requested.
 - a. Access to this request form is limited to HCS/AAA JRPs/SHPCs and Program Managers.
3. This request should be assigned to the appropriate chapter owner when completing this form. If you are unsure of who the chapter owner is, please reference the [LTC Manual Chapter Owners Information](#) tile on the main page of the [LTC Manual SharePoint site](#). If multiple chapter owners are impacted by the request, please direct it to the most appropriate policy owner. It is the responsibility of the policy owner to seek input from and to invite into conversation all impacted policy owners to adequately address the request. Please give the chapter owner up to **seven business days** to acknowledge receipt of the request and **ten business days** total to provide a resolution.
4. There are three possible outcomes that the chapter owner may respond to *chapter update requests* with: accepted, partially accepted and declined. If the suggestion is accepted, it will be integrated into chapter on the next update cycle. If it is partially accepted, an explanation of why will be offered as well as the next steps for the accepted information. If the suggestion is declined, a reason for this decline will be included in the response section of the form. Once



completed, the chapter owner will mark the request as “completed” in the “Status of Request” section of the form.

5. If *policy clarification* is requested, please allow up to **ten business days** for the chapter owner to respond with the needed clarification.
6. If *no response is received after ten business days*, the regional/AAA lead should escalate the request to the LTC Manual Coordinator who will continue the escalation of the request to the chapter owner’s supervisor and/or Office Chief.

Detailed directions for submitting requests are available in the [How Can JRPs/SHPCs and Program Managers Submit a Request for Policy Update or Clarification?](#) section.

All AAA/HCS JRPs/SHPCs and program managers will have access to the [LTC Manual SharePoint page](#) where policy owner’s responses to policy clarification requests will be logged. To access this log, you will go to the [LTC Manual SharePoint site](#), and navigate to the “Chapter Revision Requests” tile. Rather than submitting a [Request for Policy Update or Clarification](#) form, you can search the log of completed requests. Please see the [How Can JRPs/SHPCs and Program Managers Access and Search the Log of Resolved Requests for Policy Update or Clarification?](#) section for more information on this process.

If a chapter or policy owner receives a request for clarification or chapter update via email or another method, direct the requestor back to the SharePoint site and process to submit their request.

AAA COLLABORATION AND REVIEW PROCESSES

How Should Policy Owners Collaborate with AAA Partners on the Formulation of Policy?

Inviting our AAA partners, along with case management directors at HCS and contract management directors at the AAA, into conversations to collaborate on policy formulation ensures that both the AAA and HCS can support and implement the intended change(s). Please allow adequate time for AAA partners to review and provide feedback on requests for input. W4A appreciates being a part of early conversations that may impact the work done by the AAAs. Implementation of Management Bulletins or chapter updates go markedly smoother when collaboration that integrates AAA staff input is sought out.

How are Policy Updates Communicated to the AAA?

Communication with AAA’s W4A team typically goes through the State Unit on Aging (SUA) Office Chief, who is the single point of contact for management bulletins at the AAA. These communications are shared with all AAA directors. Management bulletins are categorized to be either high- or low-impact.



For any changes that have a higher impact on the work being done by the AAAs, seven to ten business days are needed to gather feedback and address the feedback with the appropriate office chief.

Any time that policy impacts all case managers or contracts at the AAA, notification needs to go through the W4A for review prior to chapter submission. This communication is expected to come from the policy owner.

How is Risk Assessed by the AAA?

AAA staff assess impact by considering both the risk and workload impacts at the AAAs. If a management bulletin or chapter update increases both the case managers workloads and the risk associated with the work, it would be considered a “high-risk” impact. The calculation of risk can be somewhat subjective to AAAs, but it is considered high if there is an increased likelihood for poor client outcomes with an increased potential for litigation against the AAA. Conversely, if the update is a rarely applied policy, then it would be deemed a “low risk” impact.

How Does the AAA Provide Feedback on Requests?

When the notification is received by the State Unit on Aging (SUA) office chief, they will send an email, cc’ing the requestor and any other necessary parties, making the request to preview the policy update to the W4A executive director and chair. The executive director and chair will disseminate this information and solicit feedback from key AAA staff. Typically, feedback is requested to be returned within a week, depending upon the content of the proposed update. The W4A executive director compiles the feedback from the AAA partners and provides it back to the original requestor.

SHAREPOINT COORDINATION PROCESSES

A SharePoint site has been constructed to make the LTC Manual update process more efficient. The SharePoint site can be accessed here: [LTC Manual SharePoint page](#). This will be a shared workspace designed to make the policy update processes more efficient. The key features of this site are:

- Access to the most recent PDF of the compiled, searchable LTC Manual and link to the LTC Manual website.
- Shared space to maintain draft versions of LTC Manual updates for the LTC manual coordinator to quickly access.
- Shared space for finalized chapter updates to be held, entitled, [Finalized LTC Manual Chapters](#).
 - The program managers or policy owners will place files into this folder after they’ve successfully navigated the approval process.
 - The webmaster team will access these finalized files from this folder to post on the public facing [LTC Manual website](#).



When saving documents to the “LTC Manual Chapter Draft” or “Finalized LTC Manual Chapters” folders, policy owners should utilize the appropriate naming convention for drafts of “**Chapter #_short title_date_draft**” or for finalized documents of “**Chapter #_short title_date_final**” (e.g. **Chapter1_LTCPolicyManual_June2025_final**).

- Quick access links to lists of chapter owners and subject matter experts (SMEs) and their respective fields. This information can aid in the collaborative efforts for joint management bulletins or chapter updates.
- A request form with tracking mechanisms for policy clarification or update requests with an associated log.
 - This request form and log will be accessible only to program managers and JRPs/SHPCs at HCS and AAAs.
 - The log will serve as an efficient way to communicate the resolution of submitted requests statewide, thus reducing or eliminating the need for redundant responses for policy owners.
- Access to Chapter 1: The LTC Policy Manual: Roles and Responsibilities and the active links for all resources contained within it.

The basic flow for LTC Manual chapter updates on the SharePoint site during an open triannual review period are as follows:

1. Policy/chapter owner makes edits to their LTC Manual chapter Word document in the chapter’s assigned folder on the LTC Manual Drafts folder. Obtaining Office Chief/Unit Manager’s approval, as instructed.
2. Once all necessary edits are made, notify the LTC manual coordinator that the chapter (with track changes showing) is ready for staff review & comments, along with 3-5 bullets summarizing the updates made.
3. Comments are provided back to the LTC manual coordinator, who shares this information with chapter owners.
4. Policy/chapter owners can either incorporate the suggested information into their draft Word document or decline the suggestion. If information is updated in chapter, obtain the necessary office chief or unit manager’s approval before finalizing the chapter.
5. Accept all necessary track changes and finalize the chapter before moving the document into the Finalized LTC Manual Chapters folder.
6. Notify the LTC manual coordinator that your chapter is ready and in the correct SharePoint folder.
*Please use the appropriate naming conventions when uploading files to the LTC Manual SharePoint folders.

LTC Manual Drafts: “Chapter#_ShortTitle_MonthYear_Draft”



Finalized LTC Manual Chapters: "Chapter#_ShortTitle_MonthYear_Final."

Who Can Access the Various Tools on the LTC Manual SharePoint Site?

The LTC Manual SharePoint site is primarily a tool for JRPs/SHPCs, regional program managers and HQ policy/chapter owners. Access for JRPs/SHPCs and program managers from both the AAA and HCS has been granted to ensure that information is distributed timely and consistently. Program managers and JRPs/SHPCs will be able to access the form to request clarification or update to policy and the log of all previously submitted requests. HQ policy/chapter owners will have full access to the entirety of the SharePoint site. The following diagram depicts what job classifications have access to viewing and/or editing rights, ability to request policy clarification or updates and access to the policy clarification or request log.

Job Title	Viewing Rights	Editing Rights	Ability to Request Policy Clarification or Updates	Access to Policy Clarification or Request Log
Case Managers	No	No	No	No
Supervisors	No	No	No	No
JRPs/SHPCs/Trainers	Yes	No	Yes	Yes
Program Managers/FSAs	Yes	No	Yes	Yes
Policy Owners/Chapter Owners	Yes	Yes	Yes	Yes

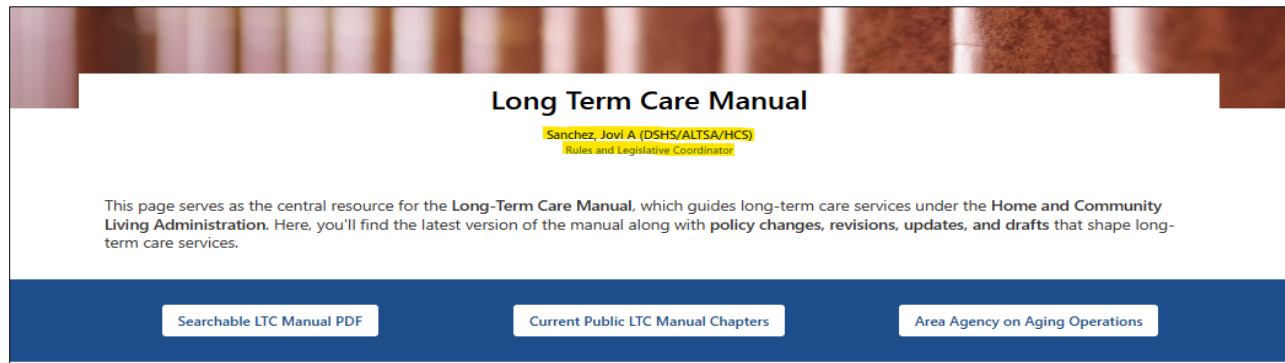
**With the exception that JRPs/SHPCs/Trainers and Program Managers/FSAs will be added as contributors to the SME page/library on the LTC Manual SharePoint site to upload and maintain the regional SME contact lists.

What Process Can Policy Owners Follow to Access the LTC Manual SharePoint Site?

The LTC Manual SharePoint can be accessed easily by clicking the following hyperlink: [Long-Term Care Manual SharePoint site](#). If you need access to this site, but currently do not have it, please contact the site administrator directly. The site administrator is noted directly below the image banner and main title of the page (see image below with site owner information highlighted).

CHAPTER 1: The Long-Term Care Policy Manual: Roles and Responsibilities

Long-Term Care Manual



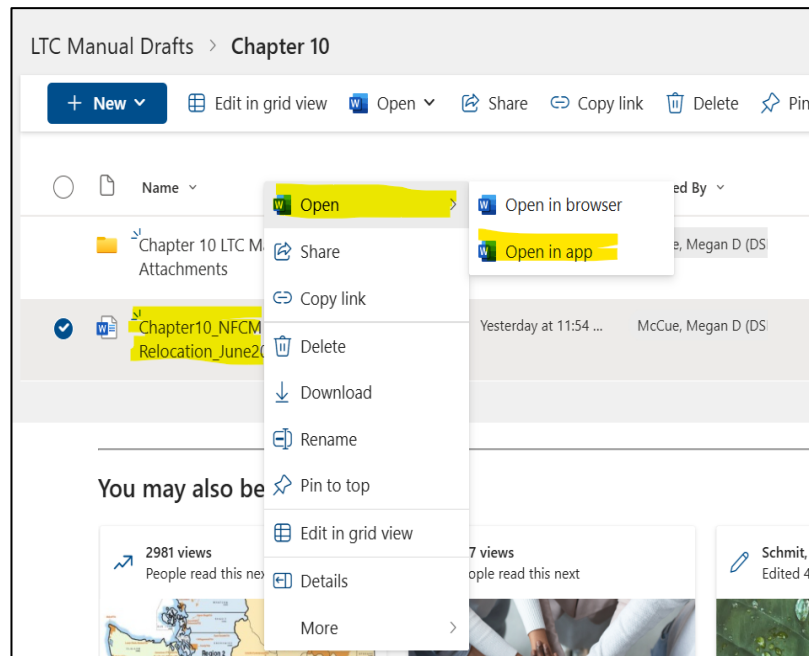
How do Policy Owners Access Chapter Drafts on the LTC Manual SharePoint Site in Preparation for the Next Revision Cycle?

The most recent files for each chapter will be found in the "LTC Manual Drafts" folder on the SharePoint site.

1. To access the most recent files of chapters on the LTC Manual SharePoint site, please click on the following link: [Long Term Care Manual](#).
2. Scroll down to the "LTC Manual Drafts" button or utilize the following hyperlink to navigate directly to the LTC Manual Drafts library: [Long Term Care Manual Drafts](#).
3. Locate your chapter's folders. Each chapter has its own folder that contains the most recently updated chapter and subchapter files. These folders are not arranged in numeric ascending order. **Please note that we use a specific naming convention for these files. Please continue with this naming convention. An example of the naming convention is **Chapter 1_LTC Policy Manual_June2025_Draft**.
4. **Access your draft.** Each draft can be found in the appropriate folder. If you double click the link, this will open the BROWSER view of your file. This view, at times, appears to have formatting issues that the application or Desktop version does not have. Because of this, it is recommended to open your draft file in the Word App. To do this, right-click on the file name of your file, hover over or left-click "Open," then hover over and left-click "Open in app" (see below).

CHAPTER 1: The Long-Term Care Policy Manual: Roles and Responsibilities

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5. **Make updates to your chapter.** Each file when opened in the app will be set to “auto-save” any of the changes/updates you make. Continue to update this file and maintain it in this drafts folder. When all your edits have been completed, you can notify your office chief to review for their approval and notify the LTC manual coordinator that the draft is ready to be shared out for comments.
6. Before the chapter can be finalized, the following must be completed:
 - a. Integrate all accepted comments into the chapter,
 - b. Final edits have been made,
 - c. Track changes have been removed/accepted, and
 - d. Links have been checked and verified for accuracy.
7. Once these steps are completed, your program manager or their designee can drop the finalized file (following the appropriate naming convention, e.g. *Chapter 1_LTC Policy Manual_June2025_Final*) into the [Finalized LTC Manual Chapters](#) folder. Once the files have been vetted by the LTC manual coordinator to ensure they are in a finalized state and are uploaded to the LTC Manual webpage, the LTC manual coordinator will archive the files into a dated folder (e.g. June 2025 Finalized Chapters). This is where the finalized version of the LTC Manual will be compiled into the single PDF document.

How do Policy Owners Work on Chapter Drafts in the LTC Manual Chapter Draft Folder on the LTC Manual SharePoint Site?

The LTC Manual SharePoint can be accessed easily by clicking the following hyperlink: [Long-Term Care Manual SharePoint site](#). Under the banner and main title of the page, you will find a tile entitled [LTC Manual Drafts](#). This folder is where policy owners collaborate with co-owners and work on the most up-to-date version of the chapter in preparation for a future triannual cycle. Think of it as a living



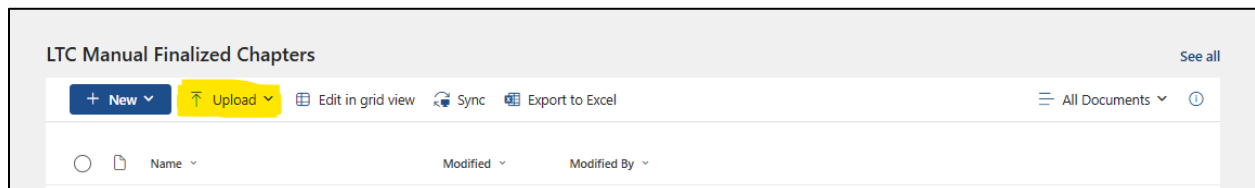
document where all revisions and edits can be made. It is important to follow the naming conventions found in the [What is the Process for Coordinators and Policy Owners When Completing Chapter Updates?](#) section of this chapter. The finalized draft document in your draft folder will, at the end of the revision process, be the document that you will rename and begin updating or reviewing, if updates aren't warranted, for the next chapter revision cycle.

- For example, the document named Chapter1_LTCPolicyManual_June2025_Draft can be re-named Chapter1_LTCPolicyManual_October2025_Draft.

Once re-named, you can begin making edits to be integrated at a subsequent revision cycle. You should not have to upload any documents into these draft folders unless you are creating a new chapter or subchapter.

How do Program Managers (or Their Designees) Upload Finalized Chapter Drafts into the Finalized LTC Manual Chapter Draft Folder on the LTC Manual SharePoint Site?

To upload documents into the [Finalized LTC Manual Chapters](#) folder, simply open the folder, click the upload action button (noted below) and locate the appropriate file to upload.



Once each tri-annual period ends, the LTC manual coordinator will review the finalized documents before moving them into an archived dated folder (e.g. June 2025 Finalized Chapters), in case they are needed for future reference. The webmaster team will utilize the identified folder to retrieve chapters to be posted on the [LTC Manual webpage](#).

Both of the above changes to attachments will require also updating the link in the chapter itself. This should be saved for chapter updates and not utilized in between update cycles.

How Can JRPs/SHPCs and Program Managers Submit a Request for Policy Update or Clarification and How do Policy Owners Respond to Said Request?

The LTC Manual SharePoint can be accessed easily by clicking the following hyperlink: [Long-Term Care Manual SharePoint site](#). Scroll down until you locate the tile entitled, "Chapter Revision Requests." By clicking on this tile, you will be directed to a SharePoint list entitled [Policy Request Updates or Clarification Log](#). Here you will click the blue tile entitled, "+ Add new item" To complete the form, you will provide the following information:

1. Brief description of the request
2. Your name or email address



3. Date of request (auto-populates)
4. Chapter name and number related to request
5. Chapter owner name or email
 - a. There will be a list of chapter owners on the main page, if you are unclear who to address the matter with. The LTC manual coordinator is also able to assist with assignments, if additional support is needed. This section can be left blank at initial submission.
6. Description for planned action request
 - a. Outline the matter that prompted the request for clarification or update
 - b. Outline your proposed change or clarification
 - c. Describe why this change or clarification is being requested
 - d. Attaching track changes in a word document is also acceptable to address a & b above and can be done at the bottom of the form page.

Once the request has been completed, press “save”, and the request will be sent to the policy owner.

The remainder of the form will be completed by the chapter or policy owner. When a request is assigned to a policy owner, that policy owner will receive an email with a link to the item that needs their attention. To respond to the request, the policy owner will open the item and click “Edit All,” the policy owner can then complete their initial response or final response and click “Save” at the bottom of the page.

The information that policy owners will be responsible for in the request form includes:

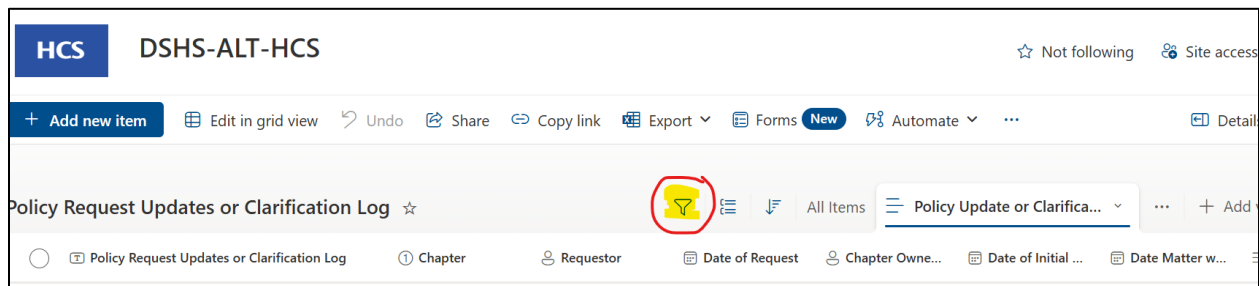
1. Date of initial response by chapter owner
2. Chapter owner response
3. Additional comments from chapter owner to explain if the request was either accepted, partially accepted, or declined and provide a why.
4. Date matter was addressed by owner
 - a. This is the date that the matter was fully resolved.
5. Change Status of Request to either “In Progress” when you are working on the request or “Completed” when the final response has been entered.
6. Please hit “Save” before closing out the request screen.

How Can JRPs/SHPCs and Program Managers Access and Search the Log of Resolved Requests for Policy Update or Clarification?

JRPs and program managers should be granted access to the log of resolved requests on the [Long-Term Care Manual SharePoint site](#). If you do not have access, please reference the [What Process Can Policy Owners Follow to Access the LTC Manual SharePoint Site?](#) Section.

From the LTC Manual's main SharePoint site, you will scroll down until you locate the tile entitled, "Chapter Revision Requests." By clicking on this tile, you will be directed to a SharePoint list entitled [Policy Request Updates or Clarification Log](#).

In this SharePoint list, you can search all resolved requests by filtering the items by "status of request". You can also utilize the filter feature to search by chapter name, chapter owner or title. You may also utilize the filter icon shown highlighted below:



RESOURCES

Accessibility Resources

[WebAIM: Contrast Checker](#)

[Plain language guidelines | Governor Bob Ferguson](#)

Training Opportunities to Learn More About Accessibility: [Auditing for Accessibility Series | DSHS News](#)

DSHS guides on making word and pdf documents accessible: [Accessibility Resources and Training](#)

Chapter and MB Resources

[Management Bulletin Writing Instructions](#)

[Guide to the MB Process](#)

[Blank HCS Management Bulletin Initial Draft Guide](#)

[Chapter Template and Style Guide 2025](#)

Acronyms

AAA	Area Agencies on Aging
ALTSA	Aging and Long-Term Support Administration

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DDA	Developmental Disabilities Administration
DMS	Document Management Services
DSHS	Department of Social and Health Services
HCLA	Home and Community Living Administration
HCS	Home and Community Services
JRP	Joint Relations Procurement
LTC	Long-Term Care
MB	Management Bulletin
MSD	Management Services Division
RAC	Recipient Aid Category
RCS	Residential Care Services
SER	Services Episode Records
SHPC	Social and Health Program Consultant
SME	Subject Matter Expert
SUA	State Unit on Aging
W4A	Washington Association of Area Agencies on Aging

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
July 2026	Megan McCue	Chapter updated to clarify MB and chapter revision processes, revert DDCS to DDA, and update LTC manual attachment process	
April 2026	Megan McCue	Chapter updated to adjust DDA to DDCS	
June 2025	Megan McCue	Chapter creation	

APPENDIX

[Management Bulletin Writing Instructions](#)

[Guide to the MB Process](#)

[Blank HCS Management Bulletin Initial Draft Guide](#)

[Chapter Template and Style Guide 2025](#)

Records Management

The purpose of this chapter is to provide general guidance and procedures regarding Records Management, including Records Retention and Public Records Requests.

Ask the Expert

Cynthia Mitchell HCS, Public Records Program Manager
360.725.2537 HCSPublicRecords@dshs.wa.gov

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BACKGROUND

The law requires DSHS and its employees to keep DSHS records for a specific period under approved record retention schedules. Failure to keep records under the approved record retention schedules, or failure to stop destruction of records when there is notice of potential lawsuit, or an active lawsuit, audit, or public records request, could subject the employee and DSHS to penalties and fines.

RECORDS MANAGEMENT

Records Management helps the administration and agency ensure compliance with [RCW 40.14](#). It is the responsibility of the appointing authority to notify the HCS [Public Records Program Manager](#) (PRPM) of any staff change of their local records coordinator/custodian.

- Planned Box Disposition (PBD) Reports – Are distributed monthly to the designated records coordinator. Things to consider when reviewing your PBD report:
 - What type of records are scheduled for destruction?
 - View the contents of the box (Barcode, View Box)
 - Client records – check your Litigation Holds notices
 - Upon receipt of a Litigation Hold, request the records from the (State Records Center) (SRC) and place in a *separate file* cabinet with LOCK.
 - *Adult Protective Services (APS) – immediately forward to the [APS Records Manager](#) for coordination or approval of destruction.*
- [Record Retention Schedules](#)
- [Record Management Training](#)

PLEASE NOTE: If there is Potential Litigation - err on the side of preservation or contact your Public Records Coordinator. Refer to [Administrative Policy 5.05](#) and [Administrative Policy 5.07](#).

Record Coordinators and Custodians Responsibility:

Each Region has a Record Retention Coordinator.

Area Agencies on Aging – Each AAA has a Public Record Coordinator and a Record Retention Coordinator.

A Records Coordinator is responsible for providing assistance to those archiving program records according to the DSHS record retention schedule.

- Comply with procedures established by the Agency Records Officer, as outlined in AP 5.04.
- Assist the Agency Records Officer with records inventories.
- Review their unique DSHS Record Retention Schedules annually.
- Identify essential record series, establish office procedures for their preservation and protection.
- Establish procedures for compliance with the General Records Retention Schedule



and unique DSHS Records Retention Schedules record retention schedules including regular or periodic records disposition.

Prior to the destruction of any DSHS records, determine if those records need to be kept for a public records request, legal purpose (anticipated litigation or discovery), audit, or program requirement.

Employees Responsibility for Records Management:

- Take [DSHS Records Management](#) mandatory training annually.
- Consult with the HCS [Public Records Program Manager](#) on all matters relating to the maintenance, retention, transfer and/or destruction of public records in accordance with RCW 40.14.040.
- Comply with retention procedures established by this policy and division policies.
- Keep DSHS records the employee is responsible for until the records have met the end of their approved retention period or have been imaged in accordance with the Requirements for the Destruction of Non-Archival Paper Records After Imaging.
- Keep electronically stored information (ESI) in its original electronic format with metadata intact. (Printing and keeping a of ESI is not a substitute for the electronic version unless specifically approved by the State Records Committee).
- Keep any DSHS records created, sent, organized, received, or stored on DSHS or non-DSHS resources according to the retention schedule regardless of physical location.
- Prior to the destruction of any DSHS records, determine if those records need to be kept for a public records request, lawsuit, audit, or program requirement.

Records Coordinators Monthly Disposition Report Responsibility:

The below is an example of a Disposition Report for Office 9113. The records are scheduled for disposition 04/01/2023. The Disposition Report is due to HCS Records Manager by no later than 03/30/2023. (Disposition reports are one month ahead).

WASHINGTON STATE RECORDS CENTER
Planned Box Disposition Report

Report due back at the Records Center: 04/01/2023

Disposal of these boxes start: 04/01/2023

Agency: Social And Health Services, Dept Of

Agency OFM Number: 300

Office: Shs/HCS Region 2 North (Everett)

Archives Office Number: 9113

In signing this document I agree that all the information pertaining to the disposition of these records listed here are true and correct. I have not modified the original format of this report in any way other than completing the form as instructed. I acknowledge that if any information is removed from this report it will still be processed by the SRC as it appeared in its original format.

Records Officer Signature: _____

Legal Hold	L
Program Need Hold	P
Audit Hold	A
Return Disposition	R

Disposition Report ID: 12066

RMS Office ID: 2425

Total Boxes: 6

							Holds				Disp
Barcode	Office	DAN	Transmittal Title/Series Title	Inclusive Dates	Cutoff Date	Disp Date/Type	L	P	A	R	
12345900	Shs/HCS Region 2 North (Everett)	74-05-05111	Case Record Social Services, Final Volume Case Record – Social Services, Final Volume	2/2014-8/2016	9/2016	9/2019 D					
12345910	Shs/HCS Region 2 North (Everett)	74-05-05111	Case Record Social Services, Final Volume Case Record – Social Services, Final Volume	1/2003-8/2016	9/2016	9/2019 D					
12345911	Shs/HCS Region 2 North (Everett)	74-05-05111	Case Record Social Services, Final Volume Case Record – Social Services, Final Volume	5/2012-8/2016	9/2016	9/2019 D					

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If you sign and return the above form, you are providing approval for boxes to be destroyed. If you need to hold any boxes for legal purposes or other program purposes, mark the appropriate column;

L = legal hold;

P = program hold;

A = audit hold; and

R = return boxes to your office

If you check the R column, please provide an address where you want the boxes returned.

If you do not return the form or return it blank, boxes will be returned to the address on the transmittal sheet.

Barcode Movement of Client Records:

Barcode is the DSHS records management system for social service and financial records. You will need to check Barcode for archived records.

- The SRC Barcode database is not connected to the DSHS Barcode database. The SRC does not track folders in BARCODE. Therefore, they cannot place folders in transit to you; consequently, the location in DSHS Barcode will read 999. You **must** move/track the folder into your location.

Should you experience difficulty moving the folder into your location, please follow the below steps in Barcode:

- At the top of the screen, select:

SUBSYSTEMS

- Select: **Wand**
- Select: **UNITS** (far right)
 - Select: your **LOCATION** (and the staff person)
 - Select: **Wand** to (bottom left)
Wand or type: the folder tracking tag (located under Barcode, bottom right and it starts with a period ".")
 - EXAMPLE: **DV1XVR**

You can keep entering folders and when done, click done.

- Records need to be tracked “in” and “out” from location 999

Transferring and Returning a Case in DMS NOTE: [Chapter 5 Case Management](#) provides information on Transferring a physical and electronic case record and paper file from one office to another. At any point during a case transfer, the social worker/case manager may request a case transfer consultation or case staffing.

DSHS PUBLIC RECORDS ACT:

The Department of Social and Health Services strongly supports principles of open government and transparency in its operations. ALTA employees must comply with the Public Records Act (PRA) in granting access to records, with the exception of exempt confidential information, as outlined in [DSHS Administrative Policy 5.02](#).

Adhering to [AP 5.02](#), public records coordinators (PRC) must use the Agency Records request tracking system (ARRTS), to log, route, and track all public records requests received by DSHS.

At a minimum, ARRTS must be used to track receipt of the request, task assignments, requests for clarification, issuance of a five-day letter, due date, extensions of time granted, and completion of the request with time recorded for each task. Copies of relevant documents affecting the request must be uploaded into ARRTS, including the request, five-day letter, extension letters, and response cover letters.

To avoid a potential privacy breach, PRCs must carefully review records being disclosed to determine if any parts are exempt.

WHAT IS THE PUBLIC RECORDS ACT?

- The Public Records Act (PRA) was passed by Initiative in 1972. Chapter [42.56 RCW](#) provides the statutory groundwork for disclosure of public records.
- The PRA requires all public records maintained by state and local agencies be made available to all members of the public when requested, with the exception of narrow statutory exemptions.

- Agencies must respond promptly and provide fullest assistance to requesters
- Anyone has the right to make a public records request
- Transparency is DSHS value
- DSHS Administrative [Policy 5.02](#) outlines DSHS policy for processing public records requests.

WHAT IS A PUBLIC RECORDS REQUEST?

The process to seek access to public records held by DSHS, including client records.

WHAT RECORDS ARE PUBLIC RECORDS?

All records an agency holds are public records regardless of content or format. A public record is defined in [RCW 42.56.010\(3\)](#) as any writing that is prepared, owned, used or retained by any state or local government agency that contains information that relates to the conduct of the government or the performance of any governmental or proprietary function. The term “Writing” is very broadly defined in the PRA to include not only traditional written records, but also photos, maps, videos, voicemails, emails, text messages and tweets ([RCW 42.56.010\(4\)](#)).

Examples of Public Records:

- | | |
|---|-----------------------|
| ■ Hard copy client file and subject files | ■ Handwritten notes |
| ■ Files on network shares | ■ Text messages |
| ■ Database records | ■ Facebook postings |
| ■ Email | ■ DSHS YouTube videos |
| ■ Calendars | ■ Voicemail |
| ■ Back up tapes for servers and on multi-function devices | |
| ■ Records on personal devices used to conduct business | |

RECEIVING/RESPONDING TO PUBLIC RECORDS REQUESTS:

A request for public records may be made by any means, including in writing, in person, by e-mail, or by telephone. Use of the Request for DSHS Records Form ([DSHS 17-041](#)) is optional but encouraged to clarify the scope of the request and verify the identity of the requester for confidential records. The central point of contact for DSHS for the public is the DSHS public records officer, but requests may be received by any DSHS employee at any DSHS location. Verbal requests must be transcribed within one business day and forwarded to hcspublicrecords@dshs.wa.gov.

Employees Responsibility: Every employee must comply with the Public Records Act in granting access to records. Records created, used, and kept by employees in the course of doing business are considered to be public records of DSHS. DSHS employees generally have no expectation of privacy in any records stored on DSHS administered IT resources nor in public records stored on non-DSHS

administered IT resources. To comply with obligations under the Public Records Act, these records may be indexed, searched, accessed, collected and distributed without notice to the employee or employees who created, contributed to, or otherwise used the records, unless notice is required by law or contract.

Employees who receive a public records request must immediately send all record requests to HCSPublicRecords@dshs.wa.gov. RCW 42.56. 520 provides that a response to a request for public records must be made within five business days. The day the request is received does not count as one of the five days. Weekends and holidays observed by the agency are also excluded in the calculation. All employees must comply with preserving and the destruction of records, as described in [DSHS Administrative Policy 5.04](#)

If the record/s can easily be given to the requester at the time of the request and does not require redaction, please include HCSPublicRecords@dshs.wa.gov as a cc. If the request is verbal, the employee receiving the request must transcribe and transmit the request to HCSPublicRecords@dshs.wa.gov within one business day.

PRC Responsibility:

DSHS public records coordinators are the primary employees designated to process and respond to public records requests in accordance with this policy and agency procedures set by the DSHS public records officer. If employees other than public records coordinators respond to public records requests, they must also follow [administrative policy 5.02](#). Public records coordinators must have trained back-up staff and procedures to handle and respond to public record requests when they are unavailable. Public records coordinators also serve as a resource and provide training to other staff and requesters on issues involving public records requests.

When requested by a PRC to respond to public records requests, employees must:

- i. Search for records within their control that are responsive to the request. This responsibility includes any public records of the department created, sent, organized, received, or stored on DSHS and non-DSHS administered IT resources and includes those kept on or off DSHS property.
- ii. Provide access to original records or copies of records in the format requested by the public records coordinator. This responsibility includes connecting any external devices, including non-DSHS administered IT resources such as laptops or external drives, to the network or otherwise granting access to records as needed for indexing, searching, and collecting records in response to a public records request.
- iii. Provide search terms to assist with an email search, preserve identified records in their original format (including metadata for electronic records) and retain them, even if a printed copy exists, until the public records coordinator notifies you that retention is no longer needed, ensuring no employee redactions or alterations.

When the Public Records Coordinator receives a records request, he/she will:

1. Keep accurate notes including the date, the name of the person requesting the information, their address and a phone number you can reach them at, and the specific information that he/she is requesting.
2. Compose and send a letter within 5 business days. The day the request is received does not count as one of the five days.
3. The “five-day letter” must do one of the following:
 - Produce the requested records;
 - Provide the specific internet address where the records may be located on the DSHS website;
 - Seek clarification of the request;
 - Deny the request and give the statutory basis for denial; or
 - Estimate when the records will be produced and explain why that time is needed.

The “five-day letter” must include the following:

- ARRTS Request ID #
- Date request received;
- Describe records requested
- State if request is under PRA or other law (such as RCW 13.50 or RCW 26.23)
- Include whether more information is needed (such as an authorization)
- Include dates for requester to respond by
- Estimate of time for first installment or entire response if known
- Notice of potential production fees under RCW 42.56.120 and WAC 388-01-080
- Format of response if known (native format if requested)
- PRC contact name and information

Estimate Reasonable Response Time

- If final production is not sent with five-day letter, PRC must provide time estimate and explain why more time is needed to:
 - Clarify the request
 - Locate and assemble the records (including routing in DSHS),
 - Notify third parties affected by request or
 - Review and redact exempt information
 - Exception to reasonable time: Client request for own records from HIPAA covered programs – must produce in 30 calendar days with only one 30 day extension allowed

Clarify as Needed

- Explain what records we have and try to determine what requestor wants
- May do by phone or in writing, including by email

- If requestor does not clarify and we cannot identify or locate records requested without clarification, state that request may be denied if they don't respond within ## days
- If request is too broad, cannot deny but inform and work with requester - you can ask for narrowing of scope or prioritization, but they don't have to agree
- Confirm clarification in writing and resolve discrepancies in five day letter: "We understand your request to be for Let us know by XX date if this understanding is not correct."
- When in doubt, contact requestor

OBTAINING CONSENT TO SHARE CONFIDENTIAL INFORMATION ([DSHS 14-012](#))

- You are required to obtain consent prior to sharing confidential information about a client. Use [DSHS 14-012](#) form to document this consent.
- The client or representative (e.g. Durable Power of Attorney (DPOA) or guardian)¹ may sign this form. The instructions on the consent form ([DSHS 14-012](#)) under the signatures portion of the instructions explain who can sign the consent form. In those cases where the client understands but can only make a mark in the signature box, a mark is sufficient. In these cases, a witness should sign and then make a note about the client's inability to properly sign and the reason.
- You must use this form in order to obtain, use, or share confidential information about a client for the purpose of providing services to the client. If you need to list multiple providers on the consent form and cannot fit all the information in the blanks provided, you may mark the box, "See attached list," and attach a list to the consent form to accommodate all information. [Please see LTC Chapter 2A.](#)

VERIFY RIGHT TO CONFIDENTIAL RECORDS

- Consider who is making request
- Client requesting own records – verify identity
- Third party requesting unredacted client records – written authorization
- Requests about employees – most information is not confidential but get identification or authorization to avoid redactions
- Special considerations for email
 - Insufficient to prove identity
 - Use secure email for any emails including client information outside the state government network (.wa.gov)
- If not verified, deny request for confidential records



- Need for authorization for client records applies to subpoenas and some court orders
- Prohibition of requests for lists of individuals for commercial purposes – use Declaration on Commercial Purposes form 27-155.

Retaining records: DSHS employees must retain public records, in accordance with applicable retention schedules and [administrative policy 5.04](#).

Employees must retain all public records, including those created on:

- Hard Drives
- Local Personal Folders
- Portable Storage Media (Flash drives, CD, DVD, USB drives)
- Portable Devices (Laptops, Smartphones, tablets)
- Network Drives
- SharePoint Sites
- Office, Desk and Filing Cabinets
- Recording Devices (Cameras, video cameras, audio recordings, and surveillance video).
- Personal Devices or locations outside of DSHS
- Follow AP 5.02 - all staff must search their records and assist PRCs to produce records.

Adequate Search

- Adequate search is required to fully assist the requester.
- Documentation of the search conducted is strongly recommended. Use DSHS Forms [02-629](#) (PRC) and [02-630](#) (employee) as appropriate.
- Notes can be placed in the task resolution in ARRTS
- Databases to be searched CARE, BARCODE, TIVA, ACD, ACES, etc.

For high profile requests and potential litigation, The PRC may provide you with the Employee records search form 02-630.

PUBLIC DISCLOSURE – AAA RESPONSIBILITY

Once a case is transferred from DSHS to a AAA, the AAA is responsible to produce all client records within the designated records set.

If client records are requested and the client is Case Managed by a AAA, the HCS public records coordinator will:

- Prepare the 5-day letter and forward the 5-day letter including the request to the appropriate AAA for response by the designated date.

The AAA public records coordinator will:

- Respond to the records request per the contract with DSHS.



- Send HCS public records coordinator a copy of the closure letter sent to the requester once the request is complete, including the time spent by all AAA staff of fulfilling the request.

PUBLIC DISCLOSURE – INDIVIDUAL PROVIDERS (IP) AND CONSUMER DIRECT CARE NETWORK WASHINGTON (CDWA)

Effective October 1, 2021, staff receiving a public records request for records relating to an IP should forward the request to HCSPublicRecords@dshs.wa.gov

The PRC will be responsible for processing the request. The PRC will review the request to determine what records are being requested, and who the owner of record is for the date range of the records requested.

- DSHS is the owner of record up to hire date of the IP with the Consumer Directed Employer (CDE). Prior to April 2022.
- As of April 2022, CDE is the owner of record for all IP's hired through CDE.
- **Please forward all inquiries directly to:** infolegal@consumerdirectcare.com. For records owned, maintained, or used by DSHS, the PRC will process the request as usual.

DISCLOSURE OF GUARDIAN AD LITEM (GAL) INFORMATION

It is the Case Manager's (CM) responsibility to provide records to the client or their designated representative when conducting day to day business activity. For all public record requests, they should be submitted to hcspublicrecords@dshs.wa.gov (GAL requests for APS see <https://intra.alsa.dshs.wa.gov/aps/sharepoint.htm>).

DISCLOSURE OF ADMINISTRATIVE HEARING RECORDS

The Case Manager provides the case record and all relevant information to the administrative hearing coordinator. This should not be treated as a public records request. [Please see LTC Chapter 26.](#)

DISCLOSURE OF ADULT PROTECTIVE SERVICES (APS) INFORMATION

Please Refer all APS records request to APSPublicRecords@dshs.wa.gov.

FORMS

[17-041](#) Request for Records

[17-063](#) Authorization

[14-012](#) Consent
[02-629](#) Dshs Coordinator Search Document
[02-630](#) DSHS Employee Records Search Request

Related RCWs and WACs

[RCW 42.56](#) Public Records Act
[RCW 40.14](#) Preservation and Destruction of Public Records
[RCW 13.50](#) Keeping and Release of Records By Juvenile
[RCW 26.23](#) State Support Registry
[WAC 388-01](#) Dshs Organization/Disclosure of Public Records

RELATED ADMINISTRATIVE POLICIES AND CHAPTERS

Administrative Policy 5.01	Privacy Policy -- Safeguarding Confidential Information
Administrative Policy 5.02	Public Records Requests
Administrative Policy 5.03	Client Rights Relating to Protected Health Information
Administrative Policy 5.04	Records Retention
Administrative Policy 5.05	Management of the Litigation Discovery Process
Administrative Policy 5.07	Employees Response to Litigation Related Documents
LTC Chapter 2A	Privacy
LTC Chapter 26	Administrative Hearings

ACRONYMS

ACD	Agency Contracts Database
ACES	Automated Client Eligibility System
AAA	Area Agency on Aging
ALTSA	Aging and Long-Term Support Administration
AP	Administrative Policy (DSHS)
APS	Adult Protective Services
ARRTS	Agency Records request tracking system
Barcode	ESA's primary document management system and used by other DSHS administrations. ALTSA images client correspondence including social and financial records.
CARE	Comprehensive Assessment for Reporting and Evaluation
CDE	Consumer Direct Employer
CM	Case Manager
DA	Discovery Accelerator
DPOA	Durable Power of Attorney
ESA	Economic Services Administration
ESI	Electronically Stored Information
GAL	Guardian Ad Litem



IP	Individual Provider
PBD	Planned Box Disposition
PHI	Protected Health Information
PRA	Public Records Act
PRC	Public Records Coordinator
PRR	Public Records Request
PRPM	Public Record Program Manager
RC	Records Coordinator
SRC	State Records Center
TIVA	Tracking Incidents of Vulnerable Adults (previously known as ADS Registry)
RCW	Revised Code of Washington
WAC	Washington Administrative Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
9/2/2026	C. Mitchell	Updated all links, added DSHS Public Records Act & examples, added What is a Public Records Request & definition, updated Examples of Public Records, added Verify Right to confidential Records, and changed the order of some info	

Privacy

The purpose of this section is to address the importance of safeguarding client’s information, which includes client protected health information (PHI), to:

- Protect the privacy rights of clients when DSHS uses, obtains, maintains, or discloses client confidential information;
- Ensure responsible information governance and management practices;
- Promote public trust and confidence in the use of services provided by the DSHS; and
- Maintain the confidentiality, integrity, and availability of PHI and other confidential information, while protecting against any reasonably anticipated threats, hazards, and inappropriate uses or disclosures.

What is Privacy?

The right of a person to be free from intrusion into or publicity concerning matters of a personal nature.
(Merriman Webster Legal Dictionary)

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Cynthia Mitchell HCS Division Privacy Program Manager
360.725.2537 cynthia.mitchell@dshs.wa.gov

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BACKGROUND

Employees who work at the Department work daily with many confidential records and must act to protect those records and the privacy rights of individuals. The Department is a Hybrid Covered Entity under the HIPAA Privacy Rule, which requires safeguards for client information and the reporting of any breach of security of client information. As a covered entity, DSHS must notify affected clients of Health Information Portability and Accountability Act (HIPAA) privacy rights. (45 CFR 164.520) DSHS programs that are designated as Health Care Components or HCCs are part of the Hybrid Covered Entity.

The obligations of Department employees are set out in DSHS [Administrative Policy 5.01](#) and the [IT Security Policy 15.10](#). The rights of clients are described in [DSHS Administrative Policy 5.03](#)

Employees must follow DSHS policies and procedures in the [DSHS information security manuals](#) for accessing, handling, and disclosing confidential information. In addition, employees of HCCs (including BAOUs) must follow the HIPAA rules for use or disclosure of PHI.

DSHS PRIVACY POLICIES

Administrative Policy 5.01- Privacy Policy

Establishes Privacy Officer and Coordinators; HIPAA Hybrid; General Requirements to protect Confidential Information.

Administrative Policy 5.03- Client Rights

Client Rights to Protected Health Information

Administrative Policy 5.08- DSHS Minimum Physical Security Standards

DEFINITIONS AND EXAMPLES

Breach: The acquisition, access, Use, Disclosure, or loss of Confidential Information in a manner not permitted by state and federal law that compromises the security, privacy, or integrity of the Confidential Information.

Breach Notification Rule: Requires covered entities and Business Associates (contractors) to provide notification following discovery of a breach of unsecured Protected Health Information (PHI); and the enforcement rule which provides authority and procedures for OCR investigations, imposition of penalties, and administrative hearings.



Business associate: A person who, on behalf of DSHS other than in the capacity of a member of the workforce, performs a function or activity involving the use or disclosure of protected health information (PHI) to carry out essential functions or perform services for DSHS. “Business associates” include subcontractors that create, receive, maintain or transmit PHI on behalf of the business associate and downstream contractors.

Client: A person who receives services or benefits from DSHS. This term includes, but is not limited to, consumers, recipients, applicants, residents of DSHS facilities or institutions, patients, and parents receiving support enforcement services. Clients include persons who previously received services or benefits and persons applying for benefits or services.

Client confidential information: Personally Identifiable Information, including PHI, which identifies a client, and that state or federal laws protect from improper disclosure or use.

Covered entity: A covered entity is a health plan, a health care clearinghouse, or a health care provider who transmits information electronically in connection with a HIPAA transaction (see 45 CFR 160.103). As defined in 45 CFR 164.103, DSHS is a hybrid entity that has designated programs as health care components within the administrations/divisions as provided on the DSHS website. As a hybrid entity, only its health care components (including BAOUs) are subject to the HIPAA rules. **See BAOUs definition in AP 5.01.**

HIPAA: The Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d et seq. To implement HIPAA, the U.S. Department of Health and Human Services Office for Civil Rights (OCR) has adopted the HIPAA Privacy Rule, Security Rule, Breach Notification Rule, and Enforcement Rule (See 45 CFR Parts 160 and 164).

HIPAA Rules: References to the “HIPAA rules” apply to the following rules that OCR enforces;

- **The HIPAA Privacy Rule:** protects the privacy of individually identifiable health information;
- **The HIPAA Security Rule:** sets national standards for the security of electronic protected health information;
- **The HIPAA Breach Notification Rule:** requires covered entities and business associates to provide notification following a breach of unsecured PHI; and the enforcement rule which provides authority and procedures for OCR investigations, imposition of penalties, and administrative hearings.

Hybrid entity: A single legal entity:

1. That is a covered entity;
 2. Whose business activities include both covered and non-covered functions; and
 3. That designates health care components in accordance with the HIPAA privacy rule.
- DSHS is a hybrid entity under the HIPAA privacy rule.



Individually identifiable: Means that a record contains information, which reveals or can likely be associated with the identity of the person or persons to whom the record pertains.

Examples:

- Names, addresses, client ID numbers, and unique characteristics. Also, may be known as *individually identifiable health information* or “IIHI”.

Minimum necessary: The minimum amount of protected health information (PHI) needed to accomplish the purpose of a request for PHI or the use of PHI needed to perform one’s job.

- The Privacy Rule requires that DSHS make reasonable efforts to ***limit the use of PHI to the minimum necessary*** for the intended purpose.

Protected health information (PHI): Individually identifiable health information about a client that is transmitted or maintained by a DSHS health care component in any form or medium. PHI includes demographic information that identifies the individual or about which there is reasonable basis to believe can be used to identify the individual. Individually identifiable health information in DSHS records about an employee or others who are not clients is not protected health information. See administrative policy 5.03 for provisions relating only to PHI of clients.

Use: Access to and application or analysis of confidential information within DSHS.

Willful neglect: The conscious, intentional failure or reckless indifference to the obligation to comply with the HIPAA rules. (See 45 CFR 160.401).

ALL CLIENT INFORMATION IS CONFIDENTIAL

All information about clients served on behalf of DSHS is confidential, including:

- The fact that they get assistance (except yes/no)
- Type of assistance or services received
- Demographic information of clients (name, address, SSN, client ID#, photos)

WHERE PRIVACY APPLIES:

- Information Technology - Creation, Transmission, Storage
- Maintaining and Storing Records
- Configuration and Access to Physical Spaces
- Interactions with Clients – In Person, Phone, Mail, Email



COMMON CAUSES IN REPORTED INCIDENTS

- Wrong Email Address (Autofill!!!!)
- Wrong Fax Number
- Excel Sheet errors
- Theft from car

OTHER POOR PRACTICES

- Leaving Devices Unsecure and Unattended
- Using Unsecure Channels of Communication
- Disposing of PHI Improperly
- Accessing PHI Out of Curiosity
- Sharing PHI on Social Media
- Discussing confidential information in a public area or in an area where the public could overhear the conversation.

BEST PRACTICES FOR PROTECTING CONFIDENTIAL INFORMATION

- Encrypt electronic devices
- Do not leave client information in a vehicle unattended
- Check email addresses before sending an email (or fax numbers when faxing)
- Check that envelopes are stuffed and addressed properly
- Do not download or store confidential records on your home computer
- Do not share client information with unauthorized third parties – (e.g. media, union representative, etc.)
- Do not send client-related emails to your personal email account or outside the network
- Properly dispose of confidential records (hot trash)
- Don't use identifiable information when others can overhear or if not needed

HIPAA BASICS

Health Insurance Portability and Accountability Act of 1996 Required rules for privacy , national standards for electronic health care transactions.

Privacy Rule (2002) – regulates the circumstances under which covered entities may use and disclose Protected Health information and requires covered entities to have safeguards in place to protect the privacy of the information.



Security Rule (2003) – requires covered entities to implement certain administrative, physical, and technical safeguards to protect electronic information.

Breach Notification Rule (2009) – requires covered entities and Business Associates to provide notification following discovery of a breach of unsecured protected health information.

Rules implementing HIPAA are in 45 CFR parts [160](#) and [164](#). All rules apply to Business Associates of covered entities and their subcontractors

HIPAA BASICS – EXCLUSIONS

HIPAA does not apply to anyone who is not a covered entity or covered entity's business associate.

Information that is not protected health information:

- Education records covered by Family Educational Rights and Privacy Act (FERPA) or students' health records
- Employment records held by DSHS in its role as employer (i.e. workforce members)
- Records of persons deceased more than 50 years

OVERVIEW OF HIPAA

- Privacy Rule – Keep PHI private
- Security Rule – Keep PHI secure
- Breach Notification Rule – If you don't keep PHI private and secure, you have to notify!
PHI = Protected Health Information (defined term under HIPAA)

SPECIAL CONSIDERATIONS FOR MAILING

- Use of First-Class mail or delivery services with tracking
- Carefully check the name and address of the intended recipient
- Check the contents before sealing and make sure there is nothing included that is intended for a different client
- Update names and addresses when notified of correction or change
- Report as potential breach if mailing sent to unintended recipient

STANDARD: DE-IDENTIFICATION OF PROTECTED HEALTH INFORMATION

- | | |
|---|------------------------------------|
| 1) Names | 6) Medical record numbers |
| 2) Telephone numbers | 7) Health plan beneficiary numbers |
| 3) Fax numbers | 8) Account numbers |
| 4) Electronic mail addresses | 9) Certificate/license #s |
| 5) Social security numbers | 10) Device identifiers & serial #s |
| 11) Web Universal Resource Locators (URLs) | |
| 12) Internet Protocol (IP) address #s | |
| 13) Vehicle identifiers and serial numbers, including license plate numbers | |
| 14) Biometric identifiers, including finger and voice prints | |
| 15) Full face photographic images and any comparable images | |
| 16) Any other unique identifying #, characteristic, or code (e.g. client ID) | |
| 17) All geographic subdivisions smaller than a State | |
| 18) All elements of dates (except year) for dates directly related to an individual,
including birth date, admission date, discharge date, date of death | |

PROCEDURE FOR MANAGING A PRIVACY BREACH

A privacy breach occurs when there is unauthorized access to or collection, use, disclosure, or disposal of Client PHI. All incidents are presumed a breach unless proven otherwise. An example of a privacy breach would be lost, stolen, or personal information mistakenly emailed to the wrong person.

STEP 1: REPORTING THE BREACH

If a Breach or potential Breach of Confidential Information is discovered, staff at a minimum must notify within one (1) business day of discovery:

- a. The technology operations center (TOC) at ETOC@dshs.wa.gov; and
- b. The administration's or division's Privacy Coordinator. (Please see [DSHS Privacy Coordinators](#).)
- c. For Breaches involving over 500 individuals, or potentially over 500 individuals, staff must also notify the DSHS Privacy Officer at DSHSPrivacyofficer@dshs.wa.gov. The DSHS Privacy Officer may also be consulted on other Breaches as appropriate and necessary.

STEP 2: CONTAINING THE BREACH

It is necessary to immediately contain the breach. Some examples of containing a breach are:



- Ensuring a police report has been filed if the breach involved criminal activity;
- recovering records;
- and confirming deletion of emails sent to wrong persons.

Privacy Breach Questionnaire: The Privacy Breach Questionnaire must be completed.

Once information is provided to us, we can determine the nature of the notification needed to ensure the breach is fully disclosed to clients affected, and whether or not additional steps are necessary to protect clients from identity theft or unwanted intrusion into their personal information.

Privacy Breach Questionnaire can be found [here](#).

Internal Lost-Stolen Data Checklist can be found [here](#).

STEP 3: EVALUATING THE RISKS ASSOCIATED WITH THE BREACH

The Risk Assessment is vital and required by HIPAA. The designated Privacy Coordinator must complete the HIPAA breach risk assessment in the DSHS Privacy Breach Application (PBA) for incidents that are determined to be a HIPAA Breach along with the DSHS security breach report. The DSHS security breach report is available for completion in the privacy breach application once an incident is determined to be a breach.

The following factors will be among those considered when assessing the risks:

- 1) Persons affected by the breach**
 - a) How many clients are affected by the breach?
- 2) Protected Health Information Involved**
 - a) What data elements have been breached?
 - Name, social security number, date of birth, and financial information that could be used for identity theft are examples of PHI.
- 3) Description and Extent of Breach:**
 - a) What caused the breach?
 - b) Was the information PHI?
 - c) Is there a risk of ongoing or further exposure of the information?
 - d) Was the information secured? Meaning was it encrypted or otherwise unusable, unreadable, or indecipherable to unauthorized individuals?
 - e) Does the confidential information involve records of clients held by a program that is a HCC of the Department or a business associate (inside or outside of DSHS) of a HCC component as listed in DSHS hybrid entity designation?

For a list of the Department's HCCs click [here](#).

4) Four Part Test: (The HIPAA breach risk assessment applies the four-part test required by HIPAA to adequately document the determination that the incident is not a Breach).

- **Part 1:** Nature and extent of PHI involved, including types of identifiers and ability to identify individual.
- **Part 2:** Nature of person who acquired, accessed, used or received the PHI:
- **Part 3:** Risk whether PHI was actually accessed or acquired by unauthorized individual:
- **Part 4:** Mitigation Actions taken as a result of the breach: **(Steps taken to ensure that the incident won't happen again).**

Mitigation is required by HIPAA under 45 CFR 164.530(f). To the extent practicable, DSHS and its employees must mitigate any harmful effect known to the agency of a breach or a use or disclosure of PHI that violates DSHS policies and procedures and the HIPAA Rules. Mitigation actions must be documented and provided to the DSHS privacy officer upon request.

Examples of Mitigation Actions:

- Verbally counseled responsible employee on HIPAA and administrative policies for managing the protection of PHI.
- Completed LC- HIPAA Mandatory Training
- Reviewed DSHS Information Security Standard Manual: Chapters 3, 7, 8

STEP 4: NOTIFICATION

If notification is required as a result of a breach of confidential information, employees must contact their administration or division privacy coordinator. Breach notice letters must contain any specific language that the applicable law requires and be sent within the required time. Any notification letters required by HIPAA or RCW 42.56.590 must be reviewed and approved by the program's designated privacy coordinator, or the DSHS privacy officer or designee.

For breach incidents that do not trigger a legal requirement for notification, it is up to the program to determine to notify. However, DSHS strongly encourages notification.

1) When to Notify Affected Individuals

- Notification to affected individuals must be made in the most expedient time possible, without unreasonable delay, and no more than thirty (30) calendar days after the breach was discovered. An agency may delay notification to the consumer for up to an additional fourteen (14) days to allow for notification to be translated into the primary language of the affected consumers.

2) How to Notify Affected Individuals

- a) Written notice. (i) Written notification by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available.
- b) Under HIPAA, a deceased person's Protected Health Information (PHI) is protected for 50 years from death. If the affected individual is known to be deceased, the covered entity must send notification via first-class mail to either the next of kin or personal representative of the individual.

3) Substitute Service

- a) If the covered entity has insufficient or out-of-date contact information for fewer than 10 individuals, the covered entity may provide substitute notice by an alternative form of written notice, by telephone, or other means.

4) What must be Included in the Notification

- (a) The notification must be written in plain language; and
- (b) The notification must include, at a minimum, the following information:
 - (i) The name and contact information of the reporting agency;
 - (ii) A list of the types of personal information that were or are reasonably believed to have been the subject of a breach;
 - (iii) A time frame of exposure, if known, including the date of the breach and the date of the discovery of the breach; and
 - (iv) The toll-free telephone numbers and addresses of the major credit reporting agencies if the breach exposed personal information.

ATTORNEY GENERAL AND FEDERAL TRADE COMMISSION WEBSITES

If affected individuals are concerned about their identity or credit being impacted, they can find information on actions to take to protect themselves on the websites of the Washington State Office of the Attorney General at: <http://www.atg.wa.gov/identity-theftprivacy> and for the Federal Trade Commission at: <http://www.ftc.gov/bcp/edu/microsites/idtheft/>.

THREE MAJOR CREDIT REPORT AGENCIES

In addition, the affected individuals can contact the three major credit report agencies:

- *Equifax*, PO Box 740241, Atlanta, GA 30374, www.equifax.com, 1-800-685-1111
- *Experian*, PO Box 2002, Allen, TX 75013, www.experian.com, 1-888-397-3742
- *TransUnion*, PO Box 2000, Chester, PA 19016, www.transunion.com, 1-800-916-8800

OTHERS TO NOTIFY

- a. NOTICE TO THE SECRETARY
 - i. If a breach affects fewer than 500 individuals, the covered entity may notify the Secretary of such breaches on an annual basis. Reports of breaches affecting fewer than 500 individuals are due to the Secretary no later than 60 days after the end of the calendar year in which the breaches are discovered.
 - ii. If a breach affects 500 or more individuals, covered entities must notify the Secretary without unreasonable delay and in no case later than 60 days following a breach.
- b. MEDIA
 - i. If a breach affects more than 500 individuals, the covered entity is required to notify prominent media outlets serving the state or jurisdiction.
 - This is typically done in the form of a press release to local media outlets servicing the affected area. Similar to individual notices and notices to the secretary, media notification must be provided without unreasonable delay and in no case later than 60 days following discovery of the breach must include the same information required for the individual notice.
 - ii. AP Policy 2.07 requires press releases to go through the DSHS Office of Communications.
- c. STATE ATTORNEY GENERAL OFFICE (AGO) (RCW 42.56.590)
 - Under 42.56.590(7) for any breach over 500, a covered entity must also notify the AGO no more than thirty days after the breach was discovered.
 - (a) The notice to the attorney general must include the following information:
 - (i) The number of Washington residents affected by the breach, or an estimate if the exact number is not known;
 - (ii) A list of the types of personal information that were or are reasonably believed to have been the subject of a breach;
 - (iii) A time frame of exposure, if known, including the date of the breach and the date of the discovery of the breach;
 - (iv) A summary of steps taken to contain the breach; and
 - (v) A single sample copy of the security breach notification, excluding any personally identifiable information.
 - (b) The notice to the attorney general must be updated if any of the information identified in (a) of this subsection is unknown at the time notice is due.

DESTRUCTION OR RETURN REQUIREMENT:

If you receive healthcare information that you are not authorized to receive, *contact the sender to notify so they are aware you have received the information in error*, and then destroy the information without further dissemination.

- You may also follow the sender's instruction on how to return the health care information to the entity *and confirm no further dissemination*.

CORRECTIVE AND DISCIPLINARY ACTION FOR VIOLATIONS

- Employees found to be in violation of DSHS policies and procedures relating to confidentiality of PHI or other Confidential Information may receive corrective or disciplinary action, up to and including dismissal. Training and other mitigation steps may also be required as a result of Breaches or violations of confidentiality laws. DSHS and its employees are subject to civil and criminal fines and sanctions by the Department of Health and Human Services – Office for Civil Rights for violations of the HIPAA Rules. Civil penalties for violations of HIPAA Rules may be imposed up to \$50,000 per violation for a total of up to \$1,500,000 for violations of each requirement during a calendar year. Criminal penalties may total up to \$250,000- and ten-years imprisonment.

FOR MORE INFORMATION

If you are unsure about appropriate use or disclosure of PHI, or if you need more information about your obligations to protect the privacy of information, consult the following resources:

- Your employer's administrative and IT security policies
- Your employer's Privacy Officer
- 45 CFR Parts [160](#) and [164](#) (The Privacy Rule, which establishes federal protection for the privacy of health information.

RESOURCES

Related RCWs and CFRs

RCW 42.56.590	Personal information—Notice of security breaches
45 CFR 164.520	Notice of Privacy Practices for Protected Health Information
45 CFR 160	General Requirements
45 CFR 164	Security and Privacy

Related Administrative Policies

Administrative Policy 5.01	Privacy Policy -- Safeguarding Confidential Information
Administrative Policy 5.03	Client Rights Relating to Protected Health Information
IT Security Policy 15.10	Information and Technology Security
DSHS information security manuals	DSHS Information Security Manual
Administrative Policy 2.07	Visual Communications Policy
Administrative Policy 5.08	DSHS Minimum Physical Security Standards

Related links and websites

HIPAA Breach Notification Rule	HIPAA Breach Notification Rule
HIPAA Covered Programs (HCC List)	Department's HCC List
http://www.atg.wa.gov/identity-theftprivacy	WA State Office of the Attorney General
http://www.ftc.gov/bcp/edu/microsites/idtheft/	The Federal Trade Commission
www.equifax.com	Equifax
www.experian.com	Experian
www.transunion.com	TransUnion

Sample letters and forms

Sample RCW 42-56-590 Client Notification Letter
Sample HIPAA breach notification letter by HCC
Privacy Breach Questionnaire
Internal Lost-Stolen Data Checklist

CONTACTS

DSHSprivacyofficer@dshs.wa.gov	The DSHS Privacy Officer
ETOC@dshs.wa.gov	The technology operations center (TOC)
DSHS Privacy Coordinators	DSHS Privacy Coordinators

ACRONYMS

AGO	Attorney General Office
AP	Administrative Policy
BAOU	Business Associate Organizational Units
FERPA	Family Educational Rights and Privacy Act
HCC	Health Care Component
HIPAA	Health Information Portability and Accountability Act
IP	Internet Protocol
OCR	Office for Civil Rights
PBA	Privacy Breach Application
PHI	Protected Health Information
TOC	Technology Operations Center
URL	Universal Resource Locators

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
9/2/2026	Cynthia Mitchell	Updated the Purpose, added Privacy definition Added DSHS Privacy Policies Added more info about breach notification rule Removed unsecure phi info Added Business Associate definition Added Client definition Added Client Confidential Information definition Updated definition of Covered Entity Updated HIPAA Rules Added Individually identifiable: Updated Hybridization Updated Min Necessary definition Added PHI definition Added Use definition Added Willful neglect definition Added Where Privacy Applies Added Common Causes in Reported Incidents Added HIPAA Basics Removed – when HIPAA does not apply AND added HIPAA Basics – and Exclusions Added Overview of HIPAA Added Requirements of Mitigation to Part 4 Updated Step 4: Notification information Updated when to Notify affected indiv Updated how to notify affect indiv	



		Updated substitute service Updated what must be Included in the Notification Updated Three major credit report agencies Changed Consequences for Breaches to - Corrective and disciplinary action for violations Updated definition to 45 CFR Parts 160 and 164 Updated cfr's Updated links/websites Updated 42.56.590 client notification letter Updated contracts and acronyms	
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Legal Holds & Discovery

The purpose of this section is to provide guidance for the management and preservation of records and documents involved in Litigation and/or potential Litigation.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Cynthia Mitchell

Discovery Program Manager

360.715.2537

cynthia.mitchell@dshs.wa.gov

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BACKGROUND

When a Lawsuit or a Tort Claim has been filed or reasonably anticipated, employees who work at the Department are under an obligation to retain all records in its possession which could reasonably be considered relevant to the matter. Along with current records, any related records developed after a Litigation Hold Notice for a Tort Claim should be retained as well. The obligation is ongoing until the Claim has concluded.

Employees must be familiar with [Administrative Policy 5.05](#) (Management of the Litigation Discovery Process), and [Administrative Policy 5.07](#) (Employee Response to Litigation Related Documents), because any employee may:

- Be involved in litigation
- Need to determine if an event may lead to litigation
- Receive a litigation hold notice
- Receive a litigation related document, such as a subpoena, court order, notice of deposition, tort claim, or lawsuit
- Receive direction through their chain of command or the Office of the Attorney General to identify, preserve, collect or produce DSHS records

DEFINITIONS

DSHS records: Any document or recorded information, regardless of physical form or characteristics, created, sent, organized or received by the agency in the course of public business, including paper documents, e-mail, drawings, graphs, charts, audio and video recordings, photographs, phone records, data compilations, planners, calendars, diaries, draft documents, electronically stored information (ESI) and metadata.

Litigation hold notice: A written communication that instructs ‘affected individuals’ who are likely to have DSHS records pertaining to a legal issue to take immediate action to identify and preserve the records for future retrieval.

Preservation: The process of locating and safeguarding DSHS records from destruction that reasonably and likely relate to a potential or actual lawsuit or tort claim.

Reasonably anticipated litigation: A reasonable expectation that an event may lead to the filing of a lawsuit or a tort claim against DSHS or its employees. There is no formal standard to determine whether an event will lead to a lawsuit.

Tort claim: A formal written filing with the state office of risk management under [RCW 4.92.100](#) in which the claimant alleges that certain kinds of harm or damages were caused by the state of Washington, its agencies or state employees in which people claim they have been harmed by torts (wrongful acts), including negligence, by government agencies or their employees.

WHAT TO DO IF YOU RECEIVE A LITIGATION HOLD NOTICE

1. Stop what you are currently working on and read the entire Litigation Hold Notice.
2. Follow all instructions in the Litigation Hold Notice. For example, if you have records about the circumstances described in the Notice, suspend normal records retention practices and place those records on litigation hold until further notice.
3. Distribute the Hold Notice to any staff that may potentially hold related program records.
4. Ensure that you and your staff understand and are complying with the elements of the Hold Notice.
5. Locate and Identify DSHS records you may have that relate to the Litigation issues.
 - You must make a reasonable good faith effort to identify relevant records that are in your possession. This includes:
 - Searching desk files
 - File cabinets
 - Email and other electronic files that may contain information relevant to the Litigation issues.
6. Separate and preserve:
 - a. Located email or other electronic records.
 - Do not print out hard copies of the electronic records and then turn around and delete the electronic record. You must preserve the original electronic version of located record.
 - b. Identified hard copy documents that may be relevant.
 - Duplicate records should be reserved.
7. Err on the side of preserving the records:
 - If you have questions about whether certain records fall under the directive of the Litigation Hold Notice, you are instructed to err on the side of preserving the records.
8. Contact your administration's [Discovery Coordinator](#) or the [DSHS Discovery Manager](#) if you have questions or need assistance.

OBLIGATION TO PRESERVE RECORDS

Employees are required to preserve potentially relevant records relating to all legal related proceedings until the matter concludes and the records retention policy permits destruction. This includes records in any form including all electronically stored information and metadata.

CONSEQUENCES

Serious penalties could be imposed on the Department if employees fail to take reasonable steps to locate and preserve potentially relevant information. In addition, employees could be subject to disciplinary action for failure to comply.

RESOURCES

Contacts

[Discovery Coordinators](#)

Related RCWs

[RCW 4.92](#) [Actions and Claims Against State](#)

Related Administrative Policies

[Administrative Policy 5.05](#)
[Administrative Policy 5.07](#)

[Management of the Litigation Discovery Process](#)
[Employees Response to Litigation Related Documents](#)

WHAT TO DO IF YOU ARE SUED OR INVOLVED IN A LAWSUIT:

- [Lawsuits Against the State and Employees - What to Do](#)



REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
9/2/2026	Cynthia Mitchell	Updated Links	



Assessment and Care Planning

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

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

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Dru Aubert Care Management Unit Manager
360.725.2524 dru.aubert@dshs.wa.gov

For questions or clarification needs on limited English proficient persons, contact:

Linda Garcia Americans with Disabilities/Limited English Proficiency/Voter Registration
Assistance Program Manager
360.968.9745 linda.garcia1@dshs.wa.gov

For questions or clarification needs about the bed rail policy, contact:

HCS Residential Policy hcsresidentialpolicy@dshs.wa.gov

For questions or clarification needs about sex offender notification policy, contact:

HCS Community Support so.notifications@dshs.wa.gov

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PERSON-CENTERED CARE PLANNING

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

Strengths & Preferences

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

Goals

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

Informed Choice

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

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

Example.

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

GOALS AND FUNCTIONS OF THE CARE ASSESSMENT

What are the functions of an assessment?

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

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

Assist the individual to develop a plan that:

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

What is the function of the CARE tool?

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

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

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

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

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

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

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

Who completes the CARE assessments?

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

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

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

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



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

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

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

Types of CARE Assessments

Initial Assessment

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

Initial/Reapply Assessment

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

Annual Assessment

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

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



Significant Change Assessment

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

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

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

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

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

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

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

Can a nursing referral result in a Significant Change assessment?

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

Interim Assessment

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

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

NOTES on Interim assessments:

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



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

Veteran Directed Care (VDC) Assessment

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

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

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

Can an incarcerated individual be assessed?

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

Incarcerated Applicant

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

Conducting an assessment in a jail or prison setting

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

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

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

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

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

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

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

ADDING A CLIENT TO CARE

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

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

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

How do I add a client to CARE?

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

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



3. Residence: select the client's Residence Type from the dropdown list and enter the client's residence address¹. If the mailing address is the same, mark the appropriate checkbox. **Do not delete historical residence records. If the client has moved, create a new residence record.**
4. Client Contact: if the client's mailing address is different than their residence address, indicate the mailing address and contact phone numbers.
5. If the client uses email, enter the email address in the field provided.
6. Contact Details: add all appropriate contacts. If the client did not self-refer, identify the referent here.
7. Financial: Intake may obtain financial information, but the assessor must verify that the client is financially eligible at the time services are being authorized.
8. ProviderOne: link client to correct ProviderOne (P1) record. **IMPORTANT:** Use caution when linking CARE and ProviderOne records. Compare the demographic information in CARE with ACES (Name, Date of Birth (DOB), SSN must match exactly)². ACES is the primary source for this information when linking to P1.

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

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

When do I inactivate a client record in CARE?

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

PERFORMING A CARE ASSESSMENT

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

¹ If the client identifies as being unhoused, select "Unhoused" as the Residence Type. Document known special instructions in the Comments box to assist staff in successfully contacting the client.

² Rarely, but sometimes, the information may be incorrect in ACES. When this happens, the CARE record still needs to match ACES to link correctly. When ACES information is incorrect, the client should work with their financial worker to correct it.



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

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

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

Steps in performing a CARE Assessment

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

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

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

- Ask the client if they or anyone in the home have any concerns conducting a home visit to conduct their assessment. For instance, are there perfume or animal allergens to consider that the client, household member, or staff member must refrain from, are there animals in the home that must be restrained prior to the home visit, any recent illness exposures amongst household members, or any environmental concerns, such as mold, bed bug/cockroach infestations, or do any household members own have weapons, and are these secured?
 - f. On the day of the appointment, call to confirm and document the appointment confirmation in a Service Episode Record (SER).
 - 2. Assess the client in an in-person interview and gather information related to the individual's functional abilities, goals, personal preferences, and any special instructions the caregiver may need to know to support the individual to complete tasks. At some point during the assessment request that the client speak with you privately in case they would like to share information for which they are not comfortable sharing in front of others. The assessment may be in pending status while you gather additional information to complete the assessment and care plan. During this time:
 - a. Complete Consent Form [DSHS 14-012](#). You must use this form to obtain, use, or share confidential information about a client in certain situations. Read the instructions on the Consent form carefully prior to assisting the client to complete the form and emphasize the information in the "notice to clients" section at the top of the form. Supplementing the consent form with the [DSHS Notice of Privacy Practices \(03-387\)](#) is required at an initial assessment and is suggested for subsequent assessments to enhance the client/representative's understanding of how and why information may be shared. Check the box "Other DSHS contracted providers." The case worker should write in "HCLA paid providers". If there are specific questions about sharing information, consent and privacy, please contact the DSHS or HCLA Privacy Officer.
 - b. Gather Information
 - i. The client should be used as the primary source of information whenever possible.
 - ii. Gather information from the client's legal representative or substitute decision-maker, as appropriate. If the client has a guardian or DPOA, get this paperwork and forward it to the Hub Imaging Unit (HIU) for imaging into the client's electronic file.
 - iii. Gather other information from other contacts if it is needed to complete the client's assessment.
- If the client does not appear to be able to participate in the assessment process, then the representative/collateral contact providing information must be able to understand and speak English. If not, then an interpreter must be used. Document an SER to explain why the client did not participate and an interpreter was not used.
- c. Discuss Necessary Supplemental Accommodations (NSA). Individuals who have a mental, neurological, physical, or sensory impairment that prevents them from getting program benefits



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

- d. Review all [brochures and forms](#) with the client. Also follow the [Self-Directed Care Checklist](#) for clients who would like to self-direct their services.
 - e. [Assess for informal support](#) available to fully or partially meet tasks identified in the client's care plan.
 - f. Complete the "My Goals and Plans" section on the Profile screen in CARE: Documenting and assisting clients to identify goals is an important part of person-centered service planning. Goals can identify what motivates a person, what is important to the person, and what are their desired outcomes regarding their care.
 - g. For residential clients, document any modifications to client's rights in a Service Episode Record (SER) and in the comments section on the appropriate corresponding CARE screen for which the modification relates. See [Chapter 8/Residential Services](#) for details.
 - h. Review critical indicators from the Triggered Referrals screen. When possible, review while in the home with the client and/or representative as some have specific deadlines for follow-up. The following are some examples of when you would refer to or coordinate with nurses or make other referrals:
 - i. [Skin Observation Protocol](#) has been triggered. NOTE: The [HCLA skin breakdown prevention plan](#) will print on the client's assessment details when potential skin issues exist.
 - ii. Other critical indicators have been triggered (e.g., nutritional status affecting the plan of care).
 - iii. Depression, Drug/Alcohol Abuse, Suicide, or Pain has triggered consideration of referrals.
3. Verify and Determine Eligibility. **Financial and functional eligibility must be determined concurrently** for clients receiving Core services (such as, CFC, COPES, MPC, New Freedom, etc.). Communicate with financial staff regularly on status of financial eligibility and confirm financial eligibility has been established, or complete Fast Track procedures as necessary. Document financial verification on the Financial screen in CARE or forward documents to HIU for imaging into the client's file before authorizing or re-authorizing services for a new plan period. Develop a proposed plan of care with input from the client and relevant parties and if appropriate, hold an interdisciplinary case staffing to discuss the proposed care plan given a client's particular situation.
4. Have a discussion with clients and present all the programs and services for which the client may benefit based on their needs, goals, and eligibility. Consider any assistive technology that may assist a client to be more independent with performing ADLs, IADLs, or health related tasks. Coordinate and plan for chosen services and supports and document in the client's plan of care. See relevant [Long Term Care Manual Chapters](#) for policy and eligibility criteria for specific programs and services available for eligible clients.

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

Additional details

Has the CM discussed with client/rep all program and service options; the option of receiving personal care (from an IP or agency provider) in own home and in all residential settings?

☒ Yes ☐ No

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

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

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

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

In-person vs. Telephonic Assessments

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

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

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

Performing a Telephonic or Other Technology Media-Type Assessment

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

Not eligible for Core services?

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

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

Limited English Proficient Persons

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

Assessing Status (Informal Supports)

Background

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

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

What are examples of informal supports?

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

Process of Determining Status

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

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

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

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

Special Considerations

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

When is the status “met”?

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

When is the status “partially met”?

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

When is the status “unmet”?

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

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

Assistance Available

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

- Less than $\frac{1}{4}$ of the time
- $\frac{1}{4}$ to $\frac{1}{2}$ of the time
- $\frac{1}{2}$ to $\frac{3}{4}$ of the time
- More than $\frac{3}{4}$ of the time

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

Less than $\frac{1}{4}$ of the time	$\frac{1}{4}$ - $\frac{1}{2}$ of the time	Over $\frac{1}{2}$ to $\frac{3}{4}$ of the time	Over $\frac{3}{4}$ but not all of the time	Need Met
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Example:

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

Number of times task is required: 21 total.

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

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



How do I know when I'm ready to complete CARE?

Does your assessment meet the [minimum standards](#) requirements? If yes, you are now ready to complete your CARE assessment.

Finalizing a CARE Assessment – Developing the Plan of Care

Background

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

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

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

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

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

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

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

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

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



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

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

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

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

Documenting potential risk in the Plan of Care

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

Obtain Plan Approval on the Plan of Care

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

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

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

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

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

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

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

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

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

Person Centered Care Planning and Preventing Conflict of Interest

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

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

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

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

Person-Centered Care Planning and Role Types

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

Authorized Representatives (A-Rep)

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

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

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

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



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

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

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

Power of Attorney (POA)

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

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

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

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

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

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

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

Guardian

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



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

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

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

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

How do I document a representative in CARE?

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

The Case Worker's Role & Decision Making Capacity

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

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

What if there is no DPOA or guardian?

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

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

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

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

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

What support is available if the case worker needs help?

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

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

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

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

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



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

Client Signature

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

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

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

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

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

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

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



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

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

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

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

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

For detailed information and the script for obtaining voice signatures, see the instructions in the [Attachments](#) section.

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

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

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

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

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

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

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

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

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

Do not:

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

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

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

What to do when the client cannot sign

1. If the client appears to have capacity but physically cannot sign documents, the reason should be documented in a Service Episode Record (SER). Signing with an "X" or comparable mark is acceptable if it is witnessed by the case worker or another party who has verified the client's identity and has witnessed them signing the document.
2. If the client appears to not have capacity but there is no Durable Power of Attorney or guardian in place, the case worker should state this in a Service Episode Record (SER). An Adult Protective

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

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

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

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

Provider Signature(s)

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

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

- a. Consumer Directed Employer
 - b. Home Care Agency
 - c. Adult Family Home
 - d. Assisted Living Facilities
 - e. Enhanced Services Facilities
2. Case worker must also obtain the provider's signature when there is a change in their task assignment. For changes in providers during the plan period, case workers should obtain signatures at the earlier date of 90 days from the *authorization start date* or before case transfer.
 3. Plans of care must continue to be sent to the provider prior to authorizing services.

More about signatures

1. When the ONLY change to a client's care plan is a change of a paid or unpaid provider:
 - a. A new assessment may not be required
 - b. A new client signature is not required
 - c. A personal care provider signature may be required if there is a change in the paid task assignment
 - d. The Service Summary in CARE must be updated and the updated version filed in the client's electronic case record (ECR) via the HCS Imaging Unit (HIU). If the changes made do not require a signature, on the signature line, write "signature not required".
 - e. Print/send the Service Summary to the client and the provider and document the client's request and consent for these changes in a Service Episode Record (SER).
2. Client and provider signatures must be obtained on Current assessments only. Signatures on plans of care that are in Pending or History are not valid approvals of the plan of care.
3. Obtain all required signatures prior to transferring a client's case to another office.

There may be extenuating circumstances which prevent the case worker from obtaining required signatures. In these rare situations, the local office must exhaust and document person centered approaches to obtain the required signatures and then discuss the matter with the receiving office directly, before transferring the case.
4. If there is more than one provider in the plan, it is acceptable to have the provider(s) sign in the blank space below the signature lines if they are signing the same copy.
5. Although it is ideal for all required signatures to be on one document, or as few documents as possible for the purposes of records management in the HIU, obtaining all required signatures is the most important priority. It is acceptable to have required signatures on separate Service Summaries stored in the HIU. If the complete Service Summary is sent to HIU prior to obtaining client and provider signatures and then the client or provider subsequently returns the signature page, staff do not need to send the entire Service Summary to HIU again. In this scenario only the additional signature pages would need to be uploaded to HIU.

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

Residential Rate and In-Home Adjustments on the Service Summary

In-Home Adjustments

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

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

Residential Rate Adjustments

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

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

Assessment Completion Timeframes

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

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



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

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

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

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

Significant Change Assessment by a Nurse

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

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

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

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

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

Significant Change Request by an Adult Family Home (AFH)

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

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

An AFH provider may request a significant change assessment by:

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

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

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



If the assessment results in an increase to the daily rate and the 30-calendar day timeframe is exceeded, the Adult Family Home provider may request a review by the department. If the Adult Family Home provider requests a review, the

Field Services Administrator (FSA) or designee will:

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

Authorization of Services

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

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

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

When do I transfer the case?

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

you have a signed/dated Service Summary returned from the client. Refer to Transfer Protocol in [Chapter 5. When do I move an assessment to Current?](#)

Move the assessment to *Current* status:

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

When do I move an assessment to History?

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

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

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

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

Local Exception to Rule/Exception to Policy

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

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

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

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

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

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

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



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

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

Headquarters Personal Care Exception to Rule (ETR) Committee Reviews

The Headquarters Exception to Rule Committee reviews the:

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

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

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

Who can request a personal care Exception to Rule?

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

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



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

1. If a client requests additional in-home personal care hours/budget above the CARE generated amount, the case worker must have a conversation with the client and/or client representative to discuss the request and to identify how the frequency and duration of the assistance with personal care tasks differs from the majority. case worker will use their professional judgment to determine if an ETR is appropriate or provide case management services to see if other options are more appropriate (e.g., using split shifts to maximize coverage when appropriate, informal supports, or other waiver and/or Community First Choice options such as Home Delivered Meals, Adult Day Health, Adult Day Care, Personal Emergency Response System (PERs), Assistive Technology, etc.)
2. If the client's initial request for an Exception to Rule is denied at the field level either verbally by the case worker or in CARE by the Field Reviewer, a Notice of Decision on Request for an In-Home Personal Care Exception to Rule (DSHS Form 15-429) via CARE > *Notices* screen, must be sent to the client. Clients do not have administrative hearing rights for initial Exception to Rule request decisions. If the Exception to Rule request is denied at the field level the client may request a review by the Headquarters Exception to Rule Committee. The client may ask for a review by contacting the case worker or by writing the Headquarters Exception to Rule Committee directly. These instructions are indicated on the 15-429 form mailed to the client. case worker will submit the requests for Headquarters review through CARE using the standard Exception to Rule Categories and Types and indicate the client's request by checking the *Client requested ETR HQ review* checkbox. **Only use this checkbox if the initial request was denied locally and the client has requested a review by Headquarters.**
3. **If the client directly contacts the Headquarters Exception to Rule Committee requesting review of an initially denied Exception to Rule, the Exception to Rule Program Coordinator will:**
 - Notify the field reviewer, field approver, or supervisor of the client's assigned office of the request for review; and
 - Forward any communication sent to the Exception to Rule committee by the client/client representative to the field office.

The field office will:

 - Contact the client regarding the client's request for review if the communication received by the client contains new or additional information that was not reported in the initial request.
 - Submit a new Exception to Rule request to the Headquarters Exception to Rule Committee through CARE using the standard Exception to Rule Categories and Types and indicate the client's request by checking the *Client requested ETR HQ review* checkbox.
4. The Headquarters Exception to Rule Committee will make an individualized determination to approve, partially approve or deny the Exception to Rule request based on [WAC 388-440-0001](#).



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

Exception to Rule Requests for in-home clients

1. For In-Home Personal Care Exception to Rule

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

- a. Use the *Date Range* dropdown to select either Plan Period or Custom. Use custom only for short-term/temporary or time specific requests.
- b. Use the *Hours* field to indicate the number of ADDITIONAL hours requested above the CARE generated hours.
- c. In the *Request Description* tab, note the CARE-generated personal care hours, the additional amount requested by the assessor or client, the schedule now, and the proposed schedule. Include any specific information about how personal care needs are addressed by formal and informal supports and any gaps in service you are proposing to address through the Exception to Rule request.
- d. In the *Justification for Request* tab, outline the specific personal care tasks performed that is different from the majority in support of the request. This information should describe how the client's situation differs from the majority (in client's classification).
- e. In the *Alternatives Explored* tab, detail other options that have been attempted or explored (such as, split shifts, community supports, waiver and/or Community First Choice services, etc.)
- f. Process for Field Review or Field Approval depending on local office policy. The Exception to Rule must have Field Approval before processing to Headquarters.
- g. Headquarters will review and finalize Personal Care Exception to Rule requests within seven (7) business days of receipt.
- h. Headquarters will review and finalize Personal Care Exception to Rule requests within three (3) business days when the processing comments of the request indicate the client is awaiting discharge from inpatient settings.
- i. Once the Exception to Rule decision has been finalized the primary case worker assigned in CARE will receive Tickler notification. The case worker must review the Exception to Rule outcome decision to confirm whether the request was approved, partially approved, or denied and to confirm the begin/end dates of an approved Exception to Rule as the dates may be something other than "plan period".

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

2. **For initial personal care Exception to Rule requests that are:**
 - a. **Approved/Partially Approved**, include the additional hours via CARE > *Care Plan* screen > *Personal care adjustments* > *HQ Approved Personal Care ETR*. This will result in the adjustment to total hours to print on the client's Service Summary, to send to the client for signature. Authorize CARE generated benefit and approved ETR amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).
 - b. **Approved/Partially Approved, or Denied**, send a Notice of Decision on Request for an In-Home Personal Care Exception to Rule (DSHS Form 15-429) via CARE > *Notices* screen, to the client. Clients do not have administrative hearing rights for initial Exception to Rule request decisions.
3. **For Exception to Rule requests that were approved in the previous plan period, or are being requested to extend a custom date range:**
 - a. **Approved/Partially Approved, denied, reduced, or terminated**, note any approved hours via CARE > *Care Plan* screen > *Personal care adjustments* > *HQ Approved Personal Care ETR*. This will result in the adjustment to total hours to print on the client's Service Summary, to send to the client for signature. Send a services Planned Action Notice to the client indicating the approval, denial, or reduction in hours. The client has an administrative hearing right for Exception to Rules authorized in the plan period that immediately precedes the new Exception to Rule request. Authorize CARE generated benefit and approved Exception to Rule amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).

Example:

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

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

Example:

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

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

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

Exception to Rule requests for residential clients

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

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

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

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

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

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

Adult Family Home provider notices about Exception to Rule requests:

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

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

For residential personal care Exception to Rule:

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



- i. **Approved/Partially Approved**, note the additional rate on the Service Summary, initial and date, and send to the client for signature. Authorize CARE generated benefit and approved ETR amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).
 - ii. **Initiated, Not initiated, Approved, or Denied**, send a Notice of Action Exception to Rule (CARE > Notices screen) to the client. For Adult Family Home requests, use Notice of Action Exception to Rule for Adult Family Home Daily Rates (CARE > Notices screen), and send a copy of this completed form to the client and the Adult Family Home provider. For all other residential settings, (such as Assisted Living, Adult Residential Facility, etc.) use Notice of Action Exception to Rule (excluding Adult Family Home, via the CARE > Notices screen). If the Exception to Rule is approved or partially approved, include, and confirm in CARE, the approved time period. The start date must not be prior to the Headquarters Exception to Rule Committee decision date. The end date cannot exceed the end date of the plan period. Clients do not have administrative hearing rights for initial Exception to Rule request decisions.
- b. For residential Exception to Rule requests that were approved in the previous plan period or are being requested to extend a custom date range:**
1. **Approved/Partially approved, reduced, or terminated**, note any approved rate on the Service Summary, initial and date, and send to the client for signature. Send a services Planned Action Notice to the client indicating the approval, denial, or reduction in rate. The client has an administrative hearing right for the Exception to Rule authorized in the plan that precede the new request. Authorize CARE generated benefit and approved Exception to Rule amount in the payment system (see *Authorizing Personal Care Exception to Rule in CARE* section below).
- d. If an Exception to Rule was approved and authorized in the plan period preceding a new request and the new Exception to Rule requests personal care rate above the amount of the previous Exception to Rule request, the additional amount is considered an initial request. Based on the decision for the additional amount by the Exception to Rule committee, follow the policy above for initial requests.

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

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

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

Home and Community Services/Area Agency on Aging Complaint Procedure

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

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

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

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



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

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

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

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

Authorizing Personal Care Exception to Rule in CARE

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

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

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

Example:

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

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

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

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

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

Example:

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

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

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

Termination of Services

Terminate services when:

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

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

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

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

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

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



RESOURCES

Related Washington Administrative Code Regulations and Revised Code of Washington Laws

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

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

Acronyms

A complete list of the department’s acronyms can be found [here](#).

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

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

REVISION HISTORY

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

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

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

Date	Made by	Change(s)	MB #
		- Clarified policy related to the Consent form 14-012. - Added reference to RCWs 70.02.230, 70.02.050 and 70.02.220. - Added The 14-012 includes the following phrase on page 1: "DSHS may still share information about you to the extent allowed by law."	
07/2025	Dru Aubert	- Added footnote that the term Health Care Authority (HCA) uses (on their website) for Medicaid "Durable Medical Equipment" (DME) was changed effective 5/1/25 to "Medical Equipment and Supplies" (MES). This new term, "MES", will not be used for HCS programs (such as COPES and RCL) that include DME services. HCS will continue to use the term "DME" to minimize any confusion for clients, families and staff. - Per the department's reorganization of DSHS to merge some administrations to Home and Community Living Administration effective 5/1/25, updated Developmental Disabilities Administration (DDA) to Developmental Disabilities Community Services (DDCS) naming, and Aging and Long-Term Support Administration to Home and Community Living Administration (HCLA) naming. - Added to "Significant Change Request by an Adult Family Home (AFH)" that, when a significant change assessment is requested for residents currently on hospice services, the timeline for case managers will be within ten (10) business days. Per AFHC CBA 25-27 Negotiated Changes. - Added to "Steps in performing a CARE Assessment" that, Adult Family Home providers or designees will be notified in advance of an assessment meeting. Per AFHC CBA 25-27 Negotiated Changes. - Added to "Who completes the CARE assessments?" that, CMs from a contracted federally recognized Indian tribe complete assessments for individuals 18 and older in their home after services are initially authorized. (WAC 388-71-0503) - Added to "Forms and Brochures" that first and last names must be used for specific individual names (collateral contacts) added to a consent form. - Removed escalation pathways from "Getting Approval on the Plan of Care" section due to changes in Guardianship and Conservatorship Assistance Program and associated escalation pathways ending 6/30/25. Added Document Review Checklist for Alternative Decision Maker Authority Form. - Clarified wording in "Timeframes" section, from "in" to "inpatient" regarding applicants in an acute care/community psychiatric hospital setting. - Added section, "What is the Role of SSS/CMs in Determining Decision Making Capacity?", formerly housed in Chapter 9a/Acute Care Hospital (ACH) Assessments. The policy applies to all settings, not solely ACH.	H25-012
9/2025	Dru Aubert	- Added examples of informal supports and clarified informal supports include resources available to complete treatments, in addition to ADLs and IADLs. Clarified for individual informal supports, to confirm they are willing and able to provide the care as an informal support on an ongoing basis looking forward. - Added to Client Rights and Responsibilities and Acknowledgement of Services forms that the most recent form presented by the SSS/CM/CRM and signed by the client replaces previously signed forms. - Added to Consent Form, that when using the form, be accurate and specific as possible (such as utilizing agency names for an individual home health agency serving the client). - As an option, added a client may choose a representative by completing the DSHS #14-532/Authorized Representative Form, and the representative may	H25-048

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

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

APPENDIX

Bed Rail Policy

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

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

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

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

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

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

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



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

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

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

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

1. Provide the client a copy of the FDA brochure "[A Guide to Bed Safety](#)". The brochure is focused on institutional settings, but the information applies to any home and community-based setting.
2. Discuss with the client, their representative (if applicable) and providers:
 - a. The risks of entrapment, injury and death from bed rails per "[A Guide to Bed Safety](#)."
 - b. Explain to the client and/or representative that there are alternatives to bed rails and that a specialist can help the client determine what alternatives are best through an individualized evaluation. Alternatives may include roll guards, foam bumpers, low beds, a trapeze or standing transfer poles. Other alternatives may be recommended as part of the evaluation.
 - c. Document the date the bed rail discussion occurred with the client and representative (if applicable) and the requirement for the individualized bed rail evaluation in a CARE Service Episode Record (SER) or a Progress Note in GetCare.
 - d. The client can choose not to participate in the evaluation; however, without a completed evaluation:
 - A bed rail cannot be used in a residential setting for a DSHS LTSS client.
 - A SS authorization cannot be used to purchase a bed rail, regardless of size or service code used: SA878 (full or half-length bed rail) or SA421 (¼ or ½ length rails).
3. The client requests a referral from their primary care provider for a bed rail evaluation from a physical therapist (PT) or occupational therapist (OT):
 - a. The bed rail assessment is paid for by the client's AH medical plan. COPES Client Training cannot be authorized for this evaluation. Exception: if the client's item has been recalled and there is an emergent need.

- b. The client must be referred to a physical therapist or occupational therapist that is in their AH provider network (managed care) or a provider with a Core Provider Agreement (fee for service).
 - c. The therapist may be employed or contracted by agencies such as home health or outpatient therapy clinics. For a client transitioning from a skilled nursing facility, this could be a SNF therapist.
 - d. Following established procedures, the therapist requests an expedited prior authorization (EPA) from the client's AH plan prior to completing the assessment.
 - e. Step 3 is not necessary if:
 - A SNF therapist will complete the assessment.
 - If the evaluation is performed in conjunction with another task the provider is authorized to complete, and the provider will not claim the AH procedure code for bed rail assessment (97165/modifier: GO).
4. The case worker requests the therapist's contact information from either the primary care provider or client.
5. The case worker completes Section 1 of [DSHS form 13-906](#) and emails it to the therapist who will perform the assessment (note: Please make sure to use the most updated version).
6. The PT or OT:
 - a. Completes the evaluation using generally accepted standards of practice and documents their recommendation(s) regarding the safe use of bed rails or alternative devices in Sections 2 and 3 on [DSHS form 13-906](#) provided by the case worker .
 - b. Returns the completed form to the case worker and sends a copy to the client's primary healthcare provider.
 - c. If unsure the intent of the bed rail recommendation, the case worker should clarify the results with the physical/occupational therapist.
7. The CARE case worker :
 - a. Documents the results of the evaluation in the "Comments" section on the *Bed Mobility* screen.
 - b. Discusses the results with the client, provider, and representative (if applicable).
 - c. Provides the residential provider a copy of the form (if applicable).
 - d. Submits the completed form with a Packet Cover Sheet - Social Services (DSHS Form 02-615) to HIU via Hotmail.
 - If you are an case worker inside the DSHS firewall, you may access the Packet Cover Sheet - Social Services (DSHS Form 02-615) via Forms Picker: [DSHS Form #02-615](#)
 - If you are a case worker outside the DSHS firewall, you may access via [here](#).
8. The GetCare case worker :
 - a. If unsure the intent of the bed rail recommendation, the case worker should clarify the results with the physical/occupational therapist.
 - b. Discusses the results with the client and provider(s).

- c. Documents the results of the evaluation and the discussion with the client and provider(s) in a Progress Note.
 - d. Uploads the completed [DSHS Form #13-906](#) into the client/care receiver's electronic file cabinet in GetCare.
9. Based on the results of the evaluation documented in the completed [DSHS Form #13-906](#), and the informed decision by client and/or representative, complete one of the steps below.
 - a. **Recommendation is an alternative device:** depending on the item, follow all established procedures for either AH durable medical equipment (DME) or specialized equipment and supplies (SES) to assist the client with obtaining the recommended item(s).
 - b. **Recommendation is full or half-length bed rail(s):** client/vendor follows established AH DME procedures (with case worker assisting, as necessary). Note:
 - AH pays for one pair of full or half bed rails every 10 years *with no prior authorization*. The client provides a prescription from their healthcare provider to a DME provider who will dispense the bed rail.
 - If a client has damaged their full or half bed rails or they have been lost before the 10-year limit has expired, the DME vendor should request a limitation extension (LE) from the client's AH plan.
 - If the LE is denied and the client is enrolled in a LTSS program that includes DME, a SS authorization can be created in *Reviewing* status using blanket code **SA878**. Upon confirmation the client has received the item, the authorization is changed to *Approved* status and the DME vendor will be able to claim using the product's HCPCS in the SS medical portal in ProviderOne.
 - c. **Recommendation is one-fourth or one-eight length bed rail (also known as bed canes, mobility bars/rails, bed support handles, standing bars, and many other names):** a SS authorization is appropriate if client desires to use the item, and the client is enrolled in a program that includes SES.
 - **Best Practice:** Utilize a *DME* vendor with the SES contract to authorize $\frac{1}{4}$ or $\frac{1}{8}$ length bed rails. When requesting the quote, verify the item has not been recalled and that it meets the ASTM standard for adult portable bed rails.
 - Create the authorization in *Reviewing* status using **SA421** after completing all other steps. Upon confirmation the client has received the item, the authorization is changed to *Approved* status and the DME vendor will be able to claim in the SS portal.
 - d. **Use of a bed rail is NOT recommended** due to concerns about the client's ability to safely use it:
 - If the client resides in (or is transitioning to) a residential setting, the client will not be able to use a bed rail, per policy. Alternative devices or equipment can be requested by the client, if recommended in the evaluation.

- If the client resides in (or is transitioning to) an in-home setting:
 - If the bed rail is being paid for by the client's AH plan and the client/representative is making an informed decision based on the results of the evaluation, the client can request a prescription for a bed rail from the primary care provider and follow up with a durable medical equipment vendor. Document informed decision in a CARE Service Episode Record (SER) or GetCare Progress Note.
 - A SS authorization cannot be used to purchase a bed rail, regardless of length.
10. If a client is not enrolled in Apple Health:
- a. For clients enrolled in TSOA: if client's private insurance does not pay for the evaluation, TSOA funds can be used to pay for it.
 - b. If a full or half-length bed rail is recommended following the evaluation, a social services authorization can be created in *Reviewing* status using blanket code **SA878**. Upon confirmation the client has received the item, the authorization is changed to *Approved* status and the Durable Medical Equipment vendor will be able to claim using the product's HCPCS in the SS medical portal in P1.
 - c. If a one-fourth or one eighth length bed rail is recommended (also known as bed cane, mobility bar/rail, bed support handle, standing bar, and many other names), follow all instructions in 8.c. above.

Self-Directed Care

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

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

Self-Directed Care Checklist

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

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

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

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

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

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

The case worker must:

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

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

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



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

Necessary Supplemental Accommodations (NSA)

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

Developing Necessary Supplemental Accommodations (NSA)

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

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

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

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

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

Implementing the Necessary Supplemental Accommodation (NSA)

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

Sex Offender Notification Letter to Personal Care Providers

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

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

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

MINIMUM STANDARDS

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

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



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

ASSESSMENT

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

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

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



ADL and IADL screens	Use the bucket selections to provide a clear description of the client's strengths, preferences, limitations, and caregiver instructions. Use the Comment box, if necessary, to provide specific instructions to the caregiver that are not available in the buckets. Status (Looking forward): If the client will receive non-HCLA-paid informal support for any ADL or IADL, the assessor will select Met or Partially Met and identify the amount of support under Assistance Available (Looking Forward), using the chart provided in the Assessing Status section or CARE Web Assessor Manual/Help screen. Examples of non-HCLA-paid informal support are family members, neighbors, Adult Day Care, or Adult Day Health. If a client declines personal care and does not want to have a paid personal care provider, the client's assessment must accurately reflect the client's chosen status of "Client Declines" which means "the client will not want assistance with the task". NOTE: if a Need is documented on the Medical screen that DME or an assistive device might be helpful, please see the Appendix > Bed Rail Policy.
Guidelines for Referrals	When a non-mandatory referral is indicated (e.g., Depression score of 10 or more or pain score of four or more, etc.), document a discussion with the client in the Comments box on the appropriate screen. Discussion may consist of providing information sheets developed at the local level for self-referral. If the client requests assistance with a referral, document this in CARE on the corresponding screen⁵. Include the date you referred the client and who is responsible to follow through.
CARE PLAN	
Client is eligible for:	Program selected must match services authorized in ProviderOne. For example, if a client is converted from CFC to CFC+COPES, the correct program must be selected in the Care Plan screen and the correct program authorized in the payment system.
Necessary Supplemental Accommodation (NSA)	Include an NSA Description, if applicable. This is appropriate if the client has a special need (mental, neurological, physical, or sensory impairment – does not include Limited English Proficiency) that prevents them from getting program benefits in the same way that a person without an impairment would get them. Indicate and describe the NSA on the 14-443 sent to the PBS through Barcode.

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

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

	delegating nurse and paid provider after the IP and/or agency provider has completed the Nurse Delegation training. Skills Acquisition Training: • A client may choose to use some of their personal care hours for Skills Acquisition Training (SAT) authorized to an agency provider, IP, or supported living provider. • Document on the ADL or IADL screen who will be providing the SAT and what task the client is wanting training on (e.g. learning to shave with electric razor with non-dominant hand due to stroke on dominant side – this would be listed in the Comments box on the Personal Hygiene screen) Back-up Systems: • Personal Emergency Response System (PERS): select “PERS unit” and/or “PERS installation” from the Walk/Locomotion equipment list. Assign a contracted PERS provider on the <i>Support</i> screen. Following LTC chapter 7b, “Community First Choice (CFC),” document the client’s eligibility for PERS unit in the <i>Safety</i> screen. • Relief Care: document a relief care provider in the Contact Details screen and assign tasks in the Supports Screen if a relief care provider is in place • Caregiver Management Training: document date materials were sent or the web link provided on the CFC screen in CARE. If more than one type of material was issued, choose only one, adding both is not required. • Community Transition Goods or Items: select “Community Transition Goods or items from the Programs list in the <i>Treatments</i> section. Describe the type of goods or items the funding will be for in the corresponding Comments box. Address in the Care Plan, including assigning a provider on the <i>Supports</i> screen when appropriate. • Community Transition Services (CTS): select “Community Transition Services” from the Programs list in the <i>Treatments</i> section. Describe the type of services the CFC CTS funding will be for in the corresponding Comments box. Address in the Care Plan, including assigning a provider on the <i>Supports</i> screen when appropriate. See Chapter 7b for eligibility criteria and more information. • CFC state fiscal year (*SFY) annual limit: CFC SFY annual limit comprises of purchases/payments for both Assistive Technology (AT) and Skills Acquisition Training (SAT). If items/services are to exceed this limit, an ETR request to the CFC Program Manager is necessary. See Chapter 7b for more information. *SFY is July 1 to June 30. – Assistive Technology (AT): Includes add-on services to the basic/standard PERS (e.g. fall detection, GPS, Medication
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	Reminder/Dispenser) and other adaptive/assistive items/devices that will increase an individual's independence or substitute for human assistance with an ADL, IADL or health-related task. Document in the relevant screen in CARE and select "Assistive Technology" from the corresponding equipment table. Please consult the CFC Covered AT Items list to confirm that desired item is approved. See Chapter 7b for more information. – Skills Acquisition Training (SAT): may be purchased using CFC SFY annual Limit. See Chapter 7b for more information. – Budget Calculator in CARE: use to identify, track, and calculate the use of a client's CFC SFY Annual Limit. This is especially useful and helpful to quickly look at what the client has already used and if the case is transferred to another case worker.
COPES Waiver Services	Waiver services must be included in the client's plan of care (Assessment Details or Service Summary) prior to authorization. In addition, the assessment must support the client's eligibility for each service. • Environmental Modification: select environmental modification in the <i>Environment</i> section on the Safety screen and describe the project in the comment box. Assign a contracted Environmental Modification provider on the <i>Supports</i> screen. • Skilled Nursing: select "Skilled Nursing/Waiver" from the Treatments list in the <i>Treatments</i> section of the <i>Medical</i> screen. Describe the type of skilled care in the Comments box. Assign a provider on the <i>Supports</i> screen. • Client Training: select "Client Support Training/Waiver" from the Rehab/Restorative Training list in the <i>Treatment</i> section of the <i>Medical</i> screen. Describe the type of training in the Comments box. Assign a provider on the <i>Supports</i> screen. • Adult Day Health (ADH): select "Adult Day Health" from the program list in the <i>Treatments</i> section of the <i>Medical</i> screen. Assign a provider on the <i>Supports</i> Screen. (Status adjustments must be coded in the relevant CARE screens for the assistance with ADLs and IADLs provided by ADH staff while at the ADH) • Adult Day Care (ADC): select "Adult Day Care" from the Programs list in the <i>Treatments</i> section of the <i>Medical</i> screen. Assign a provider on the <i>Supports</i> screen. (Status adjustments must be coded in the relevant CARE screens for the assistance with ADLs and IADLs provided by ADC staff while at the Adult Day Care center)

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

Case File Standards

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

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

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

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

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

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

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

Original Signatures and Electronic Transmission

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

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

Organization of Electronic Case Record

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

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

Training and additional information about HIU and ECR is available at the [Home and Community Living Administration Training Page](#).

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

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

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

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

- A** Articulate trainings are available to social work, technical and supervisory staff and available at the [Home and Community Living Administration training site](#).

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

Q Can I complete assignments for workers in other offices?

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

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

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

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

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

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

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

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

- A** When sending documents to the HIU, staff must send the English and translated versions together except for the CARE documents listed below. These documents do not have to be sent in English and may be sent in the translated version only:
- Assessment details
 - Care Results
 - Planned Action Notices
 - Personal Care Results (PCR) or Personal Care Results Comparison (PCRC) – In-home and Residential

- Service Summary generated by a new CARE assessment

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

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

For Braille Transcription:

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

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

- A For HCS staff:** Templates to place the envelope orders have been transferred to your sites. Staff should be able to order these through the normal process. HCS sites will reorder any "Completed" stamps needed for staff.
- **For AAA Staff:** We are not able to transfer templates to your areas for reorder. Sites needing more envelopes or "Completed" stamps* must send an e-mail to Melanie McGuire, melanie.mcguire@dshs.wa.gov. The subject line of your E-mail should read: ATTN: HIU Supplies/Barcode Site # (#= your Barcode site number). Melanie will be placing orders on the first of each month.
 - Please continue ordering "Completed" stamps through your sites supply channels if they are available. Remember stamps must be in black ink.



Forms and Brochures

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



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



Assessment Location Grid

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

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



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



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



LTSS Exception to Rule Types and Approval Authority

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

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



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



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



ATTACHMENTS

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

[Guide to Electronic Signatures via CARE Assess](#)

[Voice Signature Technical Training PPT](#)

[Voice Signature Script](#)

1. [Translated Voice Signature Script](#), for staff use

[Chart of Scenarios for Service Summary Signatures](#)

[Exception to Rule Frequently Asked Questions for Providers](#)

[Exception to Rule Frequently Asked Questions for Hospitals](#)

[Care Planning Advocate Flow Chart](#)

[How to Identify a Guardian Conservator Nominee](#)

[Power of Attorney vs. Uniform Guardianship](#)

[Document Review Checklist for Alternative Decision Maker Authority Form](#)



Social Service Intake

Chapter 4 describes the function and processes of Social Service Intake. Intake is the point of entry for all applicants seeking a functional eligibility assessment for Apple Health Long Term Services and Supports through Home and Community Services.

Ask the Expert

If you have questions or need clarification on the processes outlined in this chapter, please first contact your local Intake Supervisor. You may also contact:

Natalie Lehl **Care Management Program Manager, HCLA HQ**
Natalie.Lehl@dshs.wa.gov

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WHAT IS THE PURPOSE OF INTAKE?

- Act as a point of entry for information, referral, and requests for service.
- Dedicated to helping people make decisions about the services and supports that are best suited for the individual's particular needs based on self-referrals and referrals from other professionals such as primary care providers, hospitals, Long-Term Services and Supports (LTSS) providers, families, or friends.
- Gather brief information needed to refer to the most appropriate program and service(s) based upon the needs of the individual and the availability and requirements of all the services, including Medicaid Transformation Project (MTP) programs, Medicaid Alternative Care (MAC) or Tailored Supports for Older Adults (TSOA), that focus on supporting unpaid family caregivers. For more detailed information about the intake process for programs in the Medicaid Transformation Project programs, MAC and TSOA, see [Chapter 30b](#) of the LTC Manual.
- Provide information about Medicaid and service requirements.
- Provide education and inform applicants of eligibility requirements to access services
- Have a process that is consistent and understood by the public and agencies that refer individuals to our services.
- Take necessary action prior to Case Manager assignment and functional assessment.

WHAT DOES SOCIAL SERVICE INTAKE DO?

Social Service Intake workers provide professional level assistance to applicants by doing the following:

- Educate the applicant about LTSS, including functional and basic financial eligibility requirements.
- Inform the applicant or representative about all the LTSS offered by HCLA and the settings for which they are offered.
- Inform the applicant of the possibility of a cost of care for services and that Estate Recovery laws may apply.
- Refer applicants to alternative community resources if HCLA LTSS are not needed or are declined, including other state or federally funded programs offered through the aging and disability network including Older American's Act and Family Caregiver Support

Program
(FCSP).

For more detailed information about the intake process for programs in the Medicaid Transformation Project programs, MAC and TSOA, see [Chapter 30b](#) of the LTC Manual.



- Document relevant safety issues that an assessor should be aware of prior to making a home visit.
- Determine whether the applicant may need assistance in completing an application.
- Assign the case for a functional eligibility CARE (Comprehensive Assessment Reporting & Evaluation) assessment to be completed if the applicant is interested in receiving care in a Nursing Facility or services in another Home and Community Based setting.
- Assign the case for a Presumptive Eligibility (PE) screening if the applicant is choosing Medicaid Transformation Project (MTP) programs such as Medicaid Alternative Care (MAC) or Tailored Supports for Older Adults (TSOA), or Long-Term Services and Supports Presumptive Eligibility (LTSS PE).

WHAT IS THE DIFFERENCE BETWEEN A REQUEST FOR SERVICES AND A REFERRAL?

A **request for services** is any request that comes to Home and Community Services (HCS) regardless of source or eligibility. A request for service may not generate a referral.

A **referral** is any request for service that is accompanied by a Medicaid application or for a client with current Medicaid eligibility. A referral generates an intake. HCS is expected to assist individuals who may need assistance in completing an application.

WHAT IS THE DIFFERENCE BETWEEN AN APPLICANT, REFERENT, AND A REPRESENTATIVE?

An **applicant** is the individual seeking long-term services and support.

A **representative** is a person who the applicant has chosen or has been appointed by a court whose primary duty is to act on the applicant's behalf to make decisions about long-term services and supports. An applicant may also choose a representative who is not a DPOA or guardian (i.e., a parent, family member, advocate, or other person authorized by the applicant) to serve as a representative in connection with the provision of services and supports. Decisions made by informal decision makers (not legally appointed with verifying documents confirming the legal relationship) must be confirmed with the applicant. A representative that is not legally

The intake and referral form (DSHS 10-570) and instructions can be found on the [Electronic DSHS Forms](#) website.



appointed, must be redesignated and documented in a SER note at each Initial, Annual, and Significant Change Assessment. See [Chapter 3](#), Assessment and Care Planning, for more information.

A **referent** is the person who referred the applicant for long-term services and supports (i.e., homeless shelter staff, hospital discharge planner/social worker, facility staff, external agency partner, etc.). A referent can be contacted initially to facilitate setting up an appointment for an assessment, but a completed Consent Form ([DSHS #14-012](#)) would be needed for continued communication.

WHEN IS AN APPLICATION NEEDED?

An application is needed if the individual is not active on Medicaid.

HOW DOES THE INDIVIDUAL APPLY?

For Home and Community Services, the individual needs to apply using one of the following:

- [Washington Connection](#) online application site
- [Washington Health Benefit Exchange](#) (for [Community First Choice](#) and [Medicaid Personal Care](#) only)
- Submitting a completed HCA 18-005 form (classic Medicaid programs) or HCA 18-008 form ([Medicaid Transformation Project, TSOA program](#)).

FOR APPLICANTS CURRENTLY IN AN ACUTE CARE HOSPITAL

Applicants in acute care hospitals may apply using one of the following:

Paper Applications: Hospital staff or applicant will submit an HCA 18-005 with the [Expedited Acute Care Hospital](#) coversheet using the dedicated fax line of 1-888-220-4575. The fax line is the only way to ensure expedited timeframes for case assignments.

Washington Connection: Application completed online at [Washington Connection](#). When completing the application, the client/hospital representative should indicate the name of the hospital on the address line, and state that the client currently resides in a hospital in the additional comments section of the application.

WHEN IS AN APPLICATION FOR SERVICES NOT NECESSARY TO COMPLETE AN INTAKE REFERRAL?

There are times when an individual may not need an application to generate a referral and assignment to an assessor. These exceptions include, but are not limited to:

Adult Protective Services (APS) referrals related to abuse, neglect, or financial exploitation referrals must be reported using the APS intake phone line or [online reporting](#) site. Refer to [APS Policy & Procedure](#) for more information on the APS intake process.

- Individuals on Hospice
- Imminent risk of hospitalization or nursing facility admission
- Individuals currently residing in an Acute Care hospital
- When the individual requests assistance completing the application, regardless of the setting type
- Other circumstances on a case-by-case basis as reviewed and approved by a supervisor
- Individuals residing in a Nursing Facility that are active on an Apple Health benefit.
- In these instances, assign from [Form 10-570: Intake and Referral \(Home and Community Services\)](#)

HOW DO I PROCESS AN INTAKE REFERRAL?

HCS workers will process referrals in date of order received, unless they are notified by any source about situations that warrant prioritization.

HCS workers will do the following in the identified computer programs and by phone:

- 1) Barcode/ACES Online:** Review the application and the applicant's Electronic Case Record (ECR) to obtain the following information:
 - a. Determine whether there is a communication (DSHS 07-104) from the Public Benefits Specialist that provides an estimated cost of care or other important financial eligibility information. Functional and financial eligibility are conducted concurrently and therefore details such as cost of care may not have been determined and that should not cause a delay in processing a referral.
 - b. Identify whether the applicant needs an interpreter
 - c. Identify whether the applicant has an informal decision maker, authorized representative (AREP), attorney-in-fact, or court appointed agent
 - d. Identify the applicant's current location/setting
- 2) CARE:** See CARE Web Help File/Assessor's Manual for detailed instructions for these steps.
 - a. Search CARE for an existing client record:



- If the case is active, review the Service Episode Records (SERs) to see whether any action is needed, and create an Information and Referral (I&R) record as needed. 
 - If the case is active and already assigned to a worker, an I&R record is not needed. Instead, notify the worker of referral and determine if the case needs to be reassigned to another unit.
 - If the case is not active, then reactivate the case in CARE.
 - If no record exists, create a client record and the intake in CARE. 
- b. Once determined active in CARE, enter a SER to document the date the referral was received by the intake unit.
- Use Purpose Code “Intake Referral Received” and enter the contact date that the intake unit first became aware of the referral by any method (e.g., phone, fax, DMS, etc.).
 - ✓ Use this SER purpose code **ONLY** to document the receipt of a referral. Other information may be included in this SER if it is relevant to the referral.
 - Use Purpose Code “Intake/Eligibility (HCS)” for all other intake related SER documentation (or other relevant SER codes). It is important to use this SER purpose code, using the criteria outlined here because the contact date associated to this SER will be used as a data point for reporting on intake and assessment timeliness.
- c. Search to see if client record exists in ProviderOne. If yes, link to the ProviderOne record. If no, a record must be created completing the following steps:
- Complete the Residence Screen. Ensure the correct address is entered for “Residence, Mailing, and Temporary” addresses when applicable:
 - ✓ CARE Web: Client Details > Contact Details
 - Complete all client demographics. If there is a current ACES record use the current information from ACES:
 - ✓ CARE Web: Client Details > Demographics
 - Complete the Client Contact information:
 - ✓ CARE Web: Client Details > Contact Details
 - Complete all known Collateral Contacts relevant to the applicant’s upcoming assessment:
 - ✓ CARE Web: Client Details > Contact Details
- d. Go to the ProviderOne Screen in CARE Web and link the client between CARE and ProviderOne following the steps in the CARE Web Assessor's Manual > Demographics > **ProviderOne** section.



IMPORTANT: It is very important to ensure linking of the correct records. Double check name spelling, Date of Birth and Social Security Number, especially when no match is found **BEFORE** creating a new record. If a new record is created when one already existed, it will cause payment problems.

If the individual is already residing on a private pay basis in a licensed facility that accepts Medicaid and needs to convert to Medicaid for ongoing payment purposes, skip to #4

3) Phone: Call the applicant and/or representative and discuss the following:

- Reason the individual is requesting services
- Identify the type of service(s) being requested
- Diagnoses and/or current challenges
- Activities of Daily Living/Instrumental Activities of Daily Living needs
- Is there anybody who is currently helping them with:
 - ADLs/IADLs
 - Finances
 - Getting to appointments
- Where does the individual want to receive services (In-home or residential)?
 - If in home, do they have an identified choice of provider (agency provider or Individual Provider)?
 - If residential, have they started searching for a facility type (Adult Family Home or Assisted Living Facility or specific facility)?
- The possibility of client responsibility and Estate Recovery
- If the referral came from anyone other than the applicant, ensure the referent is aware that participation in HCS services is voluntary for the applicant.
- The CARE assessment process takes about 2 ½ -3 hrs., is in-person and if conducted in a location other than where services will be provided, a home visit will be required. (Not pertinent to MAC/TSOA programs)
- Safety issues or concerns:
 - Document relevant information that an assessor should be aware of prior to making a home visit such as whether there are locked gates, unmarked roads, physical/environments hazards (i.e. extreme weather conditions or broken steps on stairways) that staff may encounter at the address, or lack of adequate cellular service.
 - Ask the client if they or others in the home have any concerns with their assigned Primary Case Manager completing a home visit to conduct their assessment. This includes but isn't limited to asking about the following:
 - ✓ Are there perfume or animal allergens to consider that the client, household member, or staff member must refrain from?
 - ✓ Are there animals in the home that must be restrained prior to the home visit?



- ✓ Have there been any recent illness exposures amongst household members?
- ✓ Are there any environmental concerns such as mold or bed bug/cockroach infestations?
- ✓ Do any household members own have weapons, and are these secured?
- ✓ Is there any illegal drug use or paraphernalia within the home?
- If LTSS are requested, assign a Primary Case Manager (PCM) in CARE by adding in the Overview screen. Add the PCM's supervisor as well. (**Note:** skip this step for MAC and TSOA applicants.). Send the applicant the booklet entitled Washington Apple Health and Long Term Services and Supports ([DSHS 22-916\(X\)](#)).
- Based on the applicant's preferred setting for LTSS, complete the following:
 - If in-home: Determine if the applicant would like to choose an Individual Provider (IP) or a home care agency provider. If they identify a person they know, who would like to become an IP [employed by the Consumer Directed Employer \(CDE\)](#), obtain the name and phone number of the individual. For more information on referring client and IPs to CDWA, refer to [Long Term Care Manual Chapter 11](#).
 - If Residential: Send the applicant the booklet entitled, [Choosing an AFH or Assisted Living Facility](#)

4) CARE HCS Intake Dashboard: In CARE, input the applicant into the HCS Intake. The following minimum data elements are required:

Name	Referral Type
ACES ID	ZIP
Received Via	LEP – Yes/No; if Yes, list language

MAKING CONTACT WITH AN INDIVIDUAL

- 1) HCS Intake staff will make an attempt to reach the applicant or representative using all telephone numbers available to them.
- 2) If the applicant cannot be reached and the Intake staff does not receive a call back within 5 calendar days, the Intake staff will send a letter documenting the attempts to reach the applicant and give 10 calendar days to contact the Intake staff or the case will be closed. [See 10 day Letter](#)
- 3) Send a copy of the letter to DMS.
- 4) If the applicant or representative does not respond to the ¹10-day letter:

¹ Following a no response action to the 10-day letter, for applicants who (are active or pending an appropriate financial program) make contact or leaves a voicemail on the intake phone line after 10 calendar days, intake should consider a 30-day grace period to re-activate a case and process the intake interview or make one more call attempt to the applicant. If there is no answer then, there is no need to restart the intake process by making a second phone call and sending another 10-day letter.

- a. Inactivate client record in CARE
 - b. Update the intake database to 'Information and Referral'
 - c. Send a 14-443 to financial documenting outcome
- 5) Document all activities in the SER in CARE

WHAT IF THE REFERRAL IS FROM A NURSING FACILITY?

A nursing facility must submit a [Nursing Facility Notice of Action \(NOA\) \(15-031\)](#) for all Medicaid clients in the facility (for financial). The facility must also submit an Intake and Referral form so that a Social Service Specialist (SSS)/Nursing Facility Case Manager (NFCM) is assigned to the case.

1. Once a referral is received from a Nursing Facility, the Intake staff will review Barcode to determine financial status within 2 business days, check eligibility in ACES, and determine if the individual is in CARE. If an application is submitted or the individual is Medicaid eligible, assign to appropriate NFCM for functional assessment and refer to [Chapter 10](#) of the LTC Manual for clarification.
 - 1) If the client record is active in CARE and assigned to the AAA or HCS case worker, determine if:
 - there is a current assessment
 - how long the client has been out of their residence (more or less than 30 days)
 - the client is choosing to return to their prior living situation or to change their living situation upon discharge
 - 2) Submit a 14-443 to Public Benefits Specialist to notify them of the client's hospitalization
 - 3) The holding agency (AAA or HCS) will transfer the case to NFCM as appropriate
 - 4) Document all activities in a SER in CARE
 - 5) If the client record is active in CARE and assigned to a Developmental Disabilities Community Services Case Resource Manager or DDA PASRR RU, assign to appropriate NFCM for NFLOC assessment in CARE and document all activities in a SER in CARE. Refer to [Chapter 10](#) of the LTC Manual for clarification.

WHAT IF THE REFERRAL IS FROM A HOSPITAL?

- 1) By the next business day after receipt of any hospital referral, Intake staff will review Barcode to determine what documents have been received and financial status.
- 2) Check eligibility in ACES and determine if individual is in CARE.
- 3) Contact the referring discharge planner at the hospital to determine the following, if the information was not already provided:
 - Is the individual still at the hospital?
 - If so, what is the anticipated date of discharge?



- If unable to confirm discharge date and application was submitted (if needed) assign to SSS within 24 hours.
- If not Medicaid eligible, has an application been submitted? If so, what was the date submitted?
- If the client record does not already exist in CARE, create the record using instructions from the CARE section above and assign to appropriate HCS SSS
- If the client record is active in CARE and assigned to the AAA or HCS case worker, determine if:
 - there is a current assessment
 - the client has been out of their residence for less than 30 days
 - the client is choosing to return to their prior living situation
 - the client is choosing to change living situations (e.g., it is unsafe for them to return to an in-home setting, and they request residential services)
- 4) Submit a 14-443 to the Public Benefits Specialist to notify them of the client's hospitalization
- 5) The Holding agency will transfer the case as appropriate
- 6) Document all activities in the SER in CARE

For further information regarding Hospital assessments, refer to [Long Term Care Chapter 9/Hospital Assessment](#)

WHAT IF AN APPLICANT WITHDRAWS THEIR REQUEST FOR SERVICES DURING THE INTAKE PROCESS?

It is not uncommon for an individual to withdraw a request for services prior to completing an intake. When an individual withdraws an application for services, attempt to connect the individual with other local resources that may be able to meet their needs and do the following in CARE:

- Enter a SER noting the reason for withdrawing
- Save the record as an Information and Referral (I&R) via the HCS Intake Dashboard.
- Inactivate the client record
- Send a 14-443 to notify the Public Benefits Specialist of the individual withdrawing (only when an individual has applied for or is active on Medicaid with HCS).
 - For Skilled Nursing Facility (SNF) residents: If a client is active on a Medicaid Medical program, Nursing Facility Case Managers (NFCMs) still have an obligation and responsibility to determine Nursing Facility Level of Care (NFLOC) and confirm ongoing functional eligibility for the Nursing Facility services by statute. Though a client may withdraw a request for community LTSS, it is unlikely that they would close out their established medical benefit which is paying for their SNF care.



WHAT IF AN INDIVIDUAL REAPPLIES FOR SERVICES?

If a request for services is received from an applicant who was assessed and found to be functionally ineligible in the past 30 days, the following steps should occur before reactivating the applicant's CARE record and creating a new referral:

- 1) Call the applicant to review their current situation and request for services.
- 2) Review the functional eligibility process with the applicant.
- 3) Since the last assessment was completed, ask if there has been:
 - a change in the individual's condition, situation, or supports
 - any recent hospitalizations
 - any new diagnoses or medical conditions, or
 - any other relevant changes
- 4) If there has been a change in condition since last assessment, process a new intake.
- 5) If there has not been a change in condition, and after reviewing the eligibility process, the applicant requests to withdraw the service request, document this conversation in the SER. Do not reactivate the case in CARE
- 6) If the individual chooses not to withdraw the request, the Intake staff will route the request to the supervisor of the last assessor.

The supervisor will:

- 1) Review the information identified in #1 of this section
- 2) Contact the individual
- 3) Review the previous assessment and determine the most appropriate course of action

If the supervisor determines a new assessment will be completed, the Supervisor will:

- 1) Determine who the assigned Social Service Specialist will be.
- 2) Route the request back to Intake for creation of a new referral.
- 3) Document all activities in the SER.

If the supervisor determines a new assessment will not be completed, the supervisor will:

- 1) Review administrative hearing rights with the individual, relative to the last assessment.
- 2) Document all activities in the SER.

WHAT IF THE REFERRAL IS FOR AN INDIVIDUAL WHO RESIDES OUT OF STATE?

An individual cannot be approved for and/or made active on Washington State Medicaid until they are a resident of the State of Washington, but Medicaid financial eligibility determinations can be initiated while the person resides in another state. The individual or authorized representative AREP can be provided with an Application for Benefits and list of necessary verifications while out of state. Applications should be submitted before arrival in Washington State, but not more than 45 days before the individual becomes a resident.



Social services cannot determine whether an individual is functionally eligible for Medicaid under Washington State guidelines unless the individual is a Washington state resident. Social Service Specialists or nurses do not go out-of-state to conduct CARE assessments (²unless there is a Memorandum of Understanding (MOU) with a border state hospital).

If someone is moving to Washington and knows where they will be residing, an assessment can be scheduled prior to or upon their arrival but will occur once the individual is residing in Washington. Coordination with the individual and scheduling of the assessment are critical to ensure services start as soon as possible after arrival in WA.

WHAT APPLICANTS AND THEIR REPRESENTATIVES NEED TO KNOW

- LTSS cannot be approved retro-actively for in-home services or in facilities other than a Nursing Facility.
- DSHS cannot pay for services while a functional eligibility determination is being processed. An exemption to this is the Presumptive Eligibility (PE) process allowing for services to be provided during the PE period (usually less than 60 days) while the final functional and financial determination is being completed. See [Chapter 30b/Initiative 2: LTSS - Medicaid Alternative Care \(MAC\) & Tailored Supports for Older Adults \(TSOA\)](#), and [Chapter 30e/Long-Term Services and Supports Presumptive Eligibility \(LTSS PE\)](#), for more information on PE.
- It is typically not possible to assess an individual the same day or week they arrive in Washington. This means an individual will need to consider other options, such as:
 - Residing with friends or family until financial and functional eligibility has been determined. If eligible, the client will need to choose in-home or residential services then select a qualified provider; or
 - Moving into their desired service setting *on a private pay basis* until functional and financial eligibility can be determined. Medicaid will not begin to pay for services until both functional and financial eligibility have been established (unless the client has been approved for fast track).
- The intake process can feel complicated. Individuals applying for services or their family members may feel anxious and overwhelmed about how to navigate the system. If a call is received or an individual is greeted at the front desk wanting to understand how to go through this process and Intake staff feels a lack of confidence explaining this, please refer the matter to someone who is knowledgeable (e.g. a Social Service Supervisor or Public Benefits Specialist Supervisor).

² Some offices may have an MOU with a border state hospital (Oregon or Idaho) which is acceptable if the individual is active on WA Apple Health. This arrangement is not allowed for Canada residents.



WHAT IF A REFERRAL IS FROM AN INDIVIDUAL WHO IS IN JAIL OR PRISON?

Individuals in a jail or prison in Washington are considered residents of the State of Washington. Referrals for individuals in jails will follow the regular intake process. Medicaid financial eligibility determinations can be initiated while an individual is in either a jail or prison facility. The individual, representative, or staff at the jail/prison can be provided with an application for benefits or directed to the online application. Applications should be submitted as soon as a potential release date is known.

The intake worker should inform the referent and/or individual that the referral should occur when the release date is expected to be less than 30 days. This is because the assessor will need to complete the assessment (move to Current and authorize services) within 45 days after the date of intake, and if the client will not return home within 30 calendar days of incarceration, the case worker will proceed with termination planning.

HOW ARE DEVELOPMENTAL DISABILITIES ADMINISTRATION CASES DIFFERENT?

HCS serves clients aged 18 and older. DDA serves clients from birth to end of life. Both HCS and Developmental Disabilities Administration (DDA) administer 1915c waiver programs, Medicaid Personal Care (MPC), and Community First Choice (CFC) services. Below is a table illustrating the 1915c waivers under each administration:

HCS	DDA
COPEs New Freedom Residential Support Waiver	Basic Plus Core Community Protection CIIBS (Children's Intensive In-Home Behavioral Supports) IFS (Individual and Family Services)

Collaboration between DDA and HCS is required to determine which agency will conduct the applicant's CARE assessment and authorize services in the event of possible dual-eligibility, or while initial eligibility or eligibility re-determination^{3**} for DDA eligibility is being conducted.

If HCS receives a referral for services from an adult receiving service through DDA:

³ WAC that outlines DDA program eligibility changed in 2005. Any DDA client who was found to be eligible for their services prior to 2005 must go through eligibility re-determination when they apply for a paid service such as MPC or CFC**



- 1) Consult with a Public Benefits Specialist in the LTC specialty unit to determine the appropriate program. Contact the specialty unit at 1-855-873-0642
- 2) If financially eligible for MPC or CFC:
 - a. Inform the client/representative of the availability of DDA case management to assess, authorize and provide MPC or CFC services.
 - b. Refer the client/representative to the DDA Non-Paid Services Intake line at 1-800-567-5582

See [Chapter 7 Intro. To Medicaid, State Plan, and 1915c Waivers](#) for detailed information.

How do I know a case has DDA involvement?

The Overview screen may look like the following:

A screenshot of a software interface titled "Case workers". It has a tab labeled "Case manager history". Below the title, there are three tabs: "ADSA HQ (007)", "DDA Colville FSO (852)", and "Office Management". Under the "Assigned Offices" section, there is a list with a "+" icon on the left and a "-" icon on the right. The list contains two entries: "ADSA HQ" and "DDA Colville FSO".

The decision whether DDA or HCS will take a case is complex and includes a number of variables. The Intake Supervisor should always be consulted when there is any question about which agency should take action on a case that has existing DDA involvement of any sort.

WHAT IS CLIENT RESPONSIBILITY?

This section is informational. Intake is only responsible for providing basic information on estate recovery and cost of care.

Client responsibility is determined by a Public Benefits Specialist. It is composed of three parts:

1. **Room and board (R&B)** is a portion of the total payment paid by the client to the residential provider for expenses related to food, shelter, heat, utilities, etc. All residential clients with income greater than the current Personal Needs Allowance (PNA) amount must pay towards the cost of Room & Board. Any R&B costs not covered by the client's income are paid for using state-only funds. Clients must pay R&B before the department pays the provider.
2. **Participation** is a portion of the client responsibility paid by the client to the provider to cover part or all their cost of care. Unlike R&B, participation begins the first day the client receives services.
3. **Third-party resource (TPR)** a portion of client responsibility that may include some types of Veterans Affairs benefits, L&I income, Trusts and Long-Term Care insurance. TPR may



also be called Third Party Liability (TPL). Third-party resource amounts may be listed on the ACES award letter and included in the line, "Total amount you must pay."

Clients who do not have to pay client responsibility:

- A client who receives supplemental security income (SSI).
- Clients who just receive CFC and not a home and community-based waiver service.
- Clients enrolled in the MAC and TSOA programs.
- Clients who are otherwise eligible for Medicaid in the community – for example clients who receive SSI-related medical coverage but do not get an SSI payment. Most of these clients receive a type of Social Security disability or retirement benefit.
- Clients who receive MAGI-based coverage (N-track).

Which clients will have to pay client responsibility?

- Clients who are eligible for CFC but need to access a waiver service to be Medicaid eligible:
 - Clients under 65, not eligible for Medicare with income over 133% FPL who do not qualify for coverage through the Healthplanfinder. Before waiver services can be approved for a MAGI client, a disability determination must be made which may take 60-90 days.
 - Clients 65 or older or those under 65 who have Medicare who have income over the SSI benefit rate who do not qualify for regular Medicaid. These clients must access a waiver service to be eligible.
- All clients who live in a residential setting will be required to pay for their room and board. A MAGI client's room and board amount will be calculated by the assigned SSS. Instructions for this are in the Social Services Authorization Manual (SSAM).
- All clients who receive CFC **and** a waiver service will potentially be required to pay participation toward the cost of all the services provided, including personal care through CFC.

How much participation will clients pay?

It depends on many variables including where they live, whether they have a spouse or not, whether they have dependents, and whether they have any unpaid medical expenses or allowable deductions. Applicants should be referred to their Public Benefits Specialist to understand what their cost of care will be if they are on any form of "Classic Medicaid."

Explain that participation is like a co-pay. The client's portion is paid first to the provider, and then DSHS pays the remainder of the client's cost of care to their in-home or residential provider. If a client has no income, they are not required to contribute to their cost of care.



There is no cost to the applicant to have a CARE assessment to determine functional eligibility for services. Also, there is no cost to have a Public Benefits Specialist fully evaluate their case to determine if they will have participation and what the amount would be. Participation will only apply once services are authorized and received.

In-Home: Most clients who are single keep up to 100% federal poverty level as a Personal Needs Allowance (PNA) and pay income over that toward their cost of care. Married clients have a lower PNA but are allowed an allocation to their spouse which reduces their income. Many married clients do not end up paying participation because the allocation to the spouse can be quite high.

Residential: Generally, with most income sources the client retains a portion of their monthly income. This is called a Personal Needs Allowance (PNA). The remainder of their income is paid as room and board and participation. In turn, all their personal care, meals, utilities, and toiletries will be provided by the facility.

WHAT IS ESTATE RECOVERY?

State law requires staff to fully disclose in advance, both verbally and in writing, the terms and conditions of estate recovery to all persons offered LTSS that are subject to recovery of payments. **All HCLA services except services offered through MAC and TSOA and APS are subject to estate recovery.**

The estate recovery program recovers the cost of Medicaid LTSS and related hospital and prescription drug services from a deceased client's estate. The estate recovery laws have changed several times since the program was enacted. The department recovers from estates according to the law in effect at the time the services were received.

More about Estate Recovery:

- DSHS recovers from the estate of a deceased client. "Estate" includes all real property (land or buildings) and all other property (mobile homes, vehicles, savings, other assets) the client owned or had an interest in when the client died.
- A home transferred to a spouse or to a minor, blind or disabled child prior to the client's death, is not considered part of the client's estate. This is a legal transfer under Medicaid rules and does not affect the client's eligibility.
- Some assets are exempt from estate recovery, and this includes most American Indian/Alaskan Native assets.
- DSHS will delay recovery under certain circumstances. Including when there is a surviving spouse who lives in the home or minor, blind or disabled children who still live in the home.

Required Publications

To meet disclosure requirements and to promote understanding by the applicant, DSHS must provide the documents linked below to all prospective and new clients and verbally explain both the estate recovery program and the community service options available.

These documents will be provided to the client/representative at the time of their assessment. If an applicant is hesitant to move forward with an assessment before learning more about estate recovery, the Social Service Specialist (SSS) should mail the documents to the applicant and document this activity in the Service Episode Record (SER). The SSS should ask the individual if they would like to have Home and Community Services continue with their application while they review the information.

- Columbia Legal Services Article: [Estate Recovery for Medical Services Paid for by the State](#);
- Northwest Justice Article: [Native Americans and Alaska Native Property Owners: Exemptions from Estate Recovery](#)
- HCS publication: [Medicaid and Options for Long-Term Care Services for Adults \(DSHS 22-619x\)](#)

RESOURCES

[LTSS Definitions WAC](#)

[Apple Health Medicaid Manual](#)

[Chapter 7 a-h: Medicaid, State Plan, and 1915c Waivers and more](#)

[Chapter 30b Initiative 2: LTSS - Medicaid Alternative Care & Tailored Supports for Older Adults](#)

[Chapter 9: Inpatient Hospital Assessments](#) and Transitions

[Chapter 10: Nursing Facility Case Management and Relocation](#)

[Chapter 11: Consumer Directed Employer](#)

Acronyms

A complete list of Washington State Department of Social and Health Services acronyms can be found [here](#).

AAA	Area Agency on Aging	IP	Individual Provider
ACES	Automated Client Eligibility System	LTSS	Long-Term Services and Supports
AREP	Authorized Representative	MAC	Medicaid Alternative Care
APS	Adult Protective Services	MPC	Medicaid Personal Care
CARE	Comprehensive Assessment Reporting & Evaluation	MTP	Medicaid Transformation Project
CDE	Consumer Directed Employer	NFCM	Nursing Facility Case Manager
CDWA	Consumer Direct Care Network Washington	PE	Presumptive Eligibility
CFC	Community First Choice	PNA	Personal Needs Allowance
DDA	Developmental Disabilities Administration	SER	Service Episode Record
DMS	Document Management System	SNF	Skilled Nursing Facility
DSHS	Department of Social and Health Services	SSI	Supplemental Security Income



ECR	Electronic Case Record	SSS	Social Service Specialist
FCSP	Family Caregiver Support Program	TPL	Third Part Liability
HCS	Home and Community Services	TPR	Third Party Resource
I&R	Information and Referral	TSOA	Tailored Supports for Older Adults

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
8/18/2020	Rachelle Ames	Overall changes to word choice and grammar to improve readability	
		Added more specific instructions or steps in multiple sections of the chapter to improve clarity of policy/procedure	
		Added policy related to documenting Intake activities in the SER	H18-049
		Added policy/procedure for referrals that come from jails or prisons	
		Upgrade to new format	
5/2023	Dru Aubert	Updated procedure to remove action steps related to CARE Desktop. If not already, CARE Desktop screens referenced in this chapter will be made read-only after 06/30/2023 CARE change/MB release.	
8/2023	Dru Aubert	Updated links. Removed former APS LTC Chapter reference; replaced with APS P&P policy location. Updated CARE Desktop reference(s) to CARE Web.	
4/2024	Dru Aubert	- Replaced naming conventions from Intake Database to CARE HCS Intake Dashboard. - Added clarification for an existing client under section, HOW DO I PROCESS AN INTAKE REFERRAL? - Added prioritization and clarified NFCM steps when case is active and assigned to DDA/DDA PASRR RU, under section, WHAT IF THE REFERRAL IS FROM A NURSING FACILITY? - Added section, WHAT IS THE DIFFERENCE BETWEEN AN APPLICANT, REFERENT, AND A REPRESENTATIVE?	
10/2024	Dru Aubert	- Added to section, HOW DO I PROCESS AN INTAKE REFERRAL?, for in-home settings, to instruct documentation of relevant information that an assessor should be aware of prior to making a home visit. - Added to section, MAKING CONTACT WITH AN INDIVIDUAL, to implement a 30-day grace period, following a no response action to the 10-day letter, for applicants who (are active or pending an appropriate financial program) make contact or leaves a voicemail on the intake phone line after 10 calendar days.	



4/2025	Anna Mitchell	Added clarification about informal decision makers, authorized representatives, attorneys-in-fact and court appointed agents	
7/2025	Dru Aubert	Updated Developmental Disabilities Administration (DDA) to Development Disabilities Community Services (DDCS) naming.	
07/2025	Natalie Lehl	- Updated Chapter owner - Made overall changes to formatting and word choice	
04/2026	Natalie Lehl	- Updated link and chapter title to Chapter 9 - Update to contact timeframes	
07/2026	Natalie Lehl	- Added clarification to NFCM intake process - Added Acute Care Hospital fax number and cover sheet for expedited support - Added additional policy for clients in jail or prison - Replaced case manager with case worker	

Case Management

Chapter 5 explains the philosophy of case management, Home and Community Services (HCS) and Area Agency on Aging (AAA) case management responsibilities, and the case management tasks required for in-home, residential, nursing facility, and hospital clients.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Natalie Lehl Care Management Program Manager
natalie.lehl@dshs.wa.gov

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BACKGROUND

Goals

The primary goals of case management are to assist the client to develop a plan of care to enable them to reside in the setting of their choice and to monitor that plan. Case workers will support the client's independence by coordinating and offering assistance to access needed services. Case workers are custodians of the state's resources and must balance a client's choice with program limits.

Case workers:

- Educate clients, family members, support systems, and other service providers that a comprehensive plan of care is developed within the choices and resources available and that meeting all needs may not be possible.
- Must not view limited choice as a restraint on creative care planning. As a manager of state resources, staff should utilize naturally occurring resources or access non-traditional means to assist a client in meeting their needs and to develop supports based upon realistic expectations and coordinated problem solving.
- Provide client-centered services, evaluating informal and community supports, with an overarching goal of preventing unnecessary institutionalization.
- Support and maximize client independence and self-direction.

Core and Supportive Functions

Core functions may not be waived by the client and include:

- **Assessment.** Perform a face-to-face assessment with the client in the client's residence to determine service needs and program eligibility at least annually.
- **Planning/Plan Monitoring.** Develop a plan of care with each client, authorize services according to that plan, and authorize the client's choice of qualified provider. Monitor, through periodic in-person visits (scheduled and unscheduled) and telephone contacts, to see if the plan is being appropriately implemented and if the services provided are meeting the client's needs.
- **Mandatory Reporting.** Report abuse, abandonment, neglect, or financial exploitation to Adult Protective Services (APS) per [Chapter 74.34 RCW](#). Mandatory reporters are not required by law to report self-neglect by a vulnerable adult.

Case workers are considered Mandated Reporters of abuse, abandonment, neglect, and financial exploitation of vulnerable adults. A mandatory reporter takes a personal risk and a risk to the agency they work for if they choose not to make a report to APS and there is a negative outcome for the vulnerable adult that was not reported to APS.



See [Adult Protective Services policy and procedure](#) and [Chapter 74.34 RCW](#) for detailed information about mandated reporting, including consequences of failure to report.

- **Report Suicide Ideation.** If the client has a plan, the means to carry it out, and a time planned, do not leave the client alone. You may withdraw to a safe distance if you fear for your own safety (loaded gun, etc.) and call 911. Contact the [Washington State Designated County Crisis Responders](#), explain what the client has told you, and that you are concerned for the client's safety.
- **Termination Planning.** It is good practice to let all clients know that their services are based on their current needs and can change if their needs change. This is especially true if they are ill with a temporary condition (such as, post-surgical, broken bone). When the CARE assessment determines that a client is no longer eligible: make necessary referrals (if needed) to transition to other services, provide adequate notice via a Planned Action Notice (PAN), and close services in the necessary timeframes.

Note: If a client is receiving a Home and Community Services (HCS) housing resource, you must contact the assigned Housing Program Manager (HPM) prior to inactivating the case. Please involve assign HPM in any case staffing's regarding the client. HCS has services to support housing needs. Please include HPMs if housing is a concern. For more information visit [Chapter 6A/HCS Subsidies and GOSH Services](#).

Supportive functions may be waived by the client and include, but are not limited to:

- **Client Advocacy.** Support client self-advocacy. Intervene with agencies or persons to help clients receive appropriate benefits or services. Clients may also request assistance with advocacy from their case worker even when they are able to advocate for themselves.
- **Assistance.** Assist clients to obtain a needed service or accomplish a necessary task that, due to physical or cognitive limitations, they cannot obtain independently.
Assistance can include but is not limited to:
 - Completing a form.
 - Researching a living situation.
 - Assistance with moving arrangements.
 - Arranging transportation.
 - Assisting with Medicaid eligibility review.
 - Other services related to the plan of care.
 - Assistance with locating, hiring, contracting, and terminating providers of their choice.
 - Assistance applying for administrative hearings and access to an administrative hearing coordinator.
- **Referrals.** Making and following up on mandatory referrals as identified in the assessment.

- **Family Support.** Assist the family or others in the client's informal support system to:
 - Make necessary changes in the home environment and/or lifestyle that client has agreed to;
 - Encourage changes in high-risk behaviors or choices that may improve the stability of the plan of care or improve health and psych/social outcomes;
 - Plan a move to or from an in-home setting, residential care, or other setting chosen by the client.
 - Encourage caregiver self-care through support groups, education, and assistance accessing resources.
- **Crisis Intervention.** Assist with short-term crisis intervention in an emergency situation to resolve an immediate problem before a long-term plan is developed or current plan is revised. Crisis intervention may include, but is not limited to:
 - Use of an [Exception to Rule \(ETR\) \(see Chapter 3\)](#).
 - Arranging for a temporary move to an Adult Family Home or a Nursing Facility.
 - Authorization of Client Training or other waiver or Community First Choice services.
 - Calling 911.
- **Access Resources.** Examples of available resources include discharge resources, local community services, assistive technology and benefits under the Medicaid State Plan.
- **Handling Challenging Cases.** Follow the ["Challenging Cases Protocol"](#) when the recommended plan of care, appropriate to the client's health, welfare, or safety, cannot be implemented.

Case Management Responsibility Settings and Criteria

Per [RCW 74.39A.095](#), case management responsibilities for long-term care clients are shared by Home and Community Services and the Area Agency on Aging.

Home and Community Services (HCS) Responsibilities

1. New admitted applicants or clients to a nursing facility (NF) who will likely stay in the NF for more than 30 calendar days: Medicaid applicants, Medicaid clients, and dually eligible for Medicare/Medicaid.
2. Long-term Medicaid residents of nursing facilities and those residents who are converting or likely to convert within 180 days to Medicaid (from Medicare or private pay).
3. Newly admitted to or current Medicaid residents in Adult Family Homes (AFH), Assisted Living Facilities (ALF), Enhanced Adult Residential Care (EARC) facilities, and Adult Residential Care (ARC) facilities.



4. Any adult with prior Adult Protective Services (APS) involvement and in need of ongoing case management and not receiving Core services. See [APS policy and procedure](#) for more information on APS.
5. Initial entry into Home and Community Living Administration funded in-home or residential long-term services and supports.
6. Hospital discharge.
7. Private Duty Nursing clients.

Area Agency on Aging (AAA) Responsibilities

1. All clients, aged 18 and older, receiving home and community-based funded services in their home.
2. In-home Medicaid clients who are temporarily in institutional settings. See the [Case Transfer Guidelines Section](#) of this chapter for additional information.
3. Based on staff resources, adults aged 60 and older, who reside in the community, are not receiving core long-term services and supports, and are assessed as able to remain in a non-residential setting, and meet one or more of the following:
 - a. Require multiple services and/or related activities performed on their behalf;
 - b. Are unable to obtain the required services and/or perform the required activities for themselves;
 - c. Do not have family or friends who are able and willing to provide adequate assistance;
 - d. Meet a-c above and require ongoing case management after an Adult Protective Services (APS) investigation has been completed.
4. If the AAA wants to limit the criteria outlined in 2, it must be approved by the Home and Community Living Administration and included in the contract.

TYPES OF CASE MANAGEMENT

In Home

Home and Community Services (HCS) will:

- Perform an initial assessment.
- Develop the service plan.
- Ensure clients are informed of choices among qualified providers.
- Authorize services.
- Make a telephone monitoring contact with the client if the case is held longer than thirty (30) calendar days. See [‘Transferring a Case’](#) for more details.



- Transfer the case to the Area Agency on Aging (AAA). Refer to the [Case Transfer Guidelines](#) within this chapter.

Once the AAA receives the case from HCS or another AAA:

1. Case worker will make a **face-to-face visit** in the client's home **within thirty (30) calendar days** of assignment to the Primary Case Manager (PCM) in CARE in the following circumstances (case must be assigned to the PCM within five (5) business days per [Case Transfer Guidelines](#)):
 - Client is identified as Targeted Case Management (TCM) by the receiving office or by the transferring office on the CARE Overview screen; or
 - Client has Behavior Point Score (BPS) >6 as documented in CARE; or
 - Client has a documented current pressure ulcer; or
 - The current assessment was performed in a
 - Skilled Nursing Facility, or
 - Hospital, or
 - A different in- home setting than the one they are currently residing in, or
 - Residence screen indicates client has been homeless in the past twelve (12) months; or

Explicit Terminal Prognosis is documented in CARE or End of Life/hospice is indicated on Case Transfer form or treatment screen

Supervisor or case worker has discretion to make a face-to-face visit even if any of the above criteria are not met to require a visit.

2. If a client does not meet the criteria for a 30-day face-to-face visit, the case worker or a case aide must make a **telephone call to the client within thirty (30) calendar days** of initial assignment to the receiving worker and confirm that the client is receiving services as identified in their care plan.
 - The telephone contact must be with the client. A client's representative may be contacted only if the client is unable to communicate. If someone other than the client is contacted, document the reason in a CARE Service Episode Record (SER).
 - If the telephone call results in any concerns that require a face-to-face visit listed in #1 above, the case manager will schedule a face-to-face visit within forty-five (45) days from the date the case was initially assigned to a worker in the receiving agency.

The telephone or face-to-face (30-day) contact includes sharing and gathering the following information:

- Case worker/Registered Nurse (RN)/Case Aide introduction to client and reason for the contact.
- Confirming that the care plan meets the client's identified needs and preferences (such as, personal care, equipment, resource/referrals, follow-up appointments, client's comfort level with the care).



- Determining if there have been any changes in the client's condition, service plan, supports or preferences for case management follow up.
- Advising client/client representative to call the case worker/RN if there are concerns at any time.
- Verifying the client has contact information for the case worker/RN and knows how and when to contact the case worker.
- Document in a CARE Service Episode Record (SER) note to document summary of the discussion/results. In CARE, choose:
 - Contact Code: Telephone Call or Home Visit; **and**
 - Purpose Code: 30 Day Visit.

For lower risk clients, Area Agency on Aging offices wishing to exceed the standard may use the

Note: If the file has been returned to Home and Community Services per the Case Transfer policy, a new 30-day period begins on the date of the latest electronic transfer to the Area Agency on Aging.

30-day call to schedule a face-to-face visit within forty-five (45) days from the date the case was initially assigned to a worker in the receiving agency.

3. One **annual face-to-face assessment** in the client's home must be completed at least every annual cycle. A **Plan Period Tickler** will warn forty (40) days before a Plan Period expires.
 - Significant Change assessments (if they occur) reset the Plan Period annual clock (See [Chapter 3/Assessment & Care Planning](#) for discussion of assessment Plan Period and when a Significant Change assessment should be considered temporary).
4. All clients will receive regular monitoring contacts to **monitor the plan of care**, especially any issues that were not resolved at the time of the last face-to-face visit. Clients who meet any of the Targeted Case Management (TCM) criteria will receive more frequent contacts (see [TCM section](#)).
 - For Non-Targeted clients, **three monitoring contacts** are required annually in addition to the face-to-face assessment. These contacts can be by phone or in person. The 30-day telephone or face-to-face visit may count as one contact in the first year. Monitoring plan contacts made by Home and Community Services will also count in the first year.

Contacts with the client to assist them with critical needs related to health and safety, maintenance of community living status, or the plan of care will count toward the required annual monitoring contacts. Activity that originates around a supportive function can also be used as a monitoring contact if service plan delivery is discussed.

You may contact a client representative or other collateral contact only if the client is unable to communicate. If you contact someone other than the client, document the reason in a CARE Service Episode Record (SER).



Document all contacts you consider as monitoring contacts in a CARE Service Episode Record (SER) using **Purpose Code “Monitor Plan”**. This will enable an automated Tickler to notify the case worker if more than four (4) months have passed since the last Monitor Plan SER entry.

Targeted Case Management (TCM)

A client is eligible for Targeted Case Management if they meet at least one of the following criteria:

- Has a potential for abuse and neglect as identified in the assessment on the safety screen or in a CARE Service Episode Record (SER). This includes all clients who have had an Adult Protective Service (APS) referral or open APS case within the past twelve (12) months.
- Lives in an environment that jeopardizes their personal safety, as identified in the assessment on the Safety screen or in a CARE Service Episode Record (SER).
- Is not always able to supervise their paid provider as identified in the assessment on the Cognitive Performance screen and no one is identified on the Cognitive Performance screen as the person responsible for supervision.
- Has thought about suicide in the last thirty (30) days, as indicated on the Suicide screen.
- Is sometimes or rarely understood, as identified in the assessment on the Cognitive Performance screen.

Additional criteria as determined by the case worker and supervisor to address identified concerns For Targeted Case Management clients, the purpose of these contacts is to monitor issues related to the client’s targeted criteria as well as client condition and service plan delivery. Document each discussion with the client in a CARE Service Episode Record (SER).

Examples of Targeted Case Management include:

- Working with the client to find a payee to manage their finances when there is evidence of financial exploitation.
- Helping the client locate housing in a safe neighborhood.
- Encouraging the client to consult a mental health specialist about their suicidal ideation and depression.

Contact requirements include:

- At least one additional face-to-face visit in the client’s home within one year from the beginning of Targeted Case Management and each year following. If the 30-day in-person visit occurs during the first year, it may count as an additional face-to-face visit.



- Visits may include Area Agency on Aging nursing assessments and /or collateral professional in-home contacts that have conferred with the case worker and agreed to represent the case worker's concerns and needs while on-site. These in-home contacts report back to the case worker after the on-site visit.
- In addition to the face-to-face requirements, at least four (4) monitoring contacts with the client are required annually.
 - You may contact a client representative or other collateral contact only if the client is unable to communicate. If you contact someone other than the client, document the reason in a CARE Service Episode Record (SER).
- Use the Targeted Case Management CARE Service Episode Record (SER) contact code to designate the date TCM began or was terminated. Document the reason(s) the client was:
 - Placed on Targeted Case Management.
 - Terminated from Targeted Case Management.
 - Not placed on Targeted Case Management if they meet targeted criteria (Possible example: Adult Protective Services investigation in last year of an Individual Provider who no longer works for client).
- Use the "Targeted Case Management?" item on the Overview screen to indicate whether the client is currently receiving TCM services.

Guidelines to Support Move from In-Home to Residential Setting

If a client desires to move to a residential facility or nursing facility, follow case management guidelines outlined below. Prior to transferring the case to Home and Community Services, you will need to:

- Inform the client of alternative options to confirm their choice of living arrangement
- Discuss the personal needs allowance (PNA) limits in residential settings and that the client will have a responsibility to pay their provider every month
- Complete the necessary forms and perform another assessment as needed.
- Contact Home and Community Services and review the request for admission, residential setting options, and the most current assessment.
- Verify that the facility has a Medicaid bed available and is contracted to provide for any special needs (such as, dementia).
- Have the client sign an [Acknowledgement of Services form \(DSHS 14-225\)](#), if appropriate.
- Request verbal approval prior to authorization of services in the new setting. Document plan approval in a CARE Service Episode Record (SER) and send documents for signature per [Chapter 3/Assessment & Care Planning](#) policy.
- Review the Assessment Details and Service Summary with the provider prior to the client's transition to the residential setting and document in the file.
- Notify financial using the [DSHS 14-443](#) within Barcode and, if applicable, get updated participation amounts from financial. If the client does not enter on the planned date, the participation may need to be adjusted.

- Close all in-home authorizations and open residential authorizations.
- Notify Home and Community Services (HCS) that the client has moved and transfer the case to HCS if the client is expected to stay more than thirty (30) calendar days in the residential or nursing facility.
- If appropriate, ensure current approved Behavioral Health Wraparound Supports (BHWS) Request for Managed Care Organization (MCO) Funding form ([DSHS 13-712](#)) is in the client's electronic case record (ECR) file. See Chapter 22a of the LTC Manual for more information regarding BHWS (BHWS funding cannot be authorized in a residential setting)

Updating Residential Settings in the CARE Assessment (excluding Nursing Facilities):

Perform either a significant change or interim assessment according to policy.

1. Update the 'Planned living arrangements' dropdown in the Assessment Main screen (When residential is chosen, the Instrumental Activities of Daily Living screens will appropriately be cleared).
2. When the client chooses an Adult Family Home (AFH), the AFH evacuation level must be selected on the Safety screen.
3. Assign treatments to the appropriate Provider Type in the Treatments Screen.
4. Update the Supports Screen assigning appropriate tasks to the residential provider.
5. Change the 'Client chose/planned living situation' setting on the Care Plan screen.

Further information can be found in the [Providing Residential Care Case Management](#) and [Nursing Facility Case Management](#) sections of this chapter.

Residential

Home and Community Services provides initial and ongoing case management to all Medicaid clients in Adult Family Homes (AFH) and licensed boarding homes who have contracted with Home and Community Living Administration to provide Assisted Living, Enhanced Adult Residential Care, and Adult Residential Care services.

Initial Case Worker Responsibilities

1. Perform an Initial assessment.
2. Complete the:
 - [Individual with Complex Behaviors \(DSHS 10-234a\)](#) for clients with challenging behaviors (assaultive, destructive, self-injurious, inappropriate sexual behaviors, or history of misdemeanor behavior).
 - Community Behavioral Health Supports (CBHS) referral form ([HCA 13-012](#)) for clients who appear to meet eligibility criteria for supportive supervision and oversight refer to [Chapter 22d](#) of the LTC Manual.



- Send the AFH provider the “Case Manager Introduction” letter found in Chapter 8 of the LTC Manual.

Coordinating with the Client and Family

1. Work with the client and the family. If the client does not request the transition to a residential setting (often a member of the client’s family will contact the social service specialist about moving a client), determine if the client is also requesting or agreeable to move to a new setting.
 - Explain that the client will have a responsibility to pay participation to their provider every month and will have only a limited amount of money for personal use. Inform the client that failure to make the required payment to their provider may result in a transfer or discharge from the facility.
 - Have the client sign an [Acknowledgement of Services form \(DSHS 14-225\)](#) if appropriate.
 - Have the client sign the Service Summary or give verbal approval prior to authorization of services in the new setting. Document plan approval in a CARE Service Episode Record (SER).
2. Use the [AFH/BH Lookup Application](#) to identify facilities with available Medicaid beds (Note: The lookup list does not reflect current Stop Placement actions). Send the list to the client and/or the family so they can visit as many as possible before making a choice. For client transitions to an AFH, if you identify clients with:
 - Dementia or special care needs, they must choose an Adult Family Home with that specialty designation.
 - An Axis I or Axis II DSM IV diagnosis, they must choose an Adult Family Home with the Mental Health Specialty designation.
 - Skilled nursing tasks needs, they must choose an Adult Family Home that has Nurse Delegation training. Skilled nursing may need to be provided by visiting nurses. Not all tasks are subject to nurse delegation, and the client may need to choose an Adult Family Home owned and operated by a Registered Nurse.

Coordinating with the Residential Provider

1. Contact the facility to confirm a Medicaid vacancy. Provide and review assessment details and service summary with the facility to determine if the facility can meet the client’s needs. Disclose the rate generated by CARE and discuss possible admission date. Document outcomes in the CARE Service Episode Record (SER).

NOTE: Case workers must respond to all voicemail and e-mail communications from Adult Family Homes within five (5) business days.

2. Within thirty (30) calendar days of the client’s admit or Medicaid conversion (as documented in CARE), assigned staff will visit the facility to meet with the client and facility staff to review and discuss the Negotiated Care Plan (NCP) or Negotiated Service Agreement (NSA) in any of the following circumstances:



- The client was admitted from a state hospital, Department of Corrections, or another specialized institution, such as Hospital Psych Unit, Eval/Treatment center, etc.; or
- Client has Behavior Point Score (BPS) >6 as documented in CARE Web Assessment Summary or Personal Care Results (PCR); or
- Has a potential for abuse and neglect as identified in the assessment on the Legal Issues screen or in the CARE Service Episode Record (SER). This includes all clients who have had an Adult Protective Service (APS) referral in the last twelve months or have an open APS case; or
- Is coded as making Poor Decisions or No/Few Decisions in the assessment on the Cognitive Performance screen and does not have an authorized representative (AREP) or informal decision maker identified in CARE; or
- Has thought about suicide in the last thirty (30) days, as indicated on the Suicide screen; or
- Is sometimes or rarely understood, as identified in the assessment on the Cognitive

Note: For clients converting from private pay to Medicaid, if they have been in a residence more than thirty (30) calendar days prior to conversion, a 30-day visit is not required. The signed Negotiated Care Plan (NCP)/Negotiated Service Agreement (NSA) may be obtained by mail or fax.

Performance screen; or

- Client has a documented current pressure ulcer; or
 - Explicit Terminal Prognosis is documented in CARE or End of life/hospice is indicated on Case Transfer form or medical screen; or
 - Supervisor or case worker has the discretion to make a face-to-face visit even if any of the above criteria are not met to require a visit.
3. If a client does not meet the above criteria for a 30-day face-to-face visit in the facility, have the facility send the Negotiated Care Plan (NCP)/Negotiated Service Agreement (NSA) to the worker. The worker must phone the client and facility staff to review and discuss the NCP or NSA within the same 30-day timeframe.
- If the telephone call results in any concerns that require a face-to-face visit listed in #2 above, the worker will schedule a face-to-face facility visit within forty-five (45) calendar days of the client's admission, conversion, or transfer to their current residence.

The 30-day telephone or face-to-face contact includes sharing and gathering the following information:

- Introduction to client and reason for the contact.
- Discussing whether the Negotiated Care Plan (NCP)/Negotiated Service Agreement (NSA) is meeting the client's identified needs and preferences and determining their satisfaction with it.

- Determining if there have been any changes in the client's condition or preferences for case management follow up.
- Advising client/client representative to call the worker if there are concerns at any time.
- Verifying the client has contact information and knows how and when to contact the case worker.
- Document in a CARE SER note, using the appropriate Contact Code (Telephone Call or Home Visit) and the "30 Day Visit" Purpose Code, containing a summary of the discussion/results.

Note: If a signed copy of the Negotiated Care Plan (NCP)/Negotiated Service Agreement (NSA) has not been returned within thirty (30) days but has been requested by the case worker, make a report to the Complaint Resolution Unit (CRU) [online](#).

- Include a copy of the Negotiated Care Plan (NCP)/Negotiated Service Agreement (NSA) with signatures of the provider and client in the client's electronic file once received by mail or fax.
4. If items were not taken into account during the development of the Negotiated Care Plan (NCP)/Negotiated Service Agreement (NSA), meet with the provider and attempt to resolve these issues prior to signing the agreement. Formal meetings should occur as appropriate to resolve issues of concern.

Hospital

To learn more about hospital discharge planning, please see [Chapter 9/Hospital Assessment](#).

Nursing Facility Case Management

To learn more about Nursing Facility Case Management, see [Chapter 10/Nursing Facility Case Management and Relocation](#)

Joint Case Management

Joint case management may occur when there is a case staffing or when there is shared responsibility for a case.

Case Staffing

When do I hold a case staffing? Hold a case staffing when:

1. Case management needs arise as a result of a current or past Adult Protective Services investigation.

2. Significant complications or confusion exist that may place the client at risk of premature institutionalization, including concerns about the caregiver or environment.
3. There is a need to discuss and transfer case management oversight for complex cases that meet the criteria for targeted case management.

How do I conduct a case staffing?

1. If possible, hold it in the clients' residence or wherever they are receiving care.
2. Always include clients unless they choose not to or an extenuating circumstance prohibits them from participating.
3. As needed, include staff from Home and Community Services, Area Agency on Aging, other agencies, and formal and informal supports.
4. Ensure that clients have completed and signed a consent form authorizing all case staffing participants to discuss their information.
5. Involve your supervisor and/or administrator if there is disagreement among staff on how to resolve an issue.

Shared Cases

A case is "shared" when case workers from multiple offices are part of the client's team. All team members will need to follow CARE guidelines when sharing a case, including:

- Coordinating the assessment responsibilities.
- Using the same "look-back" periods.
- Ensuring that there is one primary case worker per division (The Area Agency on Aging is considered part of Home and Community Services Division).

Shared Case Example:

When a Respite client applies for Core services, the case will be transferred to the Home and Community Services office. However, the Respite worker will need to remain on the team as long as Area Agency on Aging respite services are in place.

For information on sharing cases with Developmental Disabilities Administration (DDA), see the [online tutorial](#).

Non-Core Case Management

If a client is not eligible for Core services, they may qualify for non-core services funded through the Older Americans Act (OAA), Senior Citizens Services Act (SCSA) or through other funding for locally available services. Non-core services could include services such as respite care, nutrition programs, exercise programs, or other locally available services. Clients who may need and be eligible for non-core services should be referred to the local Area Agency on Aging/Information & Assistance office for assistance. The Area Agency on Aging provides case management to clients receiving these services.

Ongoing Case Worker Responsibilities

Visiting and Assessing the Client Annually or Sooner

1. Determine the frequency of contact with each client based on the client's:
 - **Care needs:** Does health status change frequently and/or is the client unstable
 - **Cognition:** Does the client have impaired cognition and/or communication skills?
 - **Emotional, psychiatric, and/or behavioral** problems.
 - **Support system:** Does the client have a family or social support network?
2. Perform Annual or Significant Change assessments. Obtain and document client consent to services in the CARE Service Episode Record (SER) using the Plan Approval purpose code. Provide the plan of care (assessment details and service summary) to the provider.

Coordinating with and Monitoring Providers

1. Review the NSA at every face-to-face assessment to ensure that the client's needs are met. Reassess and ensure the NSA gets updated and is consistent with the DSHS plan of care.
2. Communicate with the providers. The HCS Regional Administrator and the RCS Regional Administrator may arrange for regularly scheduled meetings between staff to facilitate communication about the coordination of their efforts with providers that are having problems meeting a client's needs.

These meetings:

- Provide an opportunity to discuss new homes, new contractors, problem situations and concerns that need to be monitored
 - Should include appropriate HCS, RCS, AAA staff (such as social workers, community nurses, etc.), adult family home licensors, contract monitoring staff, nursing services personnel, and local ombudsman
 - Should explore options which include, but are not limited to, nurse consulting or nursing services intervention, referral to other community resources or services, and use of the discharge resources. See the [Nursing Facility Case Management Chapter](#) of the LTC Manual for more details on discharge resources.
3. Review the records kept by the provider to monitor the services provided against the frequency and level of care described in the DSHS Plan of Care/NSA/NCP.
 4. Review with each client the frequency and quality of the service the client receives from the provider. If the client is not receiving the services they need or finds the services unsatisfactory, discuss this with the client, their representative, and the provider to attempt to resolve this issue. As needed, consult with the Nursing Care Consultant (NCC), the AAA Nursing service, the



Long-term Care Ombudsman, and Residential Care Services staff. Refer to the Move and Relocation procedures if this intervention is not successful in resolving the issue(s).

5. If needed, document in the SER the services not provided and the reason. Document concerns regarding the quality of the service provided and how the issue was resolved by HCS staff, NCC, or Nursing Services.
6. If the facility fails to develop an NSA, report this to Residential Care Services and document in the SER.
7. Consult with Nursing Services about their visitation schedule.
8. Refer the client for a nursing assessment to determine the appropriateness of Nurse Delegation services if it is determined that the client needs professional assistance with any nursing tasks.

Contacting the Complaint Resolution Unit (CRU)

Make an online report:

- Immediately if there is any indication of abuse, neglect, exploitation, or abandonment of a residential client.
- To enter a complaint if the residential provider does not implement the plan of care or does not achieve the appropriate outcomes.
- To report any issue of concern regarding the quality of life and care for all residents. Provide

Note: APS investigates allegations of mistreatment of a vulnerable adult living in a residential setting, Nursing Facility, or Behavioral Health Center when the alleged perpetrator is not affiliated with the residential setting. The online reporting system may be used to report to APS or CRU. The system will direct the complaint to the appropriate department.

sufficient information about the issue for RCS staff to initiate an investigation.

Complaint Resolution Unit (CRU) staff or RCS investigators may contact you for additional information. Document in the SER any activities or actions taken. This information will be available to RCS staff to complete their investigation or to take corrective action.

DOCUMENTATION AND SERVICE EPISODE RECORDS (SERS) IN CARE

The intent of the SER in CARE is to document all contacts and activities related to the client's assessment, service plan, coordination and monitoring of care, and termination of services. Information about the functionality of the SER and a full list of contact and purpose codes can be found in the CARE Web Assessor's Manual

Importance of Documentation

There are a number of reasons to maintain current and accurate documentation in the SER, including:

- Smoother transitions for the client and receiving case workers
- Allows current and future case workers responsible for the client's case to view historic and current interactions with the client and collateral contacts
- Provides a more holistic view of the individual
- Reduces the risk of gaps in service delivery
- Promotes more person-centered case management services for the individual
- Provides a record reflecting that appropriate person-centered case management practices, rules and policies were followed

Documentation Best Practice

- **Be objective and factual:** Avoid subjectivity, opinions and judgements. Document only the facts about what was seen, heard, and/or information that was provided.
- **Be clear and concise:** Do not use abbreviations and acronyms only recognizable to the case worker or other local staff. Only information relevant to the client and situation should be documented.
- **Use readable and professional writing style:** Check for grammar and spelling errors before submitting the SER. Avoid text speak, using all caps, and exclamation marks.
- **Record Action:** Each individual action or decision should be recorded separately.
- **Include individual names:** Use full names and title/role client contacts, vendors, and other client supports. However, APS investigator names should be excluded from SERs. See the APS Restrictions for additional guidance.
- **Enter SERs in a timely manner:** This will promote accuracy and more accurate recollection of conversations and events.
- **Make sure SER entries are for the correct client in CARE:** Once a SER is submitted, it cannot be deleted. If an error is made, append the SER in error and briefly explain the error without using any other client's name. Document SER in the correct client record.

Restrictions

- Do not document the names of other clients in a SER.
- Do not copy and paste emails in SER notes. Instead, summarize the relevant content of the e-mail.
- Adult Protective Services (APS)

- It is important to restrict the information about an APS report in the CARE SER due to confidentiality laws around APS information and risk of disclosure of the confidential APS record.
- In general, do not document information about the APS worker or APS intakes or outcomes in the CARE SER. If this information is needed, it can be found within the APS screen in CARE Web.
- Create a SER that includes any observations that you have based on your own interaction with the client or collateral contacts regarding a situation of concern and any APS report that you made as a mandatory reporter.
- If there was a conversation with an APS worker, you should only document general information. For example, the conversation happened or there was a general update given on the case. Do not include details about the case in the SER.

TRANSFERRING & RETURNING A CASE

Use these protocols when transferring an electronic case record and paper file from one office to another. At any point during a case transfer, the case worker may request a case transfer consultation or case staffing. The case staffing may be done via telephone or in-person.

Determining Who Completes the Annual Assessment

When a client has an upcoming Annual Assessment due within 2 months of the Plan Period End date, the transferring office will be responsible for completing the Annual Assessment prior to transferring to the receiving office.

Example

An assessment with a plan period end date of 10/31 would need to be transferred to the receiving office no later than 08/31. If the case is not transferred by 08/31, the transferring office will be responsible for completing the assessment.

Transfer Protocol

The Assessment and Care Plan section must meet minimum standards outlined in [Chapter 3/Assessment & Care Planning](#).

The transferring case worker is responsible for the electronic case record completeness and accuracy. Prior to transferring a case:

1. When Fast Track Services are authorized, the transferring case worker will verify and document in a SER that at least pages 1 and 2 of the Medicaid application has been received by financial services.



2. Environmental modifications must be arranged and contracted prior to transfer. Completion of the modification and payment of the services may be completed after the transfer of the case. Attach the Barcode Social Service Record (SSR) cover sheet for quotes and receipts related to housing modifications before sending them to HIU.
3. Durable Medical Equipment (DME) must be arranged and ordered prior to transfer. Cases may not be transferred until a DME Exception to Rule (ETR) has been submitted and approved. Attach the Barcode Social Service Record (SSR) cover sheet for quotes and receipts related to housing modifications or DME before sending to HIU. Prior to transfer, if a client has DME needs the transferring case worker should:
 - Ensure DME is obtained by the client; and
 - Confirm that the DME meets the client's identified needs.
4. The transferring case worker must complete the HCS/AAA Case Transfer in Barcode/DMS prior to transferring the case in the Barcode system as required by policy. The Case Transfer is used to ensure all documents required for a particular program have been completed and included in the client's record. It also serves as a means to communicate any special concerns with a case to the receiving office. The financial worker will be able to see the HCS/AAA Case Transfer in the client's ECR and will know that the case was transferred.
5. In Barcode, the transferring office must send all required documents listed on the HCS/AAA Case Transfer to the Hub Imaging Unit (HIU) as "Hot Mail" including:
 - 14-012 DSHS Consent
 - 14-225 Acknowledgement of Services
 - 16-172 Client Rights and Responsibilities
 - Service Summary signed by the client (Including Electronic Signatures)
 - Service Summary signed by the provider(s)
 - RCL Consent Form

If a client chooses or is required to update their consent form (DSHS 14-012) at any time, the most current signed version replaces all previous forms upon signature. For additional information regarding consent form requirements, please refer to [Chapter 3](#) of the LTC Manual.

Unless otherwise mutually agreed upon between the transferring office and receiving office, all required documents listed on the HCS/AAA Case Transfer must be visible in the client's Electronic Case Record (ECR) upon transfer.

Prior to transferring the case, the transferring case worker must have called the client and/or the authorized service providers to verify that all services have been authorized. Use the phone call to notify the client of the imminent transfer and give the client contact information should they have questions/concerns prior to the receiving worker contacting them.

NOTE: The following forms must be re-signed and submitted to DMS when there is a break in service:

- 14-012 DSHS Consent
- 14-225 Acknowledgement of Services
- 16-172 Client Rights and Responsibilities

A break in service occurs when the client going 30 calendar days or longer without receiving services. This includes clients that are in a hospital or skilled nursing facility greater than 30 days.

6. The transferring case worker will verify record completeness using the HCS/AAA Case Transfer before submitting to the supervisor for transfer. Once the "Submit To" supervisor field is enabled, the date sent to the supervisor is populated. The supervisor will receive notification that they have a transfer on their To-Do List. The supervisor will approve for transfer. If the supervisor determines additional items are needed prior to transferring the case, the supervisor will communicate this to the transferring staff from the Case Transfer with a note. The worker will resolve and resubmit to the supervisor for transfer. See [Chapter 23a/Social Services Monitoring](#) for supervisory file review requirements.
7. The receiving agency will assign the case to an individual case worker within five (5) business days.

Barcode

DMS is a system that bases all assignments on the current case worker of record. Once a case has been transferred in CARE, and until the receiving office has identified a new primary case worker on the Client Overview screen, DMS creates duplicate document assignments to the default worker at the receiving office and the former case worker to ensure someone takes an action on a document. To alleviate this, the receiving office should assign a case worker as quickly as possible when cases are transferred between offices. However, case transfer policy states that the receiving agency will assign the case to an individual case worker within 5 business days.

Once the HCS/AAA Case Transfer is submitted, the receiving office will verify all required program documents are in the electronic case file and will have 5 days to assign the client to a case worker in CARE. During this time, assignments in Barcode are made to the default worker in both the sending and receiving office according to the matrix until the case is assigned in CARE.

Returning a Case

If the transferred case does not meet the minimum standards identified in [Chapter 3](#), Assessment and Care Planning, or has payment/authorization errors:

1. The receiving agency will notify the transferring agency within 5 business days of receipt of the file.

2. The transferring agency is expected to make necessary corrections to the file documents. During this time, new assignments in Barcode will be made to the office of the case worker assigned in CARE. Necessary changes will be made by the transferring agency within 10 business days from the date notification was received. Unless the transferring agency is notified within the timeframe, the transfer will be deemed complete.
3. Track returned cases, using the form in the following section.
4. The transferring and receiving supervisors or designees are responsible for resolving issues related to case transfers. If any disagreement occurs, it will be addressed through the chain of command established by both the transferring and receiving agencies. Unresolved differences

Note: Additional information regarding the case transfer of in-home, Nurse Delegation clients can be found in [Chapter 13](#) of this manual.

between the HCS regions and AAAs should be referred to the State Unit on Aging Office Chief and Home and Community Services Deputy Director of Field Operations, or their designees, for resolution.

Tracking Returned Cases

Use the format listed below to identify trends and patterns in files that are identified as needing correction. It is the responsibility of the receiving agency to document the reasons transferred files do not meet the transfer protocols. Use the forms in discussions between AAA and HCS at local coordination meetings. The identified trends and patterns will be used to determine training needs and to address personnel related issues.

DATE	CLIENT NAME/	AGENCY CASE TRANSFERRED FROM	WORKER CASE TRANSFERRED FROM	REASON RETURNED CODE	COMMENTS

Reason Return Codes

- A.** Assessment/care plan does not meet minimum standards
- B.** Provider not qualified
- C.** Authorization not accurate

Guidelines for Institutional (Hospital, Nursing Facility, or ICF-ID) Settings

The intent of this case transfer policy is to encourage coordinated discharge/treatment planning in the best interest of the client. The AAA case worker, DDA Case Resource Manager, or HCS residential case worker should collaborate with the HCS NFCM to determine if, and when, a case transfer is appropriate for a client who intends to return to a community setting.

In that regard AAA, DDA, and/or HCS staff may:

- Assess a client in the Skilled Nursing Facility (SNF) or hospital;
- Determine NFLOC in the NFCM screen of CARE (DDCS does not have access to this screen. Refer to [Chapter 10](#) for more information on how to complete a NFLOC for DDA clients);
- Attend care conferences at the hospital, SNF, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-ID);
- Access discharge resources for clients, including MIIE for HCS clients;
- Review charts and/or files for discharge planning purposes.

Timelines

- The client file may remain with AAA/DDCS for thirty (30) calendar days from initial admit to SNF, regardless of subsequent changes in institutional setting (hospital, SNF, ICF-ID). The client may be kept longer if a return to the in-home setting is imminent.
- If a hospital stay goes beyond 30 calendar days, the AAA case worker will coordinate with the HCS Social Service Specialist regarding possibility of transfer to HCS (Refer to LTC Manual [Chapter 9/Hospital Assessment](#) for additional information).
- AAA/DDA case worker may transfer the client to HCS immediately if the client does not intend to return to the in-home setting.

CHALLENGING CASES PROTOCOL

Introduction

Federal Home and community-based waiver services rules ([42 CFR 440.180](#)) and 1915 c waiver rules ([42 CFR 441.302\(a\)](#)) require that the state must assure that, "...necessary safeguards have been taken to protect the health and welfare of the recipients of the services.". If the plan of care cannot assure the health, welfare, and safety of the client due to client environment or resource issues, invoke the "Challenging Cases Protocol".

The purpose of the "Challenging Cases Protocol" is to create statewide consistency addressing challenging situations in which the plan of care for a client or applicant cannot be implemented service termination is not a substitute for standard case management practice. The protocol recognizes the client's preferences of care, services, and life choices. Every effort must be made toward the resolution of issues especially when denial or termination of services is being considered.

HCS and AAA staff will initiate the "Challenging Cases Protocol" when the recommended plan of care, necessary to support the client's health, welfare, or safety, cannot be carried out due to factors including, but not limited to:

1. Client challenges such as:
 - Decision making capability (per [RCW 11.130](#))
 - Refusal of services vital to health, welfare and safety
 - Illegal/criminal activity
 - Behaviors, including self-harm or harm to others (refer to the Challenging Cases Protocol "Imminent Danger" section for further guidance)
2. Physical and social condition of the client's environment:
 - Hazardous conditions for the individual or Agency Provider's Health and Safety (refer to the Challenging Cases Protocol "Hazardous Conditions" section for further guidance);, such as:
 - threatening, uncontrolled, or dangerous animals;
 - illegal drug use or drug manufacturing;
 - poor sanitation or housing structure
 - Presence of hazardous materials in the home, such as exposed sewage
 - A pattern of choosing caregivers that cannot meet their needs.
3. The client or other person(s) in the home are engaged in:
 - illegal activity or other dangerous behaviors toward caregivers, staff, or other residents.
 - discrimination, harassment, or abuse of a caregiver or case worker
 - interference with service delivery or hindering caregiver access to the client
 - interference of assessment and care planning by the case worker



Client safety is a shared responsibility involving the client, their family, friends, neighbors, social services worker, the medical community, law enforcement, and other service agencies. The protocol involves the use of an interdisciplinary/interagency team as the vehicle for community entities to review and make recommendations for a challenging case. Examples of an interdisciplinary/interagency team can include:

- Regional Resource Team
- A-Team
- ad hoc team
- Complex Case Staffing (See [Chapter 9: Inpatient Hospital Assessments and Transitions for more information on Complex Case Staffing](#))

It is important to complete all standard case management activities prior to invoking the steps of the protocol, including targeted case management and an APS referral if you have reason to believe that the client is or has been abused, neglected, abandoned, or financially exploited. If there is an active APS investigation, continue services and case management responsibilities pending the outcome of the APS investigation.

Imminent Danger

Services may be terminated if the “likelihood of serious harm” or “imminent” danger is present to the client or provider.

“Likelihood of serious harm” and “imminent” are defined in [RCW 71.05.020](#):

“Likelihood of serious harm” means (RCW 71.05.020(37):

- A substantial risk that:
 - Physical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; or
 - Physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or
 - Physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or
 - The person has threatened the physical safety of another and has a history of one or more violent acts.

Imminent” means “the state or condition of being likely to occur at any moment or near at hand, rather than distant or remote” (RCW 71.05.020 (29)). This includes any situation where a case worker feels that they are in immediate danger due to their surroundings or actions of individuals in their presence. Examples of these scenarios may include a client or individual in the client’s home brandishing a weapon and making threats that the individual is clearly capable of carrying out or evidence of a methamphetamine laboratory in the home.



If you receive information that the client or the provider is in imminent danger, or the likelihood of serious harm is present:

1. Determine whether you need to call the police immediately and/or medical assistance.
2. Determine if you have reason to believe that abuse, neglect, abandonment, or financial exploitation of a vulnerable adult is present and an APS referral is warranted.
3. Make a referral to the Local County Designated Crisis Responders if you believe the client has a mental disorder and is gravely disabled or a danger to self or others.
4. If the individual is applying for services or is a services recipient, and:
 - you have determined that the client is capable of understanding the issues impacting their or the provider's health, welfare, and safety; and
 - you have listed the possible consequences of those issues; and
 - you have consulted with your supervisor regarding services termination and your supervisor agrees that you pursue termination of services; then
 - follow the Services Denial procedure.

Hazardous Conditions

Services may be terminated when the client refuses to resolve the hazardous conditions, such as drugs, that may **pose a danger to others**.

1. Determine whether the client is capable of understanding the hazards and consequences and whether a referral for a capacity evaluation is appropriate.
2. Give the client ample opportunity to remove the drugs and/or users in the presence of providers and the social services worker. If the hazard is a methamphetamine lab, neither providers nor the social services worker should go into the residence. Immediately call 911.
3. Discuss with the client the potential of the termination of services due to the presence of hazards.
4. If the client refuses to remove the specific hazard, discuss the case with your supervisor for referral to the interdisciplinary/interagency team.
5. Follow Challenging Cases Protocol.

If the home contains sewage, vermin, lice, or other contaminants to such a degree that **may be harmful** to anyone, determine whether the client understands the danger of such hazards.

1. Make a referral to the local County Designated Crisis Responders if you believe the client has a mental disorder and is gravely disabled, or a danger to self or others.
2. Follow the [Targeted Case Management policy](#).
3. Consider making a referral to Adult Protective Services (APS) if you have reason to believe that the client is experiencing self-neglect and APS services may help them.
4. If the client's situation jeopardizes their health, welfare, or safety, follow the Challenging Cases Protocol.



Refusal to Comply with Mandatory Program Requirements and Service Delivery

Services can be terminated when clients refuse to comply with mandatory program requirements and service delivery provisions. If the client demonstrates a *substantial pattern* of behavior that prevents the determination of eligibility, carrying out the plan of care, or monitoring the services to assure the health, welfare, and safety of the client.

Examples of refusal to comply with the service delivery provisions include, but are not limited to:

- The client is frequently away from their home when the provider arrives (without prior arrangements), so that services cannot be performed.
- The client has prevented or refused multiple providers' attempts to perform vital, authorized services.
- The client, or others in the home, has demonstrated verbal abuse, discrimination, or sexual harassment toward providers on numerous occasions.

If such a pattern of behavior has resulted in resignation of multiple providers:

- Visit the client to discuss the behaviors and inability to deliver services due to the behaviors.
- Refer the client (or others in the home) to other services, such as behavioral health or substance or alcohol abuse treatment services.
- Monitor the client to determine if the client (or others in the home) has stopped the offensive behaviors. A monitoring schedule may be recommended by the interdisciplinary/interagency team; confirm the monitoring schedule with your supervisor.
- Determine whether another provider of another gender is appropriate (e.g., a male client insists on female providers and has demonstrated a substantial pattern of sexual harassment).

If the behavior is directly related to the client's disability, seek appropriate service referrals. Services cannot be terminated or denied under such reasons.

Challenging Cases Protocol Review

If the case worker has determined that the client meets one or more of the Challenging Cases Protocol criteria and has exhausted all standard case management requirements, the case worker will proceed with reviewing and implementing the Challenging Cases Protocol as identified below.

Document all actions, consultations, and statements by the client and/or others in the SER.

- The case worker and supervisor will staff to determine if implementing the Challenging Cases Protocol is appropriate. The supervisor may:
 - Perform a file review.
 - Make further suggestions for approaches or services not yet tried, such as nursing services, intensive or targeted case management, etc.
 - Recommend further monitoring and visits.
 - Recommend contacting other collaterals and/or other entities with shared responsibilities.
- If you and your supervisor feel all options have been exhausted, the supervisor will:

- Instruct you to proceed with the protocol and refer the case to the inter-disciplinary/agency team as needed. (See Interdisciplinary/Interagency Team policy below)

In rare instances, refer the case directly to the RA/AAA director (or their designee) for a decision to terminate the case (bypassing referral to the interdisciplinary/ interagency team). The supervisor must document the reasons why the case was not referred to the interdisciplinary/interagency team.

- The supervisor reviews the team's recommendations with you and may recommend:
 - Visit the client to discuss the issues and possible consequences
 - The 'team' or relevant members of the team may choose to visit the client to resolve health, welfare, and safety issues
 - If capacity is a concern for decision making, refer to capacity related information in chapter 3.
 - Determine if other services are appropriate, such as a referral to counseling.
 - Determine if other supports are available, such as any informal supports.

Interdisciplinary/Interagency Team

1. When the case worker is instructed to convene a team, current regional teams may be used for the purpose of reviewing a challenging case. This may include Regional Resource Teams or A-Teams. The supervisor must review existing team membership to determine if all disciplines/agencies relevant to the case are represented. If appropriate disciplines/agencies are not represented, the supervisor will identify appropriate members.
2. If the need to convene a team is immediate and other existing teams meeting dates are not convenient or such a team does not exist in the local community, the supervisor may arrange for an *ad hoc* team. The RA, AAA Case Management Director, or their designee may also arrange for an interdisciplinary/ interagency team to be convened.

The case worker will attempt to obtain a signed release of information from the client. If the client refuses, send notice of the challenging case review at the interdisciplinary/interagency team only to those entities with case management responsibility, giving the client's name and other identifying information. If there are team members present not affiliated with the case, the social services worker will discuss the case using the client's initials and not use the client's name.

The interdisciplinary/interagency team is responsible for:

- considering all available assessment information in its deliberations
- identifying the services needed to meet the client's needs
- identifying strategies for resolving obstacles that are preventing the implementation of the plan of care
- estimating the costs for the types and amounts of services identified as necessary to meet the client's needs
- determining whether the individual can be served safely in the community
- developing the plan of care recommendations, including case closure.



Procedure

1. The case worker, along with a supervisor, RA/CMD, and/or designee, will present and facilitate the case at the team meeting. When APS is a part of the interdisciplinary/interagency team, all team members will be required to review and sign the oath of confidentiality on the sign in form notifying attendees that they are required to “keep all shared information confidential (RCW 74.04.060). Participants may take notes but may not place these notes in client files or other official documents or reports.” If team members not affiliated with the case are present, only client initials should be used.
2. The team may:
 - decide for the social services worker and/or relevant team members to visit the client to:
 - clarify safety/welfare issues
 - review rights and responsibilities with the client
 - discuss with the client consequences of not accepting services vital to health, welfare and safety
 - involve family and informal supports
 - decide if multiple, frequent visits are necessary
 - develop a monitoring schedule involving the social services worker and/or relevant team members
 - coordinate with other community resources
 - decide to recommend that services be terminated, identifying what other services must remain open or be put into place.

The **social services worker** will document the team’s recommendations on the team’s documentation form. The **supervisor** will discuss with the case worker whether all, some, or none of the team’s recommendations are to be implemented.

Outcome Documentation

The case worker presenting the case is responsible for documenting team recommendations and actions chosen. The case worker should include the following information when entering outcome documentation in the SER:

- Team recommendations, including:
 - Team member names, organizations, and contact information
 - Person presenting the case
 - Reason for the referral (what is jeopardizing the client’s health, welfare, and safety)
 - Services in place
 - Interventions tried and failed
 - Client needs that are not being met, including:
 - Recommendations for meeting the identified needs
 - Reasons why the needs cannot be met



- If consensus on recommendations cannot be reached, the reasons given and by whom.
- If applicable, any forms used to document a referral to a team or the team's outcome. Forms may include:
 - Team specific form such as:
 - Regional Resource Team Referral Form
 - A-Team Referral Form
 - Interdisciplinary/Interagency Team Documentation Form.

If forms are used, send each team member a copy of the completed form.

Services Denial

If non-compliance or the problems continue, the case worker may, with supervisor approval:

- Contact the client to discuss obstacles to continuing services:
 - Identify a plan to remedy obstacles;
- Inform the client of possible options or denial of services if obstacles are not corrected
 - Identify options for the client;
 - If no options exist or client/representative refuses options offered, then, with your supervisor, refer to RA/AAA Director (or their designee) for a decision to deny services;
- Refer the case directly to the Regional Administrator/AAA Director (or their designee) for a decision to deny services;

The RA (or designee) must notify the HCS Deputy Director of Field Operations of the decision to deny services and the AAA Director must notify the State Unit on Aging Office Chief of the decision.

Services Termination

If after completing the Challenging Cases Protocol review, it is determined that services should be terminated, the case worker will:

- The RA (or designee) must notify the HCS Deputy Director of Field Operations of the decision to deny services and the AAA Director must notify the State Unit on Aging Office Chief of the decision, prior to the case worker in completing a termination Planned Action Notice.
- Follow client notification of adverse action as [Chapter 27/Notices](#) regarding use of the Planned Action Notice (DSHS 14-405).
 - The Action should be Terminated. Do not use Denied.
 - Ten to the end policy does not apply, but no less than ten (10) days notice must be given.
 - Amend the Planned Action Notice to ensure the Effective Date is ten (10) days from the date of the notice.
 - All authorizations and RACs should be ended one day prior to the Effective Date on the Planned Action Notice.



- If the Planned Action Notice is returned as undeliverable, send the PAN/envelope stating “Undeliverable” to HIU for scanning into the electronic client record (ECR).

- Below is an example reasoning, by choosing “Other” in CARE:

The Department is terminating your long-term care services after exhausting standard case management activities and the approaches delineated in the Department's Challenging Cases Protocol.

Following the protocol, any one factor or several factors that jeopardize the health, welfare, and safety of you and/or others can result in termination. Your services are being terminated because.....

(Examples: You have refused to resolve hazardous conditions that pose a danger to yourself and/or others; There is “likelihood of serious harm” or “imminent” danger present to you and/or others; You have demonstrated a substantial pattern of behavior that prevents the determination of your eligibility, carrying out your plan of care, or monitoring your services to assure your health, welfare, and safety.)

Every effort has been made toward the resolution of these issues, and it has been determined that in accordance with WAC, RCW, and the Department’s Challenging Cases Protocol your services will be terminated as of the effective date on this notice.

- The client must be given the opportunity to comply after the written notification is mailed.

If an individual with a history of services termination/denial due to ‘challenging cases’ issues, reapplies for services:

- Assess whether the issues that caused the termination/denial of services still exist.
- Discuss the case with your supervisor, including the previous reasons for termination/denial.
- Review the following with the client:
 - Reason for the previous termination;
 - Responsibility of the client to notify the provider and/or provider agency (if used) and the social services worker about problems related to the plan of care implementation.
- With supervisor approval, authorize services if the client agrees to follow the plan of care.
- If the client does not agree to resolve issues that caused past services termination, follow the Services Denial procedure.

RESOURCES

Related WACs and RCWs

RCW 74.34	Abuse of Vulnerable Adults
RCW 74.38.010	Legislative recognition—Public policy
RCW 74.38.040	Scope and extent of community-based services program
RCW 74.39.005(7)	Long-term Care Service Options – Purpose (Case Management)

RCW 74.39A.040 (3)(c)	Department assessment of and assistance to hospital patients in need of long-term care.
RCW 74.39A.090	Discharge planning—Contracts for case management services and reassessment and reauthorization—Assessment of case management roles and quality of in-home care services—Plan of care model language
RCW 74.39A.095	Case management services—Duties of the area agencies on aging—Consumers' plans of care—Notification to consumer directed employer
RCW 70.41.310	Long-term care—Program information to be provided to hospitals—Information on options to be provided to patients
RCW 74.42.057	Notification regarding resident likely to become Medicaid eligible
RCW 74.42.058	Department case management services

Acronyms

AAA	Area Agency on Aging	HCLA	Home and Community Living Administration
AAG	Assistant Attorney General	HCS	Home and Community Services
AFH	Adult Family Home	ICF-ID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
APS	Adult Protective Services	LTC	Long Term Care
ARC	Adult Residential Care	MCO	Managed Care Organization
AREP	Authorized Representative	NCP	Negotiated Care Plan
BH	Behavioral Health	NF	Nursing Facility
BHWS	Behavioral Health Wraparound Services	NSA	Negotiated Service Agreement
BPS	Behavior Points Score	PAN	Planned Action Notice
CA	Case Aide	PASRR	Pre-Admission Screening and Residential Review
CBHS	Community Behavioral Health Supports	PBS	Public Benefit Specialist
CDE	Consumer Directed Employer	PCM	Primary Case Manager
CDWA	Consumer Direct Care Network Washington	PCR	Personal Care Results
CM	Case Manager	PCRC	Personal Care Results Comparison
CNC	Community Nurse Consultant	PNA	Personal Needs Allowance
CPS	Child Protective Services	RA	Regional Administrator
CRU	Complaint Resolution Unit	RCS	Residential Care Services
DMHP	Designated Mental Health Professional	RN	Registered Nurse
DMS	Document Management System	SER	Service Episode Record
DOC	Department of Corrections	SNF	Skilled Nursing Facility
DSHS	Department of Social and Health Services	SSS	Social Service Specialist
EARC	Enhanced Residential Care	TCM	Targeted Case Management
ESH	Eastern State Hospital	WSH	Western State Hospital

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
10/2020	Beth Adams	Moved to new template and edits to improve grammar and aesthetics,	
2/2021	Rachelle Ames	Repaired broken links, added form links and replaced the term “placement” with more person-centered language	
2/2021	Rachelle Ames	Updated “Social Worker” terminology to “Social Service Specialist”	
2/2021	Victoria Nuesca	Updated language related to MCO and Behavioral Health Personal Care	
2/2021	Rachelle Ames	Replaced “placement” language with person-centered language	
2/2021	Rachelle Ames	Added guidance about SER documentation	
5/2022	Kellie Nelson	Updated required documents/process for conversion to CDE	
2/2023	Sun-Young Pak	- Replaced the “APS Chapter” with "Adult Protective Services policy and procedure” - Updated language related to “Mandatory Reporting” - Replaced “local Designated Mental Health Professional (DMHP)” with “local County Designated Crisis Responders” - Updated the outdated CARE screens names	
8/2023	Natalie Lehl	Fixed broken links	
6/2024	Natalie Lehl	- Updated the “Transfer Protocol” section. - Updated case management “Guidelines to Support Move from In-Home to Residential Setting”. - Clarified Termination Planning section: for a client receiving an ALTSA housing resource, the assigned HPM must be contacted prior to inactivating a case.	
10/2024	Natalie Lehl	- Example added to Transferring & Returning a Case Guidelines - Clarification on consent forms - Fixed broken link to Chapter 13	
03/2025	Natalie Lehl	Added SER Policy Language	
07/2025	Natalie Lehl	- Updated formatting, grammar, and placement of information throughout chapter - Replaced ALTSA with HCLA - Replaced DDA with DDCS - Added clarifying language to Targeted Case Management - Included Agency and AFH contact guidelines for staff response time	
10/2025	Natalie Lehl	Updated mandatory reporting requirements	

		• Added additional DME policy that must be completed prior to case transfers • Updated Chapters 9a and 9b to reflect merge • Added Complex Case Staffing to sample team list for Challenging Cases Protocol	
04/2026	Natalie Lehl	• Updated language and links related to housing and chapter 6. • Challenging Cases Protocol: Updated RCW links and definitions. Conflicting information clarified and duplicative language removed. • Added additional policy around APS documentation in SERs. • Updated Chapter links and title for Chapter 9. • Replaced outdated BHPC form with current CBHS form	
07/2026	Natalie Lehl	• Updated Challenging Cases Protocol • Replaced case manager and social service specialist with case worker • Formatting changes • Added BHWS/MCO policy	

APPENDIX

For Word version or other languages, visit [Electronic DSHS Forms](#).

[DSHS 05-246](#) **Notice of Action Exception to the Rule** (Excluding AFH)

[DSHS 10-234](#) **Individuals with Challenging Support Issues**

- For any clients entering a residential facility who have challenging behaviors (assaultive, destructive, self-injurious, inappropriate sexual behaviors, or history of misdemeanor behavior).

Community Behavioral Health Supports (CBHS) referral form

[DSHS 14-012](#) **Consent for Services**

[DSHS 14-225](#) **Acknowledgment of Services**

[DSHS 14-300](#) **PASRR Level One**

DSHS 14-405 **Planned Action Notice (in CARE)**



[DSHS 14-443](#)

Financial/Social Service Communication

For communication with the financial worker regarding the status of the client



Community Transition or Sustainability Services/Washington Roads

The purpose of this chapter is to educate staff about the state-only funded service packages of Community Transition or Sustainability Services (CTSS) and Washington Roads (WA Roads), the benefits these transition and sustainability services may offer to participants, and to provide instruction on how to utilize these state funded services in coordination with Medicaid State Plan or Waiver Programs.

Ask an Expert

If you have questions or need clarification about the content in this chapter, please contact:

Julie Cope RCL/NFCM Policy Unit Manager
360.725.2529 julie.cope@dshs.wa.gov

Amanda Speck RCL Enrollment Specialist
360.870.6309 amanda.speck@dshs.wa.gov

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BACKGROUND

In 2007, DSHS was awarded the “Money Follows the Person” (MFP) grant from the federal Centers for Medicare and Medicaid Services (CMS) for the “Roads to Community Living” (RCL) demonstration project. The purpose of the RCL project is to examine how best to successfully help people with complex long-term care needs transition from institutional to community settings.

The lessons learned and cost savings seen through the first year of the RCL project helped convince the 2009 Washington State legislature to approve additional funds for individuals who may not be eligible for RCL. The funding was for a package of services named Washington Roads.

WA Roads services were previously available only to individuals transitioning from an institution to a community setting. These services are also available as a resource for challenging or complex cases involving individuals who are currently living in the community, but who are at risk of losing their community living setting.

WA Roads services have proven to be an integral part of successful community living and, as a result, many services are now available through other funding sources and waivers. For those individuals whose eligibility allows them to access transitional or sustainability services through the State Plan or Waiver programs, those programs are priority. For those individuals who do not meet transition or stabilization eligibility criteria for the State Plan or Waiver programs, they may access State Funded Community Transition and Sustainability Services (CTSS) or WA Roads transitional and sustainability supports.

WHO IS ELIGIBLE FOR CTSS/WA ROADS SERVICES?

These state funded services are intended to fill specific gaps to provide transitional or stabilizing supports for HCS clients to sustain community living. Not all participants will meet the eligibility requirements for these state funded transition or sustainability services. Case managers should utilize existing resources for these individuals.

*See text box on next page:



HCLA clients are eligible for state funded Community Transition or Sustainability Services through CTSS or WA Roads when **one or more of three eligibility criteria** are met and the service and/or supports aren't available under their state plan or waiver. Eligibility includes individuals who are in the N05 Medicaid coverage group in ACES, and those who meet the Non-Citizens eligibility criteria as outlined by [Chapter 7g](#) with HQ approval. **Individuals are eligible when:**

1. Transitioning from an institution to a community setting, and are:

- aged 18 and older in a hospital or nursing facility;
- Medicaid recipients in the hospital or nursing facility for at least one day, or Fast Track eligible;
- functionally and financially eligible (or Fast Tracked) for State Plan or Waiver home and community-based services (HCBS) which currently include MPC, ABP-MPC, CFC, COPES, RSW, and New Freedom.
- Clients enrolled in programs for State Funded long term care for non-citizens. These eligibility groups will require HQ approval from Emily Watts or delegate. See [Chapter 7g](#) for additional information on these programs.

NOTE: After hospital or nursing facility discharge, these individuals are not required to receive ongoing home and community based services (HCBS). Please note that for Medicaid clients that do **not** meet functional or financial eligibility for HCBS, **Community Transition or Sustainability Services (CTSS)** continues to be a resource.

2. Residing in the community, are functionally and financially eligible for State Plan or Waiver HCBS, AND are experiencing of one or more of the following:

- Unstable residential or in-home settings (e.g. homeless, frequent transfers, etc.)
- At immediate risk of becoming homeless or unstable in current setting.
- Frequent institutional contacts (ER visits, SNF stays, hospital admits, etc.)
- Frequent turnover of caregivers
- Multiple systems involvement (Dept. of Corrections (DOC), psychiatric institutions, etc.)

3. Residing in subsidized housing (e.g. NED and 811 vouchers, HCS Subsidies, etc.) that was coordinated through HCLA. This eligibility criteria is regardless of whether the client is

Individuals that are not eligible for CTSS or WA Roads include:

- Clients residing in Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs) or Residential Habilitation Centers (RHCs)
- Clients enrolled in managed long-term care programs such as PACE. If using WA Roads for a client's transition or stabilization and client elects PACE, ensure that all goods and services are concluded before PACE start date.



May a DDCCS client receive CTSS/WA Roads services?

A DDCCS client that is transitioning out of a nursing facility or acute care hospital, meets all other eligibility criteria, and will exit either a NF or hospital on an HCS waiver is eligible for CTSS or WA Roads. DDCCS clients that are already residing in the community are not eligible for CTSS or WA Roads.

May a client on the Residential Support Waiver (RSW) receive CTSS or WA Roads services?

A client in an RSW setting may utilize state funded Community Transition or Sustainability services available through CTSS or WA Roads when they meet [eligibility criteria](#), as listed above. A contracted Community Choice Guide (CCG) may be employed to assist with transitional tasks, such as coordinating a move, on a very limited basis. An example of this is when a CCG is obtaining community transition goods or services to support the community stabilization. Utilizing state funding for these transitional tasks is a last-resort option and may be used only when all other resources have been exhausted. CCG Services are available under the Residential Support Waiver, so authorizing under state funded WA Roads or CTSS RACs should be rarely used.

- For Expanded Community Services (ECS): It is the responsibility of the caseworker along with the ECS Coordinator or designee to determine the appropriate ECS setting; setting determination may not be assigned to a CCG, though after the setting is chosen the CCG can support the client's move to that new community setting. In addition to staffing the case with a supervisor prior to authorizing state funded CCG services, the ECS Coordinator must review and approve of the request. The approval must be documented in a SER.
- For Specialized Behavior Supports (SBS) and Enhanced Residential Services at an Enhanced Services Facility (ESF): In addition to staffing the case with a supervisor prior to authorizing state funded CCG services, the HCS Field Services Administrator (FSA) must review and document approval of the request. The approval must be documented in a SER.
- For more information on the [Residential Support Waiver](#) please review the RSW Chapter in the LTC Manual.

State Funded CTSS/WA Roads services should only be used when:

1. Community Transition Services (CTS), available through Community First Choice (CFC), does not cover all the services or items necessary for an individual to relocate to the community from an approved 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); and the client is not eligible for RCL. Recall that a HQ-approved ETR through CFC CTS may be requested. When necessary, CFC CTS may be used in combination with state funded CTSS or WA Roads.



2. All other options have been tried and the client is at risk of losing their community setting. All CTSS and WA Roads services are provided through state-only funding and should be authorized only when no other services are available to stabilize the community setting. **CTSS or WA Roads services should not be used to supplant services that could be available through COPES or other waivers.**
3. For those individuals eligible for LTSS and are approved for a Non-citizen's eligibility group as outlined in [Chapter 7g](#), State Funded Services available through WA Roads could be approved to assist a client with returning to a community setting. This requires HQ Program Management approval by Emily Watts at emily.watts1@dshs.wa.gov or HQ delegate and may take the place of the Supervisory approval SER required for WA Roads authorization.

To ensure client well-being and cost effectiveness, you must document in CARE:

- How the services or supports are of direct benefit to the participant's successful transition and community living.
- How the authorizations are necessary for the client's health, welfare, safety, and well-being. Ensure services authorized are consistent with needs identified in the CARE assessment.
- If authorizing multiple contracted service providers, documentation is required to ensure that these consultants are not duplicating services.
- When purchasing Goods or Items: the process you followed demonstrates that the Goods/Items are in addition to those supplied by Medicare/Medicaid, and does not replace covered equipment, goods or items.
- If necessary, authorizations for a service/item exceed the maximum amount allowable, you must complete a local ETR prior to authorization.
- For those accessing state funded CTSS or WA Roads services and who are on the Address Confidentiality Program, see [Chapter 3: Assessment and Care Planning](#) for additional information.

Individuals may receive CTSS/WA Roads services in the following settings:

- Any hospital setting or nursing home (to facilitate return to the community)
- The individual's owned or leased home or apartment
- The individual's temporary community living setting, such as a shelter or hotel
- A community-based residential setting (adult family home, assisted living, an [RSW](#) setting etc.)



SERVICES AVAILABLE UNDER WA ROADS INCLUDE:

Behavior Support Services H2019

Behavior Support services are for participants transitioning from institutional to community settings or requiring stabilization while residing in the community in those instances where the authorized Medicaid benefit amount, duration or scope of service does not meet the individual's needs. (Client Training: Behavior Support is available through COPES and RCL. Client Training: Behavior Support should be accessed through those programs for all COPES or RCL eligible individuals; only individuals ineligible for COPES or RCL should receive this service through WA Roads.)

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 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

Environmental Modifications in a residential setting

Environmental Adaptations for Residential (S5165-UB) assists the client in meeting their needs to stay safely in a residential setting and is specified in their care plan. This service allows the client to live in



the least restrictive setting. This service is most frequently used to support a client's relocation of an EWC lift system from one residential setting to another.

Note: All items and services must be identified in the client's plan of care. Document the client's approval for WA Roads in a CARE SER.

SERVICES AVAILABLE UNDER CTSS AND WA ROADS INCLUDE:

Community Choice Guiding (CCG): SA263

Payment for specialty services which provide assistance and support to ensure the eligible client's successful transition to the community and/or maintenance of independent housing as authorized by HCS and/or AAA staff. Please be sure to confirm that the client is unable to access this service through COPES or Roads to Community Living eligibility before offering it using a State Funded Services RAC. CCG services may include, but are not limited to the following:

- Locating and arranging appropriate, accessible housing; including working with local housing authorities and other community resource providers. Assisting with subsidy applications, move-in logistics, and coordinating with other providers to promote housing stability.
- Supporting clients in setting housing goals, identifying preferences, and addressing barriers.
- Set up client's new home such as arranging lease documentation, arranging utility hook-ups or acquiring furnishings and household goods.
- Assist a client with touring Adult Family Homes (AFH) and Assist Living Facilities (ALF) to determine whether this setting is preferred by the client.
- Supporting the establishment of a network 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 any other involved parties.
- Assisting with filling out forms and obtaining needed documentation to aid in the client's successful transition from an institutional setting or stabilization within the community (forms may be related to Public Benefits, housing subsidy, lease agreements, etc.).
- Providing emergent assistance to avoid utility shut-off and/or eviction.
- 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, housing budgeting, Durable Medical Equipment providers and other needs identified in the Plan of Care.



- 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.

NOTE: 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.

- Assisting with locating and arranging transportation resources to effectively connect with community and community resources. An example would be a one-time purchase and reimbursement of a bus pass.

NOTE: Transportation for medical appointments should be provided by existing non-emergency medical transportation benefits if the client is eligible.

- Assisting to find a qualified caregiver. See additional information in [Chapter 7d: COPES](#)

Detailed instructions on how to make a CCG referral, including how to document this service in the CARE Assessment and complete Sustainability Goals and Tasks using Service Codes SA263 and SA266 can be found in the [Chapter 7d: COPES](#) of the LTC Manual. The updated CCG Activity Tracking Form can be found in the resources section of this chapter and in [Chapter 29: Roads to Community Living](#).

Ensure a CCG Tracking Form is available within DMS for the span of the authorization that CCG services are provided.

NOTE: Services such as pest eradication, janitorial services and packing/moving services must be performed by a contracted provider who holds the Community transition and Sustainability Services (CTSS) contract and paid directly via ProviderOne. A CCG cannot be authorized these services.

Community Choice Guiding-Issuing Payment for AT Good: SA266

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.

Based on a client's eligibility:

- The case manager will supply the detailed information for the covered assistive technology 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 assistive technology after it is verified the client received the good. Authorization for the good is under a separate service code and case managers will process the reimbursement(s) for assistive technology 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.

Detailed instructions on how to make a CCG referral including how to document this service in the CARE Assessment and complete Sustainability Goals and Tasks using Service Codes SA263 and SA266 can be found in the [Chapter 7d: COPES](#) of the LTC Manual and on the [CCG Services SharePoint](#). The updated CCG Activity Tracking Form can be found in the resources section of this chapter and in [Chapter 29: Roads to Community Living](#).

Community Transition or Sustainability Goods SA290

One-time purchase of necessary essential goods to provide basic living for a client who is discharging to the community from a hospital or nursing facility and/or needs CTSS or WA Roads stabilization services to maintain community living. Purchasing of items should only be authorized under this code when the authorized Medicaid benefit amount, duration or scope of coverage does not meet the individual's needs. Goods obtained with these funds shall be in addition to any medical equipment and supplies furnished under the State Plan, Medicare, or other insurance. Items may include, but are not limited to:

- Goods necessary to establish a residence such as essential household furnishings.
- Items needed to help stabilize community living for a client.
- To capture this in CARE, select "Community Transition Goods or Items" on the treatments screen and select the appropriate provider type and frequency from the Provider List. (It is recommended that the service goods also be listed in the comments.) Assign to the contracted provider in the Supports table.
- Goods may include:
Furniture, essential furnishings, and basic items essential for basic living outside the institution. For AFH Settings reference [WAC 388-76-10685](#), and for Assisted Living Settings reference [WAC 388-78A-3011](#) which outline resident unit furnishings in these settings. In the event a residential setting indicates they are unable to provide the required furnishings as outlined in WAC, proceed with authorizing the essential furnishings necessary to facilitate the transition, notify the provider of their requirements as outlined in WAC, and also submit a referral to RCS to document the provider's inability to meet residential unit furnishings per WAC.

See *Which Program to Use: Transition and Sustainability Goods and Services* in the [Appendix](#) as a reference guide.

Community Transition or Sustainability Services: SA291

Payment of necessary one-time services to provide basic living for a CTSS or WA Roads eligible client who is discharging to the community from a hospital or nursing facility or needs state funded stabilization services to maintain community living and payment is made directly to the provider through the DSHS payment system. Services include but are not limited to:

- Packing assistance



- Moving assistance
- Utility set up fees or deposits
- Non-recurring health and safety assurances such as pest eradication, allergen control and/or extreme cleaning
- Rental deposits: all pre-tenancy payment requirement, including first month's rent, can be bundled as one deposit and reimbursed to a Community Choice Guide or a DSHS contracted Supportive Housing provider.
- Trial visits to a prospective licensed residential setting.
- To capture this in CARE, select "Community Transition Services" in the Treatments screen and select the appropriate provider type and frequency from the Provider List. (It is recommended that the service type, such as Moving Assistance, be listed in the comments). Assign to the contracted provider in the Supports table.

See **Which Program to Use: Transition and Sustainability Goods and Services** in the [Appendix](#) as a reference guide.

NOTE: Community Transition Services – Items (SA290) 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.

NOTE: A contract is not required if another payment mechanism is utilized.
Options include:

1. Using a client services HCS P-Card (state issued credit card available to HCS HQ staff); or
2. Authorizing a contracted provider to pay for rental deposits and community living set-up fees directly and be reimbursed (such as a CCG or a DSHS contracted Supportive Housing Provider).

Unit compensation to the contracted provider for issuing payment (such as SA266) does not count towards the funding limits associated with service codes SA290 & SA291.

More information regarding the HCS P-Card can be found in the Resources section of this chapter.



Other services available under CTSS and WA Roads:

These codes should only be used when the client is not eligible for the service or item through the medical benefit or another Long-Term Services and Supports (LTSS) program:

- Durable Medical Equipment (See [Blanket code](#) lists)
- [Spec. Medical Equipment Service/Repair: K0739](#)
- [Non-Medical Equipment and Supplies: SA421](#)
- [Assistive Technology \(Non-CFC\): SA075 U2](#)
- [Non-Medical Transportation: T2003](#)

How long may state funded CTSS/WA Roads services be authorized?

Some services, such as Client Training: Behavior Support and Community Choice Guiding, may be authorized for up to three months depending on the client situation. Upon completion of the first three months, an additional three months may be authorized with documented supervisory approval when the client would continue to benefit from the service, and the service is proving effective with progress being demonstrated. Some services are identified as a non-recurring or one time service. Review the service code data sheets for specific information. Once a client's situation has stabilized, it is anticipated that services will discontinue.

HOW DO I AUTHORIZE COMMUNITY TRANSITION OR SUSTAINABILITY SERVICES (CTSS)?

1. Use the [CTSS eligibility criteria](#) listed above to verify eligibility for these state funded services.
2. Prior to any CTSS utilization, you will ensure the need for this state only services are captured in the CARE assessment.
 - a. For state funded goods or services, such as essential household goods or furnishings or pest eradication, select "Community Transition Services" and/or "Community Transition Goods or Items" on the treatments screen and select the appropriate provider type and frequency from the Provider List. (It is recommended that the service type/goods also be listed in the comments.)
3. Add the CTSS RAC (3105) to the client's RAC Eligibility list in CARE.
4. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan.
5. A client can have both the state funded CTSS RAC and a federally matched program RAC such as CFC, COPES or RSW assigned.
6. Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: [Social Services Invoice/Receipt Packet Cover \(DSHS Form 02-615\)](#)
7. Create a PAN outlining one-time CTSS are approved.



Services Add service

Program	Service	Effective date	Action	Previous amo...	New amount	Amount type	Frequency	
Community Transition or Sustainability Services	Community Transition Services	03/11/2025	Approved		1	Each	One-time	

« < 1 > »

Community Transition or Sustainability Services - Community Transition Services (Other) details

Action: Approved Effective date: 03/11/2025 Previous amount: New amount: 1 Amount type: Each

Frequency: One-time Reasons: + Functionally Eligible -

Authority: WAC 388-106-0950;WAC 388-106-0955;WAC 388-106-0960 WACs

HOW DO I AUTHORIZE WA ROADS SERVICES?

Prior to any WA Roads service utilization, you will want to SER Supervisory approval to use these state only funds.

For a resident transitioning from an institution:

1. Use the [WA Roads eligibility criteria](#) listed above to verify eligibility.
2. Note in the Service Episode Record (SER) that the client is eligible for WA Roads transition services and that you have Supervisory approval to authorize state only funds.
3. Have the client or their representative review and sign the DSHS (14-012) Consent form.
4. Add the WA Roads RAC (3120) to the client's RAC Eligibility list in CARE.
5. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan.
 - a) Authorization for emergency rental assistance (SA298) must be approved by both the supervisor and an HCS HQ Housing Specialist prior to utilization.
 - b) The WA Roads Emergency Rental Form must be submitted (see Chapter 6b: Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance) [to access form](#))
 - c) Document both approvals in the SER in CARE.
6. For WA Roads services such as Community Choice Guide, choose "Community Integration" on the Treatments screen in CARE and select the appropriate provider type and frequency from the Provider List. (It is recommended that the Sustainability Goals are completed in CARE and incorporated as part of the WA Roads service referral to the provider.)
7. Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: [Social Services Invoice/Receipt Packet Cover \(DSHS Form 02-615\)](#)



8. Upon discharge, and with the client's consent, follow the procedures outlined in [Chapter 7 of the Long-term Care Manual](#) to enroll the client in the core LTC program for which they are functionally and financially eligible.
 - a) If a client declines waiver/state plan HCBS, follow all procedures in the Long-Term Care Manual to document their decision.
9. Enter the discharge date on the Nursing Facility Case Management screen or the State Hospital screen in CARE. For Acute Care Hospitals, you may enter the Medical Hospital end date under the Short Term Stay screen in CARE.
10. Make a note in the "Additional Information" section on the Case Transfer Form that WA Roads services were used as part of discharge planning.
11. Following all instructions in the [Social Services Authorization Manual \(SSAM\)](#), select the appropriate RAC and authorize on-going services such as personal care for the client.
12. An individual transitioning from an institution using WA Roads is eligible to receive up to six months of WA Roads services post discharge to provide stabilization as necessary, without reevaluating eligibility for WA Roads services.
 - a) A client can have both the WA Roads RAC (which is not an assessment-based RAC) and an assessment-based RAC such as CFC or MPC assigned.
 - b) After six months, an individual who has transitioned to the community from an institution may have access to WA Roads services when they meet other WA Roads eligibility criteria for clients living in the community or living in HCS coordinated subsidized housing.

For HCS clients residing in community settings who are eligible for WA Roads services:

Ensure that CARE clearly documents that all care planning and service resources available through HCBS waiver/state plan have been examined and utilized.

1. Conduct staffing between case manager and supervisor to review and ensure that all aspects of CARE clearly indicate the need and approval for WA Roads.
 - a) Recommended: have a third party review the documentation in CARE prior to authorization of WA Roads services. (This process is to be determined locally. An example might include requesting a Nursing Care Consultant or JRP to review the assessment and/or care plan.)
2. Complete a SER outlining:
 - a) The Supervisor's approval to authorize WA Roads services.
 - b) The service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan.
 - c) The desired outcome of services authorized.
 - d) For members of this eligibility group who return for a brief institutional stay, WA Roads services can be authorized while in the institution, as needed, to facilitate a return to the community.



For more information on how to access Emergency Rental Assistance please see Chapter [6b](#).

3. Add the WA Roads RAC (3120) to the client's RAC Eligibility list in CARE (if there is an authorization, there must be a note in the SER, per instruction above).
 - a) A client can have both the WA Roads RAC (which is not an assessment-based RAC) and an assessment-based RAC such as CFC, COPES, or RSW assigned.
4. If there has been no change in the client's cognition, ADLs, mood/behaviors, or medical condition complete an Interim assessment to document the need for the WA Roads program.
 - a) For WA Roads services such as Community Choice Guide, choose "Community Integration" on the Treatment Screen in CARE and select the appropriate provider type and frequency from the Provider List. (It is recommended that the Sustainability Goals are completed in CARE and incorporated as part of the WA Roads service referral to the provider.)
 - b) For Washington Roads sustainability items or services, such as essential household goods, select "Community Transition Goods or Items" or for furnishings or pest eradication, select "Community Transition Services" in treatments and select the appropriate provider type and frequency from the Provider List. (It is recommended that the service type also be listed in the comments.)
5. All other case management requirements for clients receiving HCLA supports, including quarterly contacts, should be followed.
6. Regarding clients who have received HCS coordinated subsidized housing: The HCS HQ Housing Specialist will send an informational email alerting both the HCS and AAA office when a client in their region/PSA will be moving or has just moved to the community using a housing voucher.
7. Individuals in areas participating in the Steps to Employment (S2E) pilot projects who are interested in receiving employment services will be referred to the HCS Employment Program Manager for service assessment and authorization.

For an individual with a housing voucher/subsidy that has been coordinated through HCS, but who is not currently receiving HCS supports. Please Reference [Chapter 6a-d](#) for additional Housing Resource policy information.



ETR Considerations

Each region will utilize a local ETR process for State Funded CTSS and WA Roads services. HQ ETRs are only used for:

- **Personal Care through other programs:** CTSS or WA Roads services should be explored before requesting additional personal care or increased residential rates for individuals meeting CTSS or WA Roads eligibility criteria.
- **Bathroom Equipment through other programs:** Follow all procedures to request bathroom equipment through the ETR process as outlined in the Social Services Authorization Manual when there are no other resources available (e.g. medical benefit, COPES, etc.). Bathroom Equipment is now generally covered by the medical benefit.
- **Emergency Rental Assistance:** Follow all procedures to request Emergency Rental Assistance as outlined in Chapter 6b: Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance).

WA ROADS GRIEVANCE PROCESS:

Washington Roads (WA Roads) services are discretionary; case managers may identify individuals who are eligible and authorize WA Roads services based on their professional judgment. The grievance process outlined below is offered instead of the Office of Administrative Hearings process, which is available for other types of programs. **A Planned Action Notice should not be sent for WA Roads services.**

The grievance process is as follows:

1. If an individual or his or her representative does not agree with a decision that denied or terminated a WA Roads service,
 - a) the assigned case manager will send a copy of the grievance process notifying the client in writing that he or she may request a review of the decision by following the steps outlined below (use the [form below](#), printed on local letterhead); and
 - b) document in a SER that the client was notified of the denial or termination and was given a copy of the grievance process
2. The individual or their representative may request a review by contacting their social service worker's supervisor. The supervisor will review the decision and respond in writing within ten (10) business days of receipt of the request for review.
3. If the individual or their representative does not agree with the decision of the supervisor, they may request a review by the WA Roads Grievance Workgroup by writing to:



Home and Community Living Administration (HCLA)
Washington Roads Grievance Workgroup
PO Box 45600
Olympia, WA 98504

A review by HCLA's WA Roads Grievance Workgroup will take place within seven business days of receiving the written request for review.

4. The results of this review will be shared with the individual or his or her representative within three (3) business days of the date of the review.

WHAT ABOUT CONTRACTING?

Most client services contracts are executed through the AAA unless other local agreements are in place that state otherwise. All contractors providing CTSS or WA Roads services must have a current contract before providing services.

Services are performed within the scope of practice of the contractor's license and in compliance with professional rules, as defined by law or regulation, and are provided in a manner consistent with protecting and promoting the client's health and welfare, and appropriate to the client's physical and psychological needs.

Note: In addition to specific contracted duties, each provider is responsible for reporting any instances of abuse, neglect, or exploitation of a vulnerable adult or child.

RESOURCES

WA Roads Forms

[WA Roads Grievance Process Notice.pdf](#)
[02-615 Social Services Packet Coversheet.pdf](#)

Goods and Services Program and Service Package Table:

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

Client Services Purchasing Card Process (HCS Only)/ Amazon Purchasing (NFCM Only)

[HCS Purchasing Card.docx](#)
[Desk Aid for Amazon Business.pdf](#)

Community Choice Guide (CCG) Activity Tracking Form

[CCG Activity Tracking Form - Instructions and Samples Rev. 10.2025.pdf](#)

[CCG Activity Tracking Form MONTHLY 10.2025.xlsx](#)

[CCG Activity Tracking Form WEEKLY 10.2025.xlsx](#)

Rules and Policy

WAC [388-106-0950](#)

Community Transition or Sustainability Services

WAC [388-106-0955](#)

Community Transition or Sustainability Eligibility

WAC [388-106-0960](#)

Community Transition or Sustainability Services limits

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
4.2026	Samantha Dunham	• Clarification regarding PACE participants • Clarification that CCG Tracking Forms are to be sent to DMS for imaging • Updated Community Transition Goods and Services reference guide	
11.2025	Amanda Speck	• Removal of Emergency Rental Assistance instructions as this has been delinked from this funding source. • Clarified process for Non-Citizen recipients who may access state funded service packages to support transition to state funded HCBS. • Updated CCG Service Codes descriptions & Tracking forms to be aligned with contract updates.	
7.2025	Julie Cope	• Updated all ALTSA references to reflect Administration name change to HCLA • Updated all DDA references to reflect new divisional name of Developmental Disabilities Community Supports • Added clarification that CCG Services (SA263) are available under RSW, so should rarely be authorized under these state funded service packages. • Removed Emergency Rental Assistance as this service is no longer available under WA Roads.	H25-039
3.2025	Samantha Dunham	• Updated multiple references to updated Housing Chapter. • Included Amazon Business purchasing for Community Transition Goods (NFCM Only) • Updated the CCG Activity Tracking Forms	H25-010

	Desiree Vallejo	Updated PAN example	
10.2024	Julie Cope	- Included hyperlink to Housing Resources Chapter for Emergency Rental Assistance - Included hyperlink to Assessment & Care Planning Chapter for Address Confidentiality Program information.	
7.2024	Julie Cope	- Included hyperlink to COPES chapter for CCG authorization steps - Replaced CTSS PAN screen shot to reflect CARE Web. - Added CCG Activity Tracking form to Resources Section. The form includes the option for providers to submit the form directly to the Imaging Unit via fax.	
12.2023	Julie Cope	- Added P-Card Process and Procedure - Updated DMS Packet Cover form 02-615 - Clarification on SA266 use and CCG reimbursement timeliness - Added description of trial visit - Included non-medical transportation services	H23-090
2.2023	Julie Cope	Removed Emergency Rental Form and referenced Chapter 5b for this document. Strengthened language regarding using WA Roads for Non-Citizens programs.	H23-017
11.2022	Julie Cope	Updated Eligibility to include State Funded Non-Citizens Programs Relocated Housing Resource policy and procedure information to Chapter 5b	H22-064
05.2021	Stephanie VanPelt	Updated HQ purchasing protocols and DMS cover packet form (02-615)	H21-050
2.2020	Jonnie Matson	Emergency Rental Assistance Request Form Updated	
12.2019	Julie Cope	Added one time state funded sustainability supports available under CTSS RAC 3105	H19-066



HCS Subsidies

Chapter 6A outlines the policies and procedures related to the HCS Subsidy, providing guidance on its administration and management. Additionally, it addresses protocols for managing cases where a client no longer receives Long-Term Services and Supports (LTSS) but continues to have an HCS Subsidy. The chapter ensures consistency in case handling and provides steps for transitioning clients appropriately while maintaining compliance with policies.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Jonnie Matson - Rental Assistance Unit Manager - jonnie.matson2@dshs.wa.gov

Or

Samantha Thurston - Housing Integration Unit Manager - samantha.thurston1@dshs.wa.gov

For additional information please visit our website: [Office of Housing and Employment](#) (OHAE)

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BACKGROUND

The HCS Office of Housing and Employment (OHAE) is dedicated to offering housing and supported employment resources that honor client choice. We work to eliminate barriers and expand opportunities that align with an individual's vision for their life regardless of mental health, substance use disorder, race, language, age, ability, or other status.

OHAE brings together federal, state, and local resources to create opportunities and strategies to help clients access independent housing, and in collaboration with our community partners, help build an individualized array of services to support them. This chapter provides specific guidance around the HCS Housing Subsidies and the process to refer HCS clients who are eligible.

Whenever possible, we offer guidance about difficult housing situations you might encounter with your client, including tips about working with clients experiencing homelessness. Affordable housing and tenancy support are complex topics that often do not have easy or quick solutions. Please let us know about other topics or obstacles you would like to see addressed in this chapter.

HCS Housing Subsidy Vouchers

The **HCS Bridge** subsidy program was launched in 2012 as a part of the Roads to Community Living Demonstration program. Bridge rental subsidies are intended to support individuals moving from Skilled Nursing Facilities (SNFs) to community settings.

The **HCS Acute Care Hospital (ACH)** subsidy was launched in 2024 to help transition individuals from an Acute Care Hospital (ACH) setting when housing is a barrier.

The **HCS GOSH** subsidy is available as part of the larger Governor's Opportunity for Supportive Housing (GOSH) program for individuals discharging or diverting from Western State Hospital or Eastern State Hospital. The GOSH subsidy is paired with Supportive Housing services that assist the person with their transition back to the community and remains with the person if they are eligible.

The **Roads to Community Living** short-term rental assistance service is federal funding that comes via the Centers for Medicare and Medicaid Services (CMS) to support transitions out of SNFs. When individuals apply for the Bridge subsidy, this funding is utilized for 6 months of subsidy payments during the individual's RCL enrollment period.

The 1115 Health Related Social Needs short-term rental assistance service is federal funding via CMS to support individuals who are Medicaid eligible with 6 months of subsidy payments. When an individual applies for a Bridge, Acute Care Hospital or GOSH subsidy, they are screened by OHAE PMs for eligibility, and this funding is then utilized in combination with state subsidy dollars.

HCS contracts with the Spokane Housing Authority (SHA) to issue, track, and monitor these subsidy payments throughout all of Washington State to housing providers to help streamline the program.



[Video: HCS Subsidy Training Overview](#)

What is the goal of the HCS subsidies? HCS subsidies provide rental assistance for eligible HCS clients in the form of a monthly rent subsidy that is paid directly to housing providers, like tenant-based Housing Choice Vouchers. The client is responsible for a portion of the rent, paid directly to the landlord, calculated at approximately 30 percent of the household's total income.

HCS subsidies are intended to assist clients in transitioning into affordable housing while they remain on waitlists for permanent, affordable housing.

Where in Washington State are HCS subsidies available?

HCS subsidies are available statewide. The Spokane Housing Authority is contracted to administer the subsidy on behalf of HCS, but clients may live in any area of the state.

What are the basic eligibility standards for HCS subsidies?

There are three eligibility tracks for an HCS subsidy:

1. **HCS Bridge:** Clients exiting from a Skilled Nursing Facility who will transition to the community on In Home services.
2. **HCS Acute Care Hospital:** Clients transitioning from an Acute Care Hospital (ACH) setting when housing is a barrier.
3. **HCS GOSH:** Clients exiting or diverting from Eastern or Western State Hospitals. The HCS GOSH subsidy is a part of the larger GOSH service that includes Supportive Housing services. Please see the GOSH section for more in-depth information on the GOSH service and how to make a referral.

To receive the HCS Bridge, GOSH, or Acute Care Hospital Subsidy an individual must sign the HCS Subsidy Participant Agreement.

What is Global Leasing?

Global Leasing is an option for HCS subsidy recipients. Global Leasing centers on Housing First principles, aiming to quickly lease up referred clients who face high barriers to accessing housing. It braids HCS Long-Term Services & Supports (LTSS) and housing resources with risk mitigation funds as an added layer of security for both landlords and lease holders while offering housing options for clients.

What are Spokane Housing Authority's and HCS's responsibilities in determining eligibility for the HCS subsidy?

Both HCS HPMs and the Spokane Housing Authority play a role in determining eligibility for the HCS subsidy.



HCS Housing Program Managers:

Are responsible for screening and referring eligible HCS subsidy applicants to the Spokane Housing Authority. Individuals that contact the Spokane Housing Authority outside of this process will be directed to HCS Housing Program Managers.

Spokane Housing Authority (SHA):

After receiving initial application packets from HCS, SHA will process subsidy applications and manage the subsidy process statewide for HCS. SHA communicates with landlords for inspections, provides documents needed during the lease-up process, calculates the monthly HCS subsidy amount to be paid to the landlord, and communicates with client.

How do I make a referral for a client who I believe is eligible for an HCS subsidy?

- For **HCS Bridge subsidy referrals**, contact your [Regional Housing Program Manager](#) with the client's name and ACES ID or complete a [Bridge Subsidy Referral SharePoint](#) referral and submit it to your regional HPM. An individual must have been determined both functionally and financially eligible for LTSS through an assessment to receive the HCS subsidy. HPMs will screen your client by looking in CARE to determine setting and eligibility. If clients are financially eligible for HCS services, then they are financially eligible to receive the subsidy. If your client is eligible to apply, the HPM will send you the application.
- For **HCS Acute Care Hospital subsidy referrals**, completely fill out the HCS Subsidy - [Acute Care Hospital Referral SharePoint referral form](#). Once the referral is received, a Regional Program Manager will follow up with the HCS/AAA case manager within 2 business days. If the individual is found eligible for the HCS Acute Care Hospital (ACH) subsidy, the Program Manager will provide the case manager with the subsidy application. **Please note: At the time of the referral submission, the individual needs to have been assessed and determined both functionally and financially eligible and be in an Acute Care Hospital setting.** The HCS/AAA case manager will need to authorize a Community Choice Guide for housing search and transition services for the individual, or if the individual desires ongoing housing supports, a Supportive Housing Provider will need to be authorized.
- For information regarding the **HCS GOSH subsidy**, contact your regional [GOSH Program Manager](#)

What is the documentation required for my client to apply?

The HCS subsidy is a low-barrier application. Below is a list of documentation to include with the application:

- Copy of current state-issued photo ID
- Copy of Social Security card
- If available: copy of current year's Social Security award letter or other first party income verification. If not, HPM can provide an income verification letter for the application.



Please reach out to the HPM if your client does not have the above documentation. Clients should be actively working on obtaining the above documents as they will be needed to apply for units where the subsidy will be used.

How will I know when there are HCS subsidies available?

Based on the funding availability for the HCS Bridge subsidy, Program Managers will announce waitlist openings. This information is also available on the [Housing SharePoint](#).

HCS Acute Care Hospital (ACH) subsidies are limited. Program Managers will announce availabilities. This information is also available on the [Housing SharePoint](#).

HCS GOSH subsidies are regularly available to clients who are accepted in the GOSH program.

Is there a waitlist for HCS subsidies?

Currently, there is a waitlist maintained for HCS Bridge subsidies as they are limited by funding availability. Referrals and applications are only accepted when funding is available. Please check in with your regional HPM for availability.

The HCS Acute Care Hospital (ACH) Subsidy is limited. There is no waitlist.

The HCS GOSH Subsidy is regularly available to clients who are accepted to the GOSH program. There is no waitlist for the HCS GOSH Subsidy.

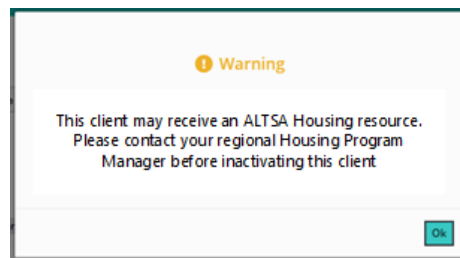
How do I document the HCS subsidy in CARE?

The HCS CM must enter the following into the CARE assessment:

- Add "Housing subsidy (HCS/AAA)" as a Treatment for HCS Bridge and HCS GOSH subsidy recipients.
 - On the Medical Screen in CARE, choose the Program "Housing Subsidy (HCS/AAA)"
 - Check "No" for Received in the Last 14 days?
 - Check "Yes" for Need
 - Choose "Agency" for the Provider
 - Choose "PRN" for Frequency
 - For Comments, type: "Client will be receiving the HCS Housing Subsidy administered by Spokane Housing Authority."
 - Add Spokane Housing Authority as a Paid Provider in the Care Planning section under the Supports Screen and assign the provider the task of "Housing subsidy (HCS/AAA)".

The Housing Subsidy treatment identifies a client who is receiving the HCS rental subsidy. This subsidy is paid for and managed by HCS and should be added when an individual receives the subsidy. This treatment should not be removed at annual or change of circumstances assessments unless approved by a Housing Program Manager.

When "Housing Subsidy (HCS/AAA)" is in the Treatment screen and you go to inactivate a client, you will receive the following pop-up message:



This warning is informational only and it will not prevent the user from inactivating the client. That said, policy is to reach out to your Housing Program Manager prior to closing the client.

Additionally, the CM must:

- Add HCS Housing Program Manager as a collateral contact.
- SERs regarding housing should be entered using *Housing* purpose code.

After transition, the client's file is typically transferred from HCS to the local AAA office. For clients utilizing the HCS Bridge subsidy, the AAA CM will be notified by the HPM that their client is receiving an HCS Bridge subsidy and will be informed on how the subsidy will be maintained. An initial email from the HPM to the AAA CM is sent, introducing themselves as the HCS Bridge subsidy contact. This email will also share information and expectations about working with a client who has an HCS Bridge subsidy. The email will include information on:

- The expectation of supporting the client's tenancy through utilizing Community Transition Services or Foundational Community Supports - Supportive Housing program.
- Assisting the HPM with the annual subsidy recertification process.

What is needed to transfer an HCS subsidy client from HCS to the AAA?

- Please see [Chapter 6D](#) - section "*Pairing Services with Housing Resources section*".
- Clients should transition from institutional settings to independent housing with an open Community Choice Guide authorization for the client's continued utilization as needed once the case is transferred to the AAA. An exception to this would be if a client has been referred to FCS Supportive Housing or GOSH services. However, clients can still access other goods and services through Community Transition Services as needed.

How do CM's assist in maintaining the HCS Subsidy?

- For Bridge recipients, HPMs typically utilize CARE to verify the client is still residing in their unit. However, the HPM may reach out to the CM and may ask for assistance in contacting the client when needed.
- CMs can utilize GOSH Supportive Housing Providers (SHPs) to assist with the recertification for GOSH clients. CMs can also authorize a Community Choice Guide (CCG) or make a referral for



Foundational Community Supports - Supportive Housing Provider to assist Bridge clients with this task.

- HCS Subsidy clients are required to complete an annual recertification to maintain their subsidy. It is a simple packet, mostly requiring client signatures. The process is as follows:
 1. The HPM will send CM recertification documents, along with a cover letter that indicates to the client a return due date.
 2. The CM will send documents to the client and collect them back with signatures.
 3. CM will scan and send the completed documents back to the HPM.
 4. If the CM is unable to connect with the client, the HPM must be informed prior to the due date on the cover letter. HPM may ask that a CCG be authorized to assist with the task.

How are the HCS subsidy payments made?

The HCS subsidy rent payments are made utilizing a process between HCS HQ and Spokane Housing Authority (SHA). ProviderOne is no longer utilized to make rent payments to SHA. Please note: an HCS Subsidy is an LTSS service.

“May a client be absent from the unit for an extended period?”

Yes, a client with a subsidy may be out of the unit and retain the subsidy in the following situations: When a client is absent from their unit for health-related reasons or incarcerated, HCS will pay the subsidy for up to 6 months (180 days).

GOVERNORS OPPORTUNITY FOR SUPPORTIVE HOUSING (GOSH SERVICES)

Supportive Housing (SH) is a philosophy and a program that is rooted in the belief that no one should have to prove “housing readiness” to be housed. The service is an evidence-based practice with decades of research, as well as personal and professional stories, that highlight the success of community living paired with intensive, personalized supports. A person is supported in the process of securing community-based, affordable housing of their choice along with individualized support to assist the person with stabilization and self-identified goals. Harm Reduction, Trauma Informed Care, Motivational Interviewing, Person Centered Planning, and Strengths-Based Approach. Program participation, medication adherence, and abstinence are not required to keep one’s housing.

SH services are available in two ways for HCS recipients:

- Individuals who are currently residing in the community may be eligible for Supportive Housing services under [Healthier Washington Medicaid Transformation](#): Foundational Community Supports (FCS) - Supportive Housing services. For more information about FCS-SH services, see [Chapter 30d](#).
- Individuals who are currently residing at Eastern or Western State Hospital or can be diverted from these institutions may access Supportive Housing Services through the [Governor’s Opportunity for Supportive Housing \(GOSH\)](#) For more information about how Supportive



Housing services can complement other Long-Term Services and Supports or for information on working with Supportive Housing clients who are not currently receiving personal care services, please see [LTC Manual Chapter 30d: Foundational Community Supports: Supportive Housing](#), specifically the ***Supportive Housing and Case Coordination*** section. For more information or materials on HCS Housing resources, please see our website [Office of Housing and Employment](#).

History

In 2016, as part of the Governor's Behavioral Health Innovation Fund, created in [ESSB 6656](#), HCS was awarded a small amount of state funds to pursue Supportive Housing services for individuals eligible for discharge from Eastern or Western State Hospitals. The original budget allowed for approximately 15 individuals to transition out of the state hospitals with Supportive Housing services with the option of a state-funded housing subsidy. HCS began contracting directly with community Supportive Housing Providers and the Governor's Opportunity for Supportive Housing (GOSH) was born. In the 2017-2019 enacted budget, funding for GOSH was expanded and HCS was authorized to hire 3 FTEs dedicated to GOSH Program Management across the state. The HCS State Hospital Discharge and Diversion (SHDD) unit was also created. While GOSH pre-dates SHDD, it is one part of this larger initiative that has been approved by the state legislature under Mental Health Transformation.

Eligibility

The GOSH service is available for individuals who choose In-Home setting and:

- are willing to work with a Supportive Housing Provider, and
- qualify for HCS services (financially & functionally eligible), and
- are discharging or being diverted from Eastern or Western State Hospitals,
 - HCS clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by SHDD team, and LTCS has not terminated during the period and wishes to live independently.
 - Individuals eligible for HCS currently in an IBHTF/RTF setting and **discharging in the next 90 days** who discharged to the facility from ESH/WSH or a GOSH eligible setting in the past 18 months and wish to live independently.
- Diversion is defined as: An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order.
- If you have a diversion client who is discharged from the hospital immediately after an assessment was completed a referral can be made 30 days post discharge.

Please note, acceptance into the GOSH program is contingent on provider capacity and discretion.



Note: An HCS client who is discharging or diverting from Eastern or Western State Hospital who already has an apartment or other independent housing in the community can still be referred to GOSH for transition support and intensive, ongoing tenancy support services to help maintain their housing.

Presumptive Eligibility

Through the Medicaid Transformation Project 2.0, Long-Term Services & Supports (LTSS) Presumptive Eligibility (PE) is an opportunity for individuals to quickly access an abbreviated benefit package of services while full functional and financial eligibility are being determined. One service included in the Presumptive Eligibility NFLOC package is Supportive Housing.

- Where does Presumptive Eligibility and GOSH Overlap?
 - Phase 1 of Presumptive Eligibility is for HCS clients who are discharging or diverting from an acute care hospital and/or a psychiatric hospital, and have an ITA hold in this setting, are eligible for GOSH. For additional information about Presumptive Eligibility, see chapter 30e.

“Does a person experiencing homelessness qualify for Presumptive Eligibility?”

GOSH clients are eligible to utilize the Motel for Interim Stay Transitions (MIST) program. MIST can be authorized for up to 6 months. If the HCS client qualifies for Presumptive Eligibility, and desires GOSH, and has no safe place to stay or resources to pay for a place, the HCS/AAA case manager can utilize MIST. When a GOSH recipients are paired with MIST, they are not considered homeless and can then access the PE benefits.

GOSH Referral Process

1. Obtain confirmation that the client would like to be referred for Supportive Housing (SH) services and additional information needed for GOSH Referral Form. Please note, there is no participation for Supportive Housing.

Note: For more information on HCS assessment and transitions for those currently residing in the state psychiatric hospitals, please see [LTC Manual Chapter 9](#).

2. Completely fill out [DSHS Form 11-153](#), “Governor’s Opportunity for Supportive Housing (GOSH) Referral” and email GOSH@dshs.wa.gov



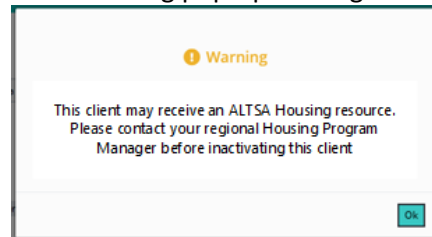
The email must include all additional required documents as attachments, as outlined on the GOSH Referral. Please note:

- a. For referrals meeting diversion criteria to be verified, CMs must include a copy of the court commitment paperwork, signed by a judge or commissioner, which documents that:
 - i. the client is on a 90- or 180-day commitment order for further involuntary treatment, or
 - ii. the client is on a civil commitment detainment under the Involuntary Treatment Act (this includes 120-hour, 14-day, 90-day or Revoked 90/180 LRA orders).
- b. Commitment orders must be verified and uploaded to DMS by Primary CM. State Hospital screen needs to be updated.
 - i. If a client meets diversion criteria and is being case managed by an Area Agency on Aging (AAA), the AAA CM may refer the client for GOSH.
3. As of the March 31, 2023 CARE Release, GOSH is on the State Hospital/Hospital/E&T screen in CARE. When you are entering a client's most recent psychiatric hospital stay, you now will be prompted to enter if a GOSH referral was made, the referral date and whether they were approved for GOSH. If you select "no" for "Was GOSH referral made?" there will be no further questions.
4. If a client is eligible for GOSH, the SHPM will make a direct referral to the HCS contracted Supportive Housing Provider (SHP) and complete a Service Episode Record (SER) with their actions. The SHP has two business days to respond to the SHPM.
5. If a client is not eligible for GOSH, the SHPM will inform the referring CM by email and enter a SER with this information.

GOSH Client Accepted

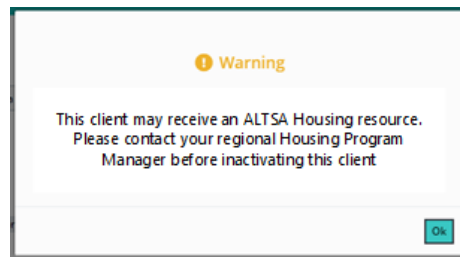
1. Once the referral has been accepted by the SHP:
 - a. The SHPM will communicate this through a secure email to CM, additional care team (discharge social worker, MCO liaison, Peer Bridger, Outpatient Behavioral Health Provider, etc.) and the SHP. The SHPM will update their section of [DSHS Form 11-153](#) and include the complete referral form as an attachment in their email.
 - b. The referring CM will submit the GOSH Referral to DMS.
 - c. The CM will open RAC 3131 – LTSS Housing Stabilization and then the pre-tenancy Supportive Housing service code, SA299-U1, to open the SH authorization in CARE. The CM will document these actions in a SER.
 - i. RAC 3131 is the RAC the SH service code is tied to.
 - ii. It is the case manager's responsibility to open, extend and close authorizations for service code SA299, U1.
 - iii. It is the CM's responsibility to complete the remaining steps for authorization of services, as outlined in [LTC Chapter 3](#), including complete electronic form [DSHS 14-443](#) in Barcode.
 - d. The case manager will create and send the client a Planned Action Notice (PAN) informing them that SH services are approved.
2. Once client is authorized for Supportive Housing, the CM must:
 - a. Add Supportive Housing Provider to Collateral Contacts screen
 - b. Add "Supportive Housing" as a Treatment
 - i. On the Medical Screen in CARE, choose the Program "Supportive Housing (HCS/AAA)"
 - ii. Check "No" for Received in the Last 14 days?

- iii. Check “Yes” for Need
- iv. Choose “Agency” for the Provider
- v. Choose “PRN” for Frequency
- vi. For Comments, type: *“Client has been referred to the Governor’s Opportunity for Supportive Housing (GOSH) service. [Enter name of Supportive Housing Provider] to assist with pre-tenancy search for affordable housing or transition back to their apartment, assist with community integration, and to provide ongoing intensive tenancy support services.”*
- vii. The Supportive Housing treatment identifies a client who is receiving Supportive Housing services through the Governor’s Opportunity for Supportive Housing (GOSH) or Foundational Community Supports - Supportive Housing. This treatment should not be removed at annual or change of circumstances assessments unless approved by a Housing Program Manager.
- viii. When “Supportive Housing (HCS/AAA)” is in the Treatment screen and you go to inactivate a client, you will receive the following pop-up message:



This warning is informational only and it will not prevent the user from inactivating the client. That said, policy is to reach out to your Housing Program Manager prior to closing the client.

- c. If client is receiving the GOSH Subsidy, add “Housing Subsidy (HCS/AAA)” as a Treatment
 - i. On the Medical Screen in CARE, choose the Program “Housing Subsidy (HCS/AAA)”
 - ii. Check “No” for Received in the Last 14 days?
 - iii. Check “Yes” for Need
 - iv. Choose “Agency” for the Provider
 - v. Choose “PRN” for Frequency
 - vi. For Comments, type: *“Client will be receiving the HCS Housing Subsidy administered by Spokane Housing Authority.”* The Housing Subsidy treatment identifies a client who is receiving the HCS rental subsidy. This subsidy is paid for and managed by HCS and should be added when an individual receives the subsidy. This treatment should not be removed at annual or change of circumstances assessments unless approved by a Housing Program Manager.
 - vii. When “Housing Subsidy (HCS/AAA)” is in the Treatment screen and you go to inactivate a client, you will receive the following pop-up message:



- viii. This warning is informational only and it will not prevent the user from inactivating the client. That said, policy is to reach out to your Housing Program Manager prior to closing the client.
- d. Add “Other” for Community Supports under Treatments
 - i. On the Medical Screen in CARE, choose the Program “Other”
 - ii. Check “No” for Received in Last 14 days?
 - iii. Check “Yes” for Need
 - iv. Choose “Agency” for Provider
 - v. Choose “PRN” for Frequency
 - vi. For Comments, type: *“Community transition items and services as identified to assist with the client’s return to independent living.”*
- e. Add the Supportive Housing Provider as a Paid Provider in the Care Planning section under the Supports Screen and assign the provider the task of “Supportive Housing (HCS/AAA)” and “Other” (for Community Transition Services)
- f. If the client is receiving the GOSH Subsidy, add Spokane Housing Authority as a Paid Provider in the Care Planning section under the Supports Screen and assign the task of “Housing Subsidy (HCS/AAA)”
- g. Please note, per Case Management policy, a task must be assigned to a Paid Provider to move an assessment to Current. You do not need to assign all paid tasks specifically to a paid care provider in order to move an assessment to Current. For GOSH clients who only have Supportive Housing services at the time of the assessment, adding the Supportive Housing Provider as a Paid Provider and assigning the provider the paid task of “Supportive Housing (HCS/AAA)” will suffice to move the assessment to Current. Do not assign the Supportive Housing Provider caregiving tasks.
- h. Use the Purpose Code “Housing” for any SERs related to GOSH services or subsidy.
- i. If there are any issues or concerns regarding a GOSH client, including eligibility concerns, protocol is for the case manager to staff with SHPM. Do not close a GOSH client prior to staffing with a SHPM.

Note: DSHS contracts directly with GOSH SHPs and the scope of work is spelled out in the contract. Therefore, SHPMs and CMs do not fill out the Sustainability Goals screen in CARE for SHPs.

GOSH Discharge Planning

1. Once Supportive Housing Provider (SHP) accepts the client, they start working with the client on:



- a. Paperwork – running a background check, Housing Assessment form, GOSH subsidy, rental applications, etc.
 - b. Documentation – in partnership with the discharge workers, ensuring the client has a current ID or someone is working with the client on obtaining a current ID, Social Security card, income verification letters, etc.
 - c. Independent housing search – the SHP does not conduct residential searches.
 - d. Determining what items the client has or can access through community resources and items the SHP might request CM to authorize through the appropriate Community Transition services (e.g., furniture, household items, phone).
 - e. Discussion around all services the client needs in the community – these conversations should be ongoing with the client and the care team.
2. Best practice is for the SHP to provide weekly email updates to the care team (CM, ~~SHPM~~, discharge social worker, MCO liaison, Peer Bridger, Outpatient Behavioral Health Provider, AAA as applicable, etc.).
 - a. If you are not hearing from the SHP, reach out to the provider directly to request client updates.
 - b. If you have ongoing communication challenges with the SHP that you are not able to work out directly, elevate to the SHPM for support.
 3. Multidisciplinary meetings will determine which agency/provider will address service referrals pending community transition.
 - a. If need for additional staffing or more support needed from multidisciplinary team, CM can consider reaching out to Regional Transition Coordinator to add client to the appropriate Cross Systems committee staffing.
 4. Any situation where a client is at risk of losing eligibility for LTSS should be staffed with the SHPM. See green box below.
 5. Do not close a GOSH client without staffing with SHPM. This can be done 1:1 with SHPM or the client can be brought to the Housing Supports Case Staffing meeting. For more information please see [chapter 6d](#).

Note: When an HCS client is already enrolled in a housing service (GOSH, MIST, housing voucher) and any type of assessment (Initial, Annual, Interim, or Significant Change) is conducted with the client, and there is a possibility client is no longer functionally eligible for LTSS, HCS/AAA CM will review the assessment with the client prior to scheduling a staffing with SHPM, and before moving the assessment to current/history. A SER note is required for the assessment review with the client.

Once discharge date has been set:

Best practice for is the CM or SHP schedule a discharge planning conference meeting approximately 7-10 days in advance of a discharge. The timeline might be shorter for clients discharging from an Evaluation and Treatment Facility or inpatient from an acute care hospital.

1. Meeting should include:
 - a. HCS CM, Public Benefits Specialist, Discharge SW, SHP, receiving AAA or HCS CM (if transitioning to Interim Setting), MCO Liaison, Outpatient Behavioral Health Team, Peer Bridger, Caregiving Agency supervisor (if known), client and any support individuals.
2. Discharge Planning Call should cover:



- a. Discharge logistics (e.g., transportation, personal items of client, medications – how much will they discharge with, what prescriptions, etc., what pharmacy, any cash that client received while working or “gate” money, confirmation they have a copy of their ID and Social Security card, etc.).
- b. Overview of the state of the apartment (furniture, food, household items, etc.).
- c. Overview of appointments for the first week and discussion on who will be assisting in transportation.
- d. Discussion on what “after care” services the client will have once discharged and what additional supports or services need to be authorized and by whom.
- e. Financial logistics (will food stamps be turned on, what cash benefits will client receive, who will coordinate taking client to DSHS or Social Security Administration office, etc.).

“Does GOSH services end if client cannot return to their previous residential setting & is admitted to the hospital?” No, if the GOSH client cannot return to their previous residential setting, the residential case manager will transfer the case immediately to an HCS hospital case manager. See [Chapter 9](#) for additional information.

GOSH Interim Setting Process

HCS’S GOSH program supports in-home transitions for those discharging/diverting from Eastern or Western State Hospital by connecting them with a Supportive Housing Provider (SHP). The SHP works to transition clients to an independent apartment in the client’s community of choice with supports. Apartments are not always secured before discharge occurs. Rather than delaying discharge, and when a client is in agreement, an interim setting may be sought while a client is waiting for housing to be secured.

To ensure there are no interruptions to Supportive Housing services or the independent housing search, any transitions in case management or the service team should include the HCS Supportive Housing Program Manager (SHPM) and Supportive Housing Provider (SHP) in communication and coordination. The Housing Team encourages discharge planning calls in advance of any transitions to an interim setting.

Please note: the role of the SHP is to search for independent housing. If a residential setting is being pursued as an interim setting and the CM is unable to conduct this search directly, they can look into the authorization of a Community Choice Guide (CCG) to search for and secure a residential setting for the client. The CCG should not also conduct a search for independent housing, as this would be a duplication of services with the SHP. The SHP’s independent housing search does not cease during this period unless the participant no longer wishes to live independently or participate in GOSH.

Options on when to use the Interim Setting process

1. An individual has been deemed ready to discharge prior to independent housing being secured and all parties agree that a continued stay is not in the individual's best interest.
2. The individual requests an interim setting and all parties agree it is a safe, viable discharge plan while waiting for independent housing.
3. An individual is diversion eligible and ready for/must discharge from their current setting.

When not to use the Interim Setting process

1. To explore a participant's "housing readiness."
2. An individual has been approved for independent housing, but the move-in date has delayed discharge. For example, repairs need to be made on the unit, so the move-in date is four weeks out. In this instance, every effort should be made to have the person wait in the State Hospital or diversion facility to avoid the extra move.

Procedures

1. HCS Case Managers search for interim housing options that are willing to accept clients in an interim status as they wait for independent housing through GOSH. It is important to locate an interim housing option in the county where the participant intends to reside permanently as this will aid the housing process. If an interim housing option is not available in the county the participant intends to reside in permanently, speak with your SHPM.
2. Once an interim housing option has been identified, the HCS/AAA Case Manager will speak with the client and/or their authorized representative and explain the temporary nature of the interim housing option while the client is still working with their SHP on securing independent housing. The HCS/AAA Case Manager will get verbal confirmation from the client that they understand and agree with this plan.
3. If an HCS residential setting is being utilized as an interim housing option, the HCS/AAA Case Manager will speak with the owner/operator/manager of the residential setting and explain that the client will reside there while they pursue independent housing. The HCS/AAA Case Manager will get verbal confirmation from the owner/operator/manager that they understand the client will be working with their SHP to find independent housing and that once independent housing is found, the client will be moving out of this setting.
4. For interim housing options that are not HCS residential settings, prior to transition, the HCS/AAA Case Manager will speak with the appropriate representative to inform them that the client is working with a SHP on securing independent housing.
5. Regardless of interim housing option, prior to transition, the HCS/AAA Case Manager will notify the SHP of the contact information for the appropriate representative of the interim housing.

An Interim Housing Option is considered anything outside of a client's own apartment/house. Examples include: HCS residential setting, Transitional Housing, motels, family/friends, etc.



6. After completing items 1-5, HCS/AAA Case Manager must enter the following SER:

"The writer has spoken with this client and/or their authorized representative and explained the temporary nature of the interim option and they understand and agree with this plan.

The writer has spoken with the owner/operator/manager of [*enter facility name*] and explained that the client will reside at this facility as an interim setting as they pursue independent housing and understand that this is temporary.

Appropriate representative of the interim housing understands client will be working with Supportive Housing team to find independent housing. Provider also understands that once independent housing is found, client will be moving out of this setting.

I have notified the SHP the contact information for the appropriate representative of the interim housing."

7. Depending on the type of facility selected as the interim setting, the following will take place:

- a. **Adult Family Home (AFH):** If both client and home approve of the placement, HCS Case Manager will transfer the case to the local HCS office and communicate that the client is on GOSH and working with a SHP.
- b. **All Interim Settings that are not licensed should be considered "In-Home":** HCS Case Manager should authorize needed Long-Term Services and Supports while the client is staying in the interim setting. HCS Case Manager should approach the local AAA office to determine if they are willing to accept the case. If AAA office declines, the local HCS office should hold the case. Transferring HCS Case Manager should communicate that the client is on GOSH and working with a SHP.
- c. **Regardless of Interim Setting:**
 - HCS or AAA CM keeps the case open. SHP will work with HCS/AAA Case Manager for authorization around Community Transition and Sustainability Services.
 - SHP should schedule time with interim setting staff working with the client (if applicable) and new HCS/AAA Case Manager to clarify roles and responsibilities and provide housing search updates.
 - SHP should include new HCS/AAA Case Manager in regular updates regarding housing search. Interim setting staff should be included as appropriate (if applicable).
 - If a client is re-hospitalized or jailed, they are not automatically exited from their GOSH services or subsidy. GOSH is a state-funded service and, as noted in Chapter 3, page 3.26, state-only exceptions exist for paying for services when a client is institutionalized. Supportive Housing

Providers continue to provide support services to clients through short-term hospitalizations or jail stays. Service authorizations are to remain open and clients active, as Supportive Housing Providers continue to work with the clients and the GOSH subsidy continues to be provided.

- If you are made aware that a participant is in jail – staff case with the GOSH Program Manager. If a participant faces multiple court hearings, hold the case until final decision of the court is carried out. During this time, HCS/AAA CM, GOSH Provider and GOSH PM will have regular staffing meetings. GOSH program and HCS/AAA will still hold case on their case load. GOSH authorization remains active and the GOSH Provider is billing during this time.
- If you are made aware that a participant is institutionalized – keep case open, regular staffing will occur between HCS/AAA CM and GOSH Provider. GOSH Provider will follow up with hospital/institution regarding the status of the client and provide updates to HCS/AAA CM. GOSH authorization remains active and the GOSH Provider is billing during this time.
- If you have any questions or concerns, reach out to your Regional SHPM. Do not close a GOSH client prior to staffing with a SHPM.

Transition to Independent Living

Once the client has moved into their own apartment:

- a. The case manager will ensure RAC 3131 – LTSS Housing Stabilization’s end date matches the CARE Plan end date.
- b. The case manager will close pre-tenancy service code SA299, U1, and open tenancy service code H0044.
 - i. Please note, the date when the tenancy service code, H0044, is opened will vary based on the terms of the SHP’s contract:
 1. The tenancy service code may start the first full day in independent housing, OR
 2. The tenancy service code may start after a 90-day transition period in independent housing.
 - ii. It is the responsibility of the case manager to close the authorization for SA299, U1 and open an authorization for H0044.
- c. The case manager will document these actions in a SER.
- d. The case manager will update the tenancy service code, H0044, on an annual basis. If there are any concerns around client eligibility, staff with the SHPM.
- e. If the case has not yet been transferred to the local Area Agency on Aging (AAA), it is best practice to have a meeting between the HCS CM, assigned AAA CM and GOSH Provider. If it is not feasible to have this meeting, the HCS CM should let the GOSH Provider know they are transferring the case and the assigned AAA CM should reach out to the GOSH Provider to let them know they are now case managing the case.

- f. The SHP continues to provide intensive tenancy support services and work with the care team for cross-system collaboration.
- g. At the time of Annual Assessment, the assigned HCS/AAA CM should reach out to the GOSH Provider as a collateral contact. The GOSH Provider provides an array of support to a client and the CM should speak with them about the services they are providing the client as part of the assessment process.
- h. SHPM remains available for any support needs.
- i. If a client is re-hospitalized or jailed, they are not automatically exited from their GOSH services or subsidy. GOSH is a state-funded service and, as noted in [Chapter 3](#), state-only exceptions exist for paying for services when a client is institutionalized. Supportive Housing Providers continue to provide support services to clients through short-term hospitalizations or jail stays. Service authorizations are to remain open and clients active, as Supportive Housing Providers continue to work with the clients and the GOSH subsidy continues to be provided.
 - i. If you are made aware that a participant is in jail, staff case with the GOSH Program Manager. If a participant faces multiple court hearings, hold the case until final decision of the court is carried out. During this time HCS/AAA CM, GOSH Provider and GOSH PM will have regular staffing meetings. GOSH program and HCS/AAA will still hold case on their case load. GOSH authorization remains active and the GOSH Provider is billing during this time.
 - ii. If you are made aware that a participant is institutionalized, keep case open, regular staffing will occur between HCS/AAA CM and GOSH Provider. GOSH Provider will follow up with hospital/institution regarding the status of the client and provide updates to HCS/AAA CM. GOSH authorization remains active and the GOSH Provider is billing during this time.
 - iii. If you have any questions or concerns, reach out to your Regional SHPM. Do not close a GOSH client prior to staffing with a SHPM.
 - iv. See [chapter 6d](#) for guidelines when a client is exiting services, but has an HCS Subsidy.

When performing a CARE assessment for a GOSH client, consider the following:

1. Ask the client who they would like to attend the assessment appointment with them. Offer suggestions for who may be helpful in providing useful information (family, friends, Supportive Housing Provider, etc.).
2. Gather information from the client's legal representative or substitute decision-maker, as appropriate.
3. Gather other information from collateral contacts if it is needed to complete the client's assessment. See [Chapter 3](#).

❖ What if a client is receiving a housing service, but declining personal care? (See chapter 6d- Housing & Service Coordination) for guidance.



GOSH Planned Action Notice (PAN)

The assigned case manager is responsible for issuing a Planned Action Notice (PAN) for all GOSH services, including approvals, terminations, and withdrawals. This will create one single notice for the client to receive. Please see [Chapter 27](#) for additional guidelines about Planned Action Notices.

The supportive housing WAC chapter starts at WAC 388-106-1700 with definitions and goes through WAC 388-106-1765. The most used WAC references for PANs have been:

- WAC 388-106-1720 - Am I eligible for supportive housing funded services?
- WAC 388-106-1730 - How do I remain eligible for Supportive Housing?
- WAC 388-106-1750 - Are there limits to the supportive housing services I receive?
- WAC 388-106-1765 - When may the department terminate or deny supportive housing services?

GOSH State Subsidy

The HCS GOSH Subsidy is a state funded housing subsidy that is available for individuals discharging or diverting from Western State Hospital or Eastern State Hospital. The subsidy is paired with Supportive Housing services that assist with transition and follow the person in the community to support housing stabilization over the long term. For more information on the HCS GOSH Subsidy, please see [6.3](#)

Reimbursements

DSHS contracts directly with GOSH SHPs. While GOSH SHPs are reimbursed for Supportive Housing services, there are no set aside monies tied to GOSH for goods. GOSH is a Long-Term Service and Support that funds Supportive Housing services and a housing subsidy. In order to support the GOSH participant's transition and sustainability in independent housing, CMs should utilize [Community Transition Services](#) or [Housing & Employment Stabilization Services](#) dependent upon participant eligibility. With prior approval from the AAA/HCS CM or SHPM, the SHP is reimbursed by the CM for the authorized purchases after it is verified that the individual received the goods. If a CM has questions or concerns about a SHP's invoice or receipt, the CM should communicate these concerns directly with the SHP. If there are repeated concerns, after attempts have been made by the CM to clarify, reach out to your Regional SHPM.

1. Based on an individual's eligibility, the following services could be reimbursed to the SHP: tenant background screening to aid housing search, paying for rental deposit and first month's rent, utility hookup fees, purchase of furniture, purchase of essential items including needed clothing, and emergency rental assistance, etc.
2. For more information regarding Community Transition Services including eligible goods/services, appropriate RACs and service codes to reimburse purchases, please review the CTS section in the LTC Manual [Chapter 9](#).
 - a. For HCS clients who have received a housing subsidy or had their housing coordinated through HCS **and** are only eligible for state funding, the HCS/AAA case manager will authorize the goods & services under RAC 3131- LTSS Housing Stabilization.
 - b. Use Service Code SA294,U4 to authorize the necessary goods and services Please note, an ETR will be required if the total amount of goods & services exceeds \$5000.



- c. Select the appropriate reason code. Options are “In-Home Community Stabilization or Employment Stabilization”
- d. When submitting an ETR, select “other” for both ETR/ETP category & type.
- e. Submit the ETR for approval/denial to “Committee, Housing ETR”
- f. Note in the Service Episode Record (SER) that the client is eligible for LTSS Housing Stabilization services and that you have Supervisory approval to authorize state only funds.
- g. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client’s service plan.
- h. Receipts or/and invoices for all purchases must be included in the participant’s electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615)

Note: When an HCS client is enrolled in Supported Employment, RAC 3131- LTSS Housing Stabilization Service Code SA294,U4, can be utilized to assist the client in obtaining or/and maintaining employment. This is a one-time expense to get identification card, food handlers’ card, interview clothes, and first set of uniforms to begin work. This is not limited to once in a lifetime but once per occurrence. See [Chapter 30c](#).

How is this funded?

Governor’s Opportunity for Supportive Housing is one part in the larger State Hospital Discharge and Diversion (SHDD) initiative that has been approved by the state legislature under Behavioral Health Transformation. These services and subsidies are funded 100% through state dollars. Utilizing state dollars only allows for greater flexibility than programs also receiving federal funding. If you have policy questions on working with GOSH participants, please contact your GOSH Program Manager.

Note: There is no participation required for GOSH services.

Can a DDA services recipient receive GOSH services?

An individual receiving DDA services who is transitioning out of or diverting from Eastern or Western State Hospital, meets all other eligibility criteria, and can exit the hospital on an HCS program is eligible for GOSH. An individual receiving DDA services who is already residing in the community is not eligible for GOSH Supportive Housing.

What about contracting?

Governor’s Opportunity for Supportive Housing contracts are executed and held at HCS headquarters. All contractors providing Governor’s Opportunity for Supportive Housing services must have a current contract for waiver or RCL/LTSS Housing Stabilization individual services before providing services. Services are performed within the scope of practice of the contractor’s license and in compliance with professional rules, as defined by law or regulation, and are provided in a manner consistent with protecting and promoting the individual’s health and welfare, and appropriate to the individual’s physical and psychological needs.



If you know of an agency that is interested in contracting for GOSH, please refer them to the [GOSH Provider Passport](#) for more information.

Note: In addition to specific contracted duties, each provider is responsible for reporting any instances of abuse, neglect, or exploitation of a vulnerable adult or child.

Working with an individual who is found ineligible for LTSS. Please see more information regarding exiting HCS subsidy holders in [Chapter 6d](#).

1. Assign the LTSS Housing Stabilization RAC (3131) and move the assessment to History, but do not inactivate the case; you will still be able to authorize Housing & Employment Stabilization services should they be needed as long as the LTSS-Housing Stabilization RAC is assigned.
 - a. Per LTC Manual [Chapter 27](#): “When an Annual or Significant Change CARE assessment results in a decrease in residential rate, in-home units or other service, or a termination of a service, the department must provide clients at least 10days’ notice prior to implementing the reduction or termination.”
 - i. Per policy, the CM should send a termination PAN for LTSS per current protocols (being 10 days before the current plan period).
 - ii. Add the option of “Other” to the PAN (in CARE) and, dependent on circumstances, enter:
 1. If a GOSH client, on the LTSS termination PAN, include this language:
 - a. “Supportive Housing services via GOSH will continue for 90 days. GOSH services will end (xx/xx/xxxx).”
 - b. Please note, the Case Manager is the one to send the GOSH services termination PAN.
 - c. The Case Manager will extend RAC 3131 and the Supportive Housing authorization for the 90-day period.
 2. If the client is a Bridge or ACH subsidy holder, include this language in the PAN under “other” reasons:
 - a. “Your Long-Term Services and Supports are being terminated, therefore your housing subsidy/rent assistance will also be terminated at the end of your current lease, or earlier if you choose.”
 - b. The Housing Program Manager will inform the case manager of the subsidy termination date, and this information can be included in the termination PAN under “other” reasons.
 - b. The HCS/AAA case manager should hold the case for 90 days.
 - c. If there is a determination that the individual needs and wants LTSS within the 90-day period, the HCS/AAA case manager should contact the HCS office for an Initial/Reapply assessment. Once the Initial/Reapply assessment is complete, the case is transferred back to the AAA.



- d. If there is no determination that the individual's needs and wants LTSS within the 90-day period, after a conversation with the Housing Program Manager, the HCS/AAA case manager may inactivate the case.
 - i. For GOSH clients, at this time, the Case Manager will end the GOSH authorization and end RAC 3131 - LTSS Housing Stabilization.
 - ii. The Case Manager will send the GOSH services PAN.

RESOURCES

[Housing Team Contacts](#)

[Office of Housing and Employment SharePoint](#)

[HCS Housing Resources](#)

[LTSS One-Pager](#)

[Global Leasing One-Pager](#)

[GOSH Interim Setting One-Pager](#)

[GOSH Provider Passport](#)

[Civil Transitions Program One-Pager](#)

[Governor's Opportunity for Supportive Housing \(GOSH\) GOSH-SH-One-Pager](#)

[Presumptive Eligibility Supportive Housing](#)

[Zero Income One-Pager](#)

[Income Discrimination Flyer Tenants: Legal Protection from Source of Income Discrimination](#)

[HCS Bridge Subsidy Brochure](#)

Video: [Options for Housing Through Long-Term Care Services](#)

RAC 3132: Health Related Social Needs - Federal

Motel Interim Stays for Transitions (MIST) SA294u1

Motel Interim Stays for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period. Federal MIST is funded via the 1115 waiver in which the Washington State Health Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. This includes temporary housing.

Who is eligible for federal MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: HCS Subsidy (Bridge or Acute Care Hospital) - Bridge Subsidy: HCS clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. Client must be required to leave their SNF for non-medical reasons; Bridge clients cannot choose to leave their SNF in order to utilize a MIST funded hotel. - Acute Hospital Care (ACH) Subsidy: HCS clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. GOSH Program: HCS clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. Other Housing Resource: - HCS clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VASH, etc. - HCS clients who have been approved for a project-based resource <u>and</u> have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. In-Home Short-Term Displacement: HCS clients who have their own home <u>and</u> a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding. Experiencing Homelessness: HCS clients experiencing homelessness, at risk of homelessness or fleeing domestic violence or other unsafe situations. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u1?	Payment for up to 6-month period for a Medicaid HCS client to stay at a motel/hotel.
What is not covered under MIST 294u1?	- Deposits - Damages (Please see RAC 3131 SA294,U2)
How much can I spend?	- Up to \$5,000 per month for a total of six months. - Note: not to exceed six months
Do I need to use a Community Choice Guide (CCG) or GOSH provider?	Yes. The HCS/AAA CM will need to coordinate with the CCG or GOSH provider and notify them that the client has been authorized for Motel Interim Stays for Transitions for a period of up to 6 months.

	- The Contracted Provider should be authorized for the duration of the MIST authorization period. - The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. - The CCG or GOSH provider can make payments, or Spokane Housing Authority can be authorized to make payments.
How do I authorize federal MIST payments?	- Upon receiving approval for MIST, the HCS/AAA CM will receive an approval email with specific instructions. should open RAC 3132. - For instructions on how to authorize MIST payments, please see the MIST Authorization Desk Guide. - If you are using Spokane Housing Authority to make the MIST payments, please see the MIST Guide for Spokane Housing Authority Payments.
When do I authorize this service?	MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for federal MIST?	No. When the approved MIST amount is above \$2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially. Federal Emergency Rental Assistance is funded via the 1115 waiver, in which the Washington State Health Related Social Needs (HRSN) Services Program will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. These includes rent.	
Who is eligible for federal ERA?	An HCS or AAA client who is experiencing or at risk of experiencing homelessness, including facing immediate eviction due to non-payment of rent.
What is covered under federal ERA?	- A one-time payment made directly to landlords on behalf of an HCS or AAA client who is facing an immediate eviction due to non-payment of rent. - Late fees can be included.

What is not covered under federal ERA?	1. ERA does not include pre-tenancy deposits or move-in costs. 2. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent. 3. Any fees other than late fees.
How do I make payment?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide, GOSH Supportive Housing Provider, or Spokane Housing Authority) to make the ERA payment on the client's behalf.
How do I authorize federal ERA	1. Use RAC 3132. 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Housing Program Manager.
Are ETRs allowed for the federal ERA?	No. 1. Note: When the approved ERA amount is above \$4000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

RAC 3131: Long-Term Services and Supports Housing Stabilization – State Funds

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy SA299u1

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy	
Who is eligible for GOSH?	HCS/AAA clients who are receiving Medicaid long-term services who are choosing In-Home setting and: 1. Are willing to work with a Supportive Housing Provider, and 2. qualify for HCS services (financially & functionally eligible), and 3. are discharging or being diverted from Eastern or Western State Hospitals. 4. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS), or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 5. HCS clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by

	the State Hospital Discharge and Diversion (SHDD) team, and wish to live independently.
What is covered under GOSH SA299,U1?	Services that support an individual's ability to prepare for and transition to housing, including direct and collateral services: 1. Screening and housing assessment for individual's preferences and barriers. 2. Developing an individual housing support plan: identifying goals, addressing barriers, establishing approaches to meet goals, including identifying available services and resources. 3. Assisting with eligibility determination, housing applications, subsidy applications, and housing searches. 4. Identifying resources for modifications and/or one-time move-in needs. 5. Assisting in arranging for and supporting details of moving into housing. 6. Training on roles, responsibilities, and rights of tenant and landlord. 7. Developing housing support crisis plan. 8. Maintaining participant and collateral contacts, and timely completion of supportive housing deliverables as outlined in "Service Standards for Providers."
What is not covered under GOSH SA299u1?	1. Rent 2. Move-in costs 3. Utilities
How much can I spend?	1. 160 units per month
Do I need to use a contracted provider?	Yes. 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH SA299u1?	Once the referral has been accepted by the SHPM: 1. The SHPM will open RAC 3131 – LTSS Housing Stabilization and then the pre-tenancy Supportive Housing service code, SA299-U1, to open the SH authorization in CARE. 2. It is the SHPM's responsibility to open, extend and close authorizations for service code SA299, U1.
When do I authorize this service?	1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
Are ETRs allowed for GOSH SA299u1?	No.
What about SA299,U1 for Civil Transitions Program?	1. Supportive Housing services are available through GOSH for those who meet Civil Transition Program eligibility (see Chapter 9b).

	2. For clients meeting Civil Transition Program (CTP) eligibility only, use the appropriate CTP RAC and then authorize SA299u1 with the Reason Code “Civil Transitions Program”. 3. If a Civil Transition Program client ends up eligible for LTSS: • End CTP RAC • End SA299,U1 authorization, then: ○ Open RAC 3131 LTSS Housing Stabilization ○ Open SA299,U1 and use Reason Code “5440 FEFE”, which stands for 5440 Functionally Eligible Financially Eligible.
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Governor’s Opportunity for Supportive Housing (GOSH) Tenancy H0044

Governor’s Opportunity for Supportive Housing (GOSH) Tenancy	
Who is eligible for GOSH?	1. HCS/AAA clients who are receiving Medicaid long-term services who: are choosing In-Home setting and: 2. Are willing to work with a Supportive Housing Provider, and 3. Qualify for HCS services (financially & functionally eligible), and 4. Are discharging or being diverted from Eastern or Western State Hospitals. 5. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 6. HCS clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.
What is covered under GOSH H0044?	Services to support individuals to maintain tenancy once housing is secured, such as: 1. Early intervention for behaviors that might jeopardize housing, e.g., late rent payment, lease violations, etc. 2. Training on responsibilities and rights of tenant and landlord. 3. Coaching on relationship building with landlords, property managers, and neighbors, and assisting in dispute resolution. 4. Linking with community resources to prevent eviction
What is not covered under GOSH H0044?	1. Rent 2. Move-in-costs 3. Utilities

How much can I spend?	1. 1 unit per month (rate \$575)
Do I need to use a contracted provider?	Yes. 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH H0044?	Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization’s end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. 3. It is the responsibility of the SHPM to close the authorization for SA299, U1 and open an authorization for H0044. 4. The SHPM will update the tenancy service code, H0044, on an annual basis. If there are any concerns around client eligibility, staff with the SHPM.
When do I authorize this service?	GOSH Services should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager. Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization’s end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. Please note, the date when the tenancy service code, H0044, is opened will vary based on the terms of the SHP’s contract.
Are ETRs allowed for GOSH H0044?	No.
What about H0044 FOR Civil Transitions program?	1. H0044 should not be used for a client only eligible for the Civil Transition Program. 2. If a Supportive Housing client who was originally Civil Transition Program client ended up eligible for LTSS and secures housing use Reason Code “5440 FEFE”, which stands for 5440 Functionally Eligible Financially Eligible.

Motel Interim Stays for Transitions (MIST) SA294u2

Motel Interim Stays for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client’s chances of ending up on services in their own home. The service is authorized for up to a 6-month period.

Who is eligible for state MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: 1. HCS Subsidy (Bridge & Acute Care Hospital) • Bridge Subsidy: HCS clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. • Acute Hospital Care (ACH) Subsidy: HCS clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. 2. GOSH Program: HCS clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. 3. Other Housing Resource: • HCS clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VASH, etc. • HCS clients who have been approved for a project-based resource <u>and</u> have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. 4. In-Home Short-Term Displacement: HCS clients who have their own home and a short-term situation that requires them to temporarily vacate. Ex: pest control or eradication, fire, or flooding. 5. Experiencing Homelessness: HCS clients experiencing homelessness, at risk of homelessness or fleeing domestic violence or other unsafe situations. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u2?	1. Payment for up to 6-month period for a Medicaid HCS client to stay at a motel/hotel. 2. Deposits. 3. Damages- (Requires HQ Approval. Please contact the Supportive Housing Program Manager).
What is not covered under MIST 294u2?	1. Monthly payment that exceeds \$4,000.
How much can I spend?	1. Up to \$4,000 per month for a total of six months.
Do I need to use a Community Choice Guide (CCG) or GOSH Provider?	Yes. 1. The HCS/AAA CM will need to coordinate with the CCG or GOSH provider and notify them that the client has been authorized for Motel Interim Stays for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period.

	3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. 4. The CCG or GOSH provider can make payments, or Spokane Housing Authority can be authorized to make payments.
How do I authorize state MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM will receive an approval email with specific instructions. should open RAC 3131. 2. For instructions on how to authorize MIST payments, please see the MIST Authorization Desk Guide. 3. If you are using Spokane Housing Authority to make the MIST payments, please see the MIST Guide for Spokane Housing Authority Payments. 4. If a client is enrolled in GOSH services, HCS/AAA CM will need to select "2017 Governors Request Supportive Housing" as the reason code. If client is not enrolled in GOSH Service, please select "No reason code needed" as the reason code.
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for state MIST?	No. 1. Note: When the approved MIST amount is above \$2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Housing Subsidy - Purchasing SA294u4

Housing & Employment Stabilization Services (H&ES). These state funded services are intended to fill specific gaps to provide transitional or stabilizing supports for clients who have received a housing or Supported Employment resource or had their housing/employment coordinated through HCS to sustain community living.

Who is eligible for state H&ES?	When an HCS client meets these qualifications: 1. Is found functionally and financially eligible and received a housing resource or had their housing coordinated through HCS; or 2. Is found functionally and financially eligible and enrolled with Supported Employment or had their employment coordinated through HCS; and 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own home, or are living in the community and need stabilization services to remain there; and
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	- Do not have other programs, services, or resources to assist them with these costs; and - Are not eligible for federal funding.
What is covered under state H&ES?	Goods necessary to establish a residence such as essential household furnishings. - Items needed to help stabilize community living for a client. - Packing assistance. - Moving assistance. - Utility set-up fees or deposits. - Non-recurring health and safety assurances such as pest eradication, allergen control and/or extreme cleaning. - Rental deposits: all pre-tenancy payment requirements, including first month's rent, can be bundled as one deposit and reimbursed to a Community Choice Guide or a DSHS contracted Supportive Housing provider.
What is not covered under state H&ES?	- Recreational or diversional items such as television, cable or DVD players. - Assistive Technology.
When do I need a provider contract?	A contracted provider (Community Choice Guide or GOSH SHP) will need to be authorized to complete purchases or/and payments on the behalf of the client.
How do I authorize state H&ES?	- Open RAC 3131-LTSS Housing Stabilization. - Use Service Code SA294,U4 to authorize the necessary goods and services. - Select the appropriate reason code. Options are "In-Home Community Stabilization or Employment Stabilization" - Note in the Service Episode Record (SER) that the client is eligible for LTSS Housing Stabilization services and that you have Supervisory approval to authorize state only funds. - Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan. - Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615), prior to sending to DMS.
When do I authorize this service?	When an HCS client meets these qualifications: - Is found functionally and financially eligible and received a housing resource or had their housing coordinated through HCS; or - Is found functionally and financially eligible and enrolled with FCS Supported Employment or had their employment coordinated through HCS; and

	- Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own home, or are living in the community and need stabilization services to remain there; and - Do not have other programs, services, or resources to assist them with these costs; and - Are not eligible for federal funding.
Are ETRs allowed for state H&ES?	Yes. - An ETR will be required if the total amount of goods & services exceeds \$5000. - Select “other” for both ETR/ETP category & type. - Submit the ETR to “Committee, Housing ETR” - Note: If the amount Exceeds \$2500, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.	
Who is eligible for state ERA?	An HCS client who is facing immediate eviction due to non-payment of rent.
What is covered under state ERA?	- A one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. - Late fees. - Other fees that are tied into the lease where client is at risk of eviction if they are not paid.
What is not covered under state ERA?	ERA does not include pre-tenancy deposits or move-in costs, including first month’s rent.
How do I make payment?	The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide, GOSH Supportive Housing Provider, or Spokane Housing Authority) to make the ERA payment on the client’s behalf.
How do I authorize state ERA?	Upon approval, the Housing Program Manager will provide instructions to authorize payment to a CCG or GOSH provider.

	2. To authorize payment for Spokane Housing Authority, please see the ERA-SHA Reimbursement Guide .
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Supportive Housing Program Manager. The HCS/AAA CM is only allowed to authorize the amount approved by the SHPM.
Are ETRs allowed for the state ERA?	Yes. 1. When the ERA request amount is above \$4000, this will generate an error message in CARE that will require the HCS/AAA CM to reach out to the Housing Program Manager to request an ETR and force the error. There is no formal ETR request process.

Community Choice Guide SA263

Payment for specialty services which provide assistance and support to ensure the eligible client's successful transition to the community and/or maintenance of independent housing as authorized by HCS and/or AAA staff.

CCG services may include but are not limited to the following:

- Locating and arranging appropriate, accessible housing; including working with local housing authorities and other community resource providers when applicable.
- Maintaining or assisting with obtaining affordable housing.
- When relevant, liaising among and with the client, nursing or institutional facility staff, case managers, housing providers (including AFH providers), medical personnel, legal representatives, formal caregivers, family members, informal supports and any other involved party.
- Necessary assistance to support the client's community living, including assistance in settling disputes with landlord.
- Educating client on tenant rights, expectations and responsibilities.
- Assisting client with filling out forms and obtaining needed documentation to aid in maintaining successful community living (forms may include initial and renewal voucher forms, lease agreements, etc.).
- Providing emergent assistance to avoid utility shut-off and/or eviction.
- Assisting client with locating and arranging transportation resources to effectively connect with community resources.
- Assisting client to locate and engage community integration activities.
- Training or education to client about accessing community settings or health services.
- Assisting client with finding a qualified caregiver.

Detailed instructions on how to make a CCG referral using Service Codes SA263 can be found in the [Chapter 7d](#): COPES of the LTC Manual.

The updated CCG Activity Tracking Form can be found in the resources section of this chapter and in [Chapter 29](#): Roads to Community Living.

Related WACs:

[WAC 388-106-0270](#): What services are available under Community First Choice (CFC)?

[WAC 388-106-0030](#): Where can I receive services?

[WAC 388-106](#): Long Term Care Services

[WAC 388-106-1700](#) to [WAC 388-106-1765](#): Supportive Housing

Acronyms:

HPM: Housing Program Manager	LTSS: Long-Term Services and Supports	SHPM: Supportive Housing Program Manager
GOSH: Governor's Opportunity for Supportive Housing	FCS: Foundational Community Supports	SH: Supportive Housing
CCG: Community Choice Guide	SHA: Spokane Housing Authority	PHA: Public Housing Authority
	AMI: Area Median Income	FMR: Fair Market Rent

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/2020		Established	
8/2020		Added Chapter Section hyperlinks, Section 5B.6 GOSH and link to Supportive Housing WACs	
10/2020		Updated GOSH Pre-Tenancy service code and provided clarification around SHPM vs CM responsibility in "GOSH Client Accepted" section. Added Housing Team contacts under section 5b.11. In section 5b.4 added instruction on how to document HCS subsidy into CARE and Bridge file transition information. Added <i>Forms</i> to section 5b.11 including (2) new forms: HCS Bridge Referral and Bridge Referral and Application Process.	

2/2021		Added SA294 subsidy payment authorization information to section 5B.4. Moved GOSH Section from 5B.6 to 5B.5. Added clarification that there is no participation for Supportive Housing services. Added GOSH “Discharge Planning” and “Transition to Independent Housing” sections to 5B.5. Updated hyperlinks.	
5/2021		Deleted SA294 payment authorization process for P1. Added the need for CM support with quarterly Bridge tenancy verifications as well as annual re-certifications. Clarified steps to add “Housing subsidy (HCS/AAA)” and “Supportive Housing (HCS/AAA)” as Treatments on the Medical Screen in CARE. Added new procedure for referring to GOSH, hyperlinked to new DSHS 11-153 GOSH Referral form. Clarified GOSH eligibility and HCS and AAA CMs can refer. Clarified GOSH authorization responsibility. Hyperlinked to Chapter 30d to connect Supportive Housing service consults and consideration. Clarified on-going eligibility for GOSH clients regarding services and subsidy. Hyperlinked to Chapter 30d in the ‘How can I use CTS/CTSS/WA Roads section’. Updated PM Roles.	
8/2021		Added new staff contacts for all regions by way of link to RCL Housing Resources website. Updated Bridge Referral form, Participant Agreement and Referral and Application Process form. Added updated ERA form. Updated 811 HCS HPM role regarding DDA/DBHR referrals. Added expanded GOSH eligibility criteria.	
2/2022		Updated various links throughout the chapter. Updated HCS Subsidy P&P inserted Document. Updated Participant Agreement inserted document. Added <i>What is needed to transfer an HCS subsidy client from HCS to the AAA?</i> Section. Updated GOSH section to add protocol to staff cases with SHPM prior to closing a GOSH client and protocol related to clients with short term institutional stays (e.g., re-hospitalization or jail).	
8/2022		Added RVP eligibility and availability. Update ERA with Hotel/Motel stay information and Process. Update link to ERA form. Add info from Chapter 5a regarding WA Roads and eligibility from HCS housing resources. Updated language around HCS to AAA case transfers and Annual Assessments for GOSH. Added some hyperlinks into the GOSH Section to animated YouTube Videos: What is the Governor’s Opportunity for Supportive Housing?	

		You've Been Referred to GOSH – Now What?; Governor's Opportunity for Supportive Housing (GOSH); Good Discharge Planning	
11/2022		Added more detailed payment/authorization information for ERA SA298. Added in section from Chapter 5a on how to work with individuals on HCS Housing Resources who are not currently receiving LTSS. Added language on keeping GOSH participants open who are in jail or institutional stays into the Interim Setting section. General text/grammar corrections throughout document. Added Bellingham/Whatcom and Spokane RVP resource.	
2/2023		Updated Unit Manager titles. Updated "NED" section to "permanent HUD voucher" section and added more process details. Updated Chapter Section list to include new 5b.5. Updated 811 sections with more details regarding application process. Removed old versions of forms and added updated versions (Participant Agreement, Tips for Maintaining LTSS, Chapter Version HCS Subsidy P&P and Bridge referral). Added page numbers to footer. Added links to Brochures and Video.	
5/2023		HCS subsidy video link. Updates to Section 5b.5. Updated ERA form.	
8/2023		Updated information in the HCS Subsidy and GOSH sections related to CARE Changes. Clarified language related to ineligibility for permanent HUD vouchers.	
11/2023		Updated Emergency Rental Assistance Form. Clarified language and updated language in section 5b.5 "Working with individuals on HCS housing resources who are not currently receiving HCS LTSS". Updated GOSH Section to include new regional referral email addresses.	
1/2024		Chapter Links added and updated ERA form added	
2/2024		Added a green box in pages 14 & 24 & 29 & 34 with a process for possible no longer functionally eligible HCS clients who are already enrolled in a housing service. Added on page 33 & 34 Motel Interim Stay for Transitions (MIST) program description. Added MIST to Table of contents Page 2. Replaced Washington Roads RAC info in pages 17 & 21 & 29 with new info (RAC 3131- LTSS Housing Stabilization). Added on page 17 (1 d. and the HCS/AAA CM will extend the WA Roads RAC) & (2 i. GOSH Program Manager will end the GOSH authorization and end RAC 3131- LTSS Housing	

		Stabilization, and HCS/AAA CM will end the WA Roads RAC). Removed from page 30 & 31 under reimbursements “while the Supportive Housing services are authorized by SHPM under the service code SA299,U1 the CM would authorize use of any CFC CTS/CTSS/WA Roads funds under a separate service code, dependent upon eligibility and funds used.”	
3/27/2024		Updated Bridge documents at bottom of document with most recent versions. Page 11 &12 amended for HCS Bridge Subsidy.	
5/7/2024		Removed Motel/Hotel language from ERA section. Corrected MIST referral email address. Added MIST Request Form. Added bullet on Civil Transition eligibility.	
6/17/2024		Added ERA email address. Updated ERA referral process. Removed “How do I make a referral for a client who I believe is eligible for ERA?” Updated MIST eligibility criteria (Bridge Subsidy, GOSH program, Civil Transitions Program, Other Housing Resource, In-Home Short-Term Displacement, & Limited Residential). Updated MIST referral Process outline. Updated & added “How is payment made for MIST?” process/procedure. Updated MIST Referral Form.	
9/3/2024		Added information regarding Bridge Subsidy waitlist, added information regarding Presumptive Eligibility, added policy information from chapter 9 regarding GOSH client unable to return to residential setting and being admitted to the hospital. Added policy information regarding if a client is incarcerated or hospitalized and how HCS pays the subsidy for up to 6 months. Added Stephen Miller contact info. Added Housing and Employment website, updated links to one pager. Updated table of contents to include Presumptive Eligibility. Added Global Leasing info. Updated GOSH eligibility criteria.	
10/2024	Joana	Chapter 5b changed to Chapter 6. Chapter 6 Established	
11/2024	Joana	Added information regarding the HCS Acute Care Hospital Subsidy, and the referral/process and referral.	
01/2025	Joana	Edited information regarding the HCS Acute Care Hospital Subsidy	
03/2025	Joana	Chapter 6 was divided up into 4 sections and renamed. Chapter 6A- HCS Subsidies & GOSH Services established. Update policy & procedure regarding	



		Housing and Employment Stabilization Services. Updated OHAE background and EDAI statement. Added a chart describing all the RACs and Service Codes associated with OHAE.	
07/2025	WJH, Jonnie	Removed Whitney Joy Howard under “ask the expert” section; Throughout chapter changed language that referenced “ALISA” to “HCS”; changed “DDA” to “DDCS”; In GOSH section: Updated GOSH eligibility language to reflect current eligibility; In GOSH interim section: Removed “RFT” language as option for Interim Housing per updated eligibility language; Added information on RCL and HRSN STRA and how it is used in combination with state dollars to support a client’s interim HCS Subsidy.	
9/2025	Jonnie	Added GOSH referral email. Removed GOSH region emails. Removed ARTF as an interim setting option for GOSH.	H25-057
3/2025	Joana	Remove language about clients able to sustain subsidy when found ineligible for services.	
04/2026	Jonnie	Removed funding chart Updated information regarding SA294,U4 Updated information regarding CMs completing PANs for GOSH services. Updated information regarding GOSH authorizations to be completed by CMs. Updated language/policy regarding clients no longer on LTSS.	
07/2026	Tom	Added that HCS subsidy referrals can now be submitted through electronic SharePoint forms. Added information to the Q&A section regarding Spokane Housing Authority making payments for MIST and ERA.	



Interim Housing Resources (Motel Interim Stays for Transitions & Emergency Rental Assistance)

Chapter 6B outlines the policies and procedures for interim housing resources available to HCS clients. These resources include Motel Interim Stays for Transitions (MIST) to support individuals who don't have a place to stay, and Emergency Rental Assistance (ERA) is for those facing immediate housing instability due to non-payment of rent. This chapter provides guidance on eligibility criteria, authorization processes, and case management responsibilities to ensure that clients receive timely and appropriate housing support while working toward long-term stability.

Ask the Expert

If you have questions or need clarification about the content in this chapter or about Motel Interim Stay for Transitions, please contact:

Jonnie Matson - Rental Assistance Unit Manager - jonnie.matson2@dshs.wa.gov

If you have questions or need clarification about Emergency Rental Assistance, please email:

emergencyrentalassistance@dshs.wa.gov

If you have questions or need clarification about Motel Interim Stays for Transitions, please email:

mistreferral@dshs.wa.gov

For additional information on HCS housing resources please visit our website:

[Office of Housing and Employment](#)

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BACKGROUND

The HCS Office of Housing and Employment (OHAE) is dedicated to offering housing and supported employment resources that honor client choice. We work to eliminate barriers and expand opportunities that align with an individual's vision for their life regardless of mental health, substance use disorder, race, language, age, ability, or other status.

OHAE brings together federal, state, and local resources to create opportunities and strategies to help clients access independent housing, and in collaboration with our community partners, help build an individualized array of services to support them. This chapter provides specific guidance around interim housing and eviction prevention services and can help you refer clients who are eligible for them.

Whenever possible, we can offer guidance about difficult housing situations you might encounter with your client, including tips about working with clients experiencing homelessness. Affordable housing and tenancy support are complex topics that often do not have easy or quick solutions. Please let us know about other topics or obstacles you would like to see addressed in this chapter.

EMERGENCY RENTAL ASSISTANCE (ERA)

ERA is a one-time payment made directly to landlords on behalf of a client receiving Long-Term Services and Supports (LTSS) who is facing an eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.

ERA does not include pre-tenancy deposits or move-in costs, including first months' rent required for moving in. There are other resources that may cover these one-time expenses; please see the [Transition Resource Guide](#) for more information.

ERA Referral Process

Complete the ERA referral form via SharePoint at [Emergency Rental Assistance Referral](#). If the SharePoint site is down, please contact the Housing Program Managers via emergencyrentalassistance@dshs.wa.gov.

The form will ask for a detailed description of the client's current situation, why they require ERA, and what their plan is for paying rent moving forward. It will also ask you to verify the total rent amount due and what is owed specifically for each month. More information or final verification of the amount due may be requested by the Housing Program Manager prior to approval. Obtain local approval from your supervisor prior to submitting the ERA referral. It may take up to 1-2 business days for the Program Manager to determine eligibility and respond. If you have any questions about ERA, please email your questions to emergencyrentalassistance@dshs.wa.gov.

For clients eligible to receive ERA through the Health-Related Social Needs (HRSN) benefit, clients may also be able to receive assistance with back utility payments in the correlating months of the back rent.



Please fill out the ERA referral form accordingly if a client has back utility bills owed. The HPM will also send approval and direction regarding utility assistance in the ERA approval email.

Once eligibility has been determined an email will be sent with instructions on how to proceed.

The HPM will communicate via email if the client has been determined eligible and will include an ERA Acknowledgment Agreement (AA) for the CM to verbally review with the client. The CM will need to acknowledge they have reviewed the form and initial it and return to the HPM prior to approval.

Upon receipt of ERA Acknowledgment Agreement (AA) the HPM will provide an approval email which will include the RAC and authorization code to use for the ERA payment. There is more than one option, so please use the RAC and code provided to you in the specific email approval for each client.

The HPM will enter a SER note stating that the client has been approved for the ERA service.

The HCS/AAA case manager will be responsible for notifying the HPM immediately if the client no longer requires the ERA payment.

Please note: When using Health Related Social Needs (HRSN) funding, the HCS/AAA case manager will be responsible for completing a Planned Action Notice (PAN). Please see Chapter 27 for additional guidelines around Planned Action Notices. Please see the Housing SharePoint for [instructions regarding HRSN PANs](#).

ERA Payment Process

1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide (CCG) or GOSH Supportive Housing Provider) to make the ERA payment on the client's behalf. If there are other tasks needed to stabilize the client's housing situation, the provider can be authorized additional time for those needs.
 - When authorizing a CCG, the HCS/AAA CM will need to utilize service code SA263 to reimburse the CCG for the time it took the CCG in making the ERA payment and/or coordinating additional support for the HCS client. A GOSH Supportive Housing provider will not need to be reimbursed additional units to make the payment and/or to coordinate additional support.
 - If there is not a CCG or GOSH Supportive Housing Provider available to make the payment, the Spokane Housing Authority may be used as an alternative. Please see the [Housing SharePoint](#) for instructions and the request form. Please note: Spokane Housing Authority is not a Community Choice Guide and does not work directly with the client. They are a third-party agency contracted only to make payments. Please note that Spokane Housing Authority has an administration fee for making the ERA payment on behalf of the client. The HCS/AAA will not need to reimburse SHA for the administration fee as of now. This may change in the future.



2. The HCS/AAA case manager or authorized contracted provider will communicate with the landlord or/and property manager and discuss how the ERA Payment will be completed (ex: credit card, in-person via money order/check, or via mailing a check/money order).
3. The HCS/AAA case manager will reimburse the contracted provider for the ERA payment made.
4. Use RAC and authorization code provided by HPM in approval email.
5. Place authorization in “Reviewing” status until a receipt has been received by the HCS/AAA CM. **Please note do not submit authorization to “approval” status until a receipt has been provided by the contracted provider.**
6. Once the HCS/AAA CM receives receipt, they will verify that the amount on the receipt matches the “Reviewing” status authorization. The HCS/AAA CM will update the authorization start and end date to match the receipt’s dates of service, which would be the months covered by the ERA.
7. If the amount on the receipt is different than what the HPM approved, you must inform the HPM prior to approving authorization. **If you receive a receipt for a higher amount than the ERA approval and the additional cost is related to a check fee/mail fee or etc., please don’t use code SA298 to cover this expense. You will need to use SA297, or SA291, or SA294,U4 depending on the client’s eligibility for federal or state funds.**
8. The HCS/AAA CM will move the authorization from “Reviewing” status to Approved.
 - Receipts for all purchases must be included in the participant’s electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615).
 - **Note:** When using RAC 3131 - LTSS Housing Stabilization to make an Emergency Rental Assistance payment, Community Choice Guide Service Code (SA263) can also be authorized under this RAC if the client is eligible for State Funding only.

MOTEL INTERIM STAYS FOR TRANSITIONS (MIST)

The Motel Interim Stays for Transitions (MIST) is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client’s chances of ending up on services in their own home. The service can be authorized for up to a six-month period

What Is the Eligibility for MIST?



At the time of the MIST referral submission, the individual needs to have been assessed and determined both functionally and financially eligible for LTSS.

Can a Client Who Declines Personal Care Receive MIST?

- For an initial assessment, a client needs to identify that they want to receive personal care or other Core services. See [Chapter 3](#).
- 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".
- Once a client is determined to be eligible for CFC, COPES or RCL, one of the LTSS from those service packages can be authorized.
- If the individual is Medicaid Personal Care (MPC) eligible, as this LTSS program is limited to personal care services (see chapter 7c), a client who is not declining personal care may access services through a state-funded benefit package. Examples Include:
 - Community Choice Guide through Housing Stability RAC 3131 (see bottom of Chapter).
 - GOSH Supportive Housing Service

Who May Qualify for MIST?

- HCS Subsidy Holders (Bridge & Acute Care Hospital)
 - Bridge Subsidy: HCS clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. Please note: MIST should not be used to transition a client out of their SNF unless they cannot stay (ex: insurance stops paying, behaviors, etc.).
 - Acute Hospital Care (ACH) Subsidy: HCS clients transitioning from an Acute Care Hospital (ACH) setting and are working with an authorized contracted provider on an independent housing search.
- GOSH Program: HCS clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at-risk of or experiencing homelessness.
- Civil Transitions Program (5440): HCS clients who are referred through the Civil Transitions Program.
- Other Housing Resource:
 - HCS clients who will be living independently and currently have a resource from a housing agency or program. Examples include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VASH, etc.
 - HCS clients who have been approved for a project-based resource and have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing units from homeless service agency.



- In-Home Short-Term Displacement: HCS clients who have their own home and a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding. *Approval is at program discretion.*
- Experiencing Homelessness: HCS clients experiencing homelessness, at-risk of homelessness or fleeing domestic violence or other unsafe situations. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing. These slots are available monthly on a limited basis. Please see the Housing SharePoint for updates.

Along with meeting one of the above eligibility criteria, to receive MIST clients must also have a Community Choice Guide or GOSH Supportive Housing provider authorized. Working with a Foundational Community Supports-Supportive Housing provider will also qualify, but please check in with HPM to ensure the FCS authorization is active and they are connected with a provider.

MIST Referral Process

- 1) The HCS/AAA case manager will complete the online request form via [MIST Referral](#)
- 2) Once the referral has been approved by the Housing Program Manager (HPM), the following will occur:
 - (a.) The HPM will email a pre-approval, providing the HCS/AAA Case Manager with the Participant Agreement form. The HCS/AAA CM or Contracted Provider will review this form with the client and obtain a signature from the client as well as the CCG/GOSH staff's signature or the HCS/AAA CM's signature, whoever reviews the Participant Agreement with the client, then return the Participation Agreement to the HPM. Please submit a copy of the MIST Participation Agreement to DMS.
 - (b.) The HPM will provide the RAC & Service Code to be used, authorization dates, and other pertinent information via email. There is more than one option, so please use the RAC and Service Code provided to you in the specific email approval for each client.**
 - (c.) The HPM will enter a SER note stating that the client has been approved for Motel Interim Stays for Transitions funds. It will include the RAC/Service Code and authorization dates.
 - (d.) The HCS/AAA CM will need to coordinate with the Contracted Provider and notify them that the client has been authorized for Motel Interim Stays for Transitions for a period of up to six months.
 - (e.) The HCS/AAA CM must notify the HPM immediately if any of the following occur:



- The client has not secured independent housing within the six-month approval period, and the authorization is ending.
- The client no longer requires MIST.
- The client has left the hotel and has not returned (whereabouts unknown).
- The client violated the Participant Agreement or has caused damage to the motel.
- The client has become ineligible for LTSS or has been inactivated.

Please note: The HCS/AAA CM will need to provide the HPM with the service start and end dates and outcome once the client is no longer using MIST.

(f.) If there are any issues or concerns regarding a MIST client, including eligibility concerns, the HCS/AAA Case Manager should staff with the assigned HPM. Do not close a MIST client prior to staffing with the assigned HPM. The client must remain active on LTSS to continue receiving MIST.

(g.) For clients eligible to receive MIST through the Health-Related Social Needs (HRSN) benefit, the HCS/AAA case manager will be responsible for completing a Planned Action Noticed (PAN). Please see [Chapter 27](#) for additional guidelines about Planned Action Notices.

Please see the Housing SharePoint for [instructions regarding HRSN PANS](#).

How Is Payment Made for MIST?

1. For a step by step guide on how to enter a MIST authorization, please see the [MIST Authorization Desk Guide](#).
2. If you have any questions about MIST, please email your questions to mistreferral@dshs.wa.gov. However, if your client is already enrolled in MIST, email questions to the assigned HPM.
3. If there is not a CCG or GOSH Supportive Housing provider to make MIST payments to the motel, Spokane Housing Authority can be used to make payment. For this option, a CCG or GOSH Supportive Housing provider must still be available to work with the client while in the motel as the Spokane Housing Authority does not work directly with clients. They are a third-party agency contracted to make payments only. Please note that Spokane Housing Authority has an administration fee for making MIST payment(s) on behalf of the client. The HCS/AAA will need to reimburse SHA for the administration fee. Use the instructions and form available on the [Housing SharePoint](#) site for this option.

MIST Guidelines:

1. **Participation Agreement:**

The client must read, agree to, and physically initial, sign and date the Participant Agreement before MIST is approved. This acknowledges the client understands what is required of them to keep their



motel service. CCG/GOSH staff or HCA/AAA staff must “cosign” this agreement where indicated. Clients must be aware that their MIST service will end when they move into an apartment or other chosen setting, if they leave the motel without notice, or if they violate the terms of the Participant Agreement. Please submit a copy of the signed MIST Participation Agreement to DMS.

2. Expectations for providers working with MIST clients:

Case Manager should include language in the sustainability goals and tasks that indicate expectations for regular contact with the client. The goals and tasks should indicate a minimum of weekly room visits as well as phone calls. Contracted providers should be tasked to also make sure the motel has their contact information for any potential issues. In addition, they should be supporting the client in active housing searches, where applicable. The Case Manager should also direct the provider to inform the LTC CM if the client vacates the room, is asked to leave, or causes damage.

3. Deposits and damages:

Contracted providers can be authorized by the Case Manager to utilize up to a \$300 deposit made to the motel upon arrival to cover damages. It can be paid by bundling it with the initial hotel payment for the first 2 weeks of the stay. Balances of damages above and beyond \$300 are the client’s responsibility to pay, but some clients won’t be able to afford this. If the client does not have the funds to pay or the damages are above \$300, referring staff should reach out to the assigned HPM for staffing. The contracted provider should not submit an invoice for reimbursement until the damage deposit is resolved (the hold of funds released or credited) to avoid paying for costs not actually charged. Pet deposits or fees are allowed if they fall within the daily room rate. This is in addition to the up-to-\$300 damage deposit per motel allowance.

4. Client ID:

Clients are usually required to have valid identification (ID) for a motel stay. Referring HCS/AAA CMs should make sure the client has a valid ID or authorize the contracted provider to assist the client in obtaining it. Many apartments also require valid ID when a client applies, so there are other good reasons that it will be helpful to make sure clients have access to their ID. Clients experiencing homelessness may be eligible for a no cost or reduced cost ID. For clients to access the no cost or reduced cost ID, the HCS/AAA case manager will complete the [Request for Identicard](#) form (DSHS form 16-029) and give it to the client to take to their local Department of Licensing office. More information about this service can be found at: [ID Help for the Unhoused](#).

5. MIST is not a crisis program:

MIST is not an emergency service or crisis program. HPMs have up to two business days to respond to submitted requests. HCS/AAA Case Managers should take this into account so they have a clear understanding of the program timeframes and appropriate expectations for responses.

RESOURCES

[Housing Team Contacts](#)

[Office of Housing and Employment SharePoint](#)

[Office of Housing and Employment Website](#)

[HCS Housing Resources](#)

[LTSS One-Pager](#)

[Zero Income One-Pager](#)

[Income Discrimination Flyer Tenants: Legal Protection from Source of Income Discrimination](#)

[Request for Identocard Form](#)

[MIST Field One-Pager](#)

[MIST in CARE Authorization](#)

Video: [Options for Housing Through Long-Term Care Services](#)

RAC 3132: Health Related Social Needs - Federal

Motel Interim Stays for Transitions (MIST) SA294u1

Motel Interim Stays for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period. Federal MIST is funded via the 1115 waiver in which the Washington State Health Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. This includes temporary housing.

Who is eligible for federal MIST?

HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications:

1. HCS Subsidy (Bridge or Acute Care Hospital)

- Bridge Subsidy: HCS clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. Client must be required to leave their SNF for non-medical reasons; Bridge clients cannot choose to leave their SNF in order to utilize a MIST funded hotel.
- Acute Hospital Care (ACH) Subsidy: HCS clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier.

2. GOSH Program: HCS clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness.

3. Other Housing Resource:

- HCS clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VASH, etc.



	- HCS clients who have been approved for a project-based resource <u>and</u> have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. In-Home Short-Term Displacement: HCS clients who have their own home <u>and</u> a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding. Experiencing Homelessness: HCS clients experiencing homelessness, at risk of homelessness or fleeing domestic violence or other unsafe situations. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u1?	Payment for up to 6-month period for a Medicaid HCS client to stay at a motel/hotel.
What is not covered under MIST 294u1?	- Deposits - Damages (Please see RAC 3131 SA294,U2)
How much can I spend?	- Up to \$5,000 per month for a total of six months. - Note: not to exceed six months
Do I need to use a Community Choice Guide (CCG) or GOSH provider?	Yes. - The HCS/AAA CM will need to coordinate with the CCG or GOSH provider and notify them that the client has been authorized for Motel Interim Stays for Transitions for a period of up to 6 months. - The Contracted Provider should be authorized for the duration of the MIST authorization period. - The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. - The CCG or GOSH provider can make payments, or Spokane Housing Authority can be authorized to make payments.
How do I authorize federal MIST payments?	- Upon receiving approval for MIST, the HCS/AAA CM will receive an approval email with specific instructions. should open RAC 3132. - For instructions on how to authorize MIST payments, please see the MIST Authorization Desk Guide. - If you are using Spokane Housing Authority to make the MIST payments, please see the MIST Guide for Spokane Housing Authority Payments.
When do I authorize this service?	MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for federal MIST?	No. When the approved MIST amount is above \$2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially. Federal Emergency Rental Assistance is funded via the 1115 waiver, in which the Washington State Health Related Social Needs (HRSN) Services Program will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. These includes rent.

Who is eligible for federal ERA?	1. An HCS or AAA client who is experiencing or at risk of experiencing homelessness, including facing immediate eviction due to non-payment of rent.
What is covered under federal ERA?	1. A one-time payment made directly to landlords on behalf of an HCS or AAA client who is facing an immediate eviction due to non-payment of rent. 2. Late fees can be included.
What is not covered under federal ERA?	1. ERA does not include pre-tenancy deposits or move-in costs. 2. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent. 3. Any fees other than late fees.
How do I make payment?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide, GOSH Supportive Housing Provider, or Spokane Housing Authority) to make the ERA payment on the client's behalf.
How do I authorize federal ERA	1. Use RAC 3132. 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Housing Program Manager.
Are ETRs allowed for the federal ERA?	No. 1. Note: When the approved ERA amount is above \$4000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

RAC 3131: Long-Term Services and Supports Housing Stabilization – State Funds

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy SA299u1

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy	
Who is eligible for GOSH?	HCS/AAA clients who are receiving Medicaid long-term services who are choosing In-Home setting and: 1. Are willing to work with a Supportive Housing Provider, and 2. qualify for HCS services (financially & functionally eligible), and 3. are discharging or being diverted from Eastern or Western State Hospitals. 4. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS), or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 5. HCS clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by the State Hospital Discharge and Diversion (SHDD) team, and wish to live independently.
What is covered under GOSH SA299,U1?	Services that support an individual's ability to prepare for and transition to housing, including direct and collateral services: 1. Screening and housing assessment for individual's preferences and barriers. 2. Developing an individual housing support plan: identifying goals, addressing barriers, establishing approaches to meet goals, including identifying available services and resources. 3. Assisting with eligibility determination, housing applications, subsidy applications, and housing searches. 4. Identifying resources for modifications and/or one-time move-in needs. 5. Assisting in arranging for and supporting details of moving into housing. 6. Training on roles, responsibilities, and rights of tenant and landlord. 7. Developing housing support crisis plan. 8. Maintaining participant and collateral contacts, and timely completion of supportive housing deliverables as outlined in "Service Standards for Providers."
What is not covered under GOSH SA299u1?	1. Rent 2. Move-in costs 3. Utilities



How much can I spend?	1. 160 units per month
Do I need to use a contracted provider?	Yes. 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH SA299u1?	Once the referral has been accepted by the SHPM: 1. The SHPM will open RAC 3131 – LTSS Housing Stabilization and then the pre-tenancy Supportive Housing service code, SA299-U1, to open the SH authorization in CARE. 2. It is the SHPM’s responsibility to open, extend and close authorizations for service code SA299, U1.
When do I authorize this service?	1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
Are ETRs allowed for GOSH SA299u1?	No.
What about SA299,U1 for Civil Transitions Program?	1. Supportive Housing services are available through GOSH for those who meet Civil Transition Program eligibility (see Chapter 9b). 2. For clients meeting Civil Transition Program (CTP) eligibility only, use the appropriate CTP RAC and then authorize SA299u1 with the Reason Code “Civil Transitions Program”. 3. If a Civil Transition Program client ends up eligible for LTSS: • End CTP RAC • End SA299,U1 authorization, then: ○ Open RAC 3131 LTSS Housing Stabilization ○ Open SA299,U1 and use Reason Code “5440 FEFE”, which stands for 5440 Functionally Eligible Financially Eligible.

Governor’s Opportunity for Supportive Housing (GOSH) Tenancy H0044

Governor’s Opportunity for Supportive Housing (GOSH) Tenancy	
Who is eligible for GOSH?	1. HCS/AAA clients who are receiving Medicaid long-term services who: are choosing In-Home setting and: 2. Are willing to work with a Supportive Housing Provider, and 3. Qualify for HCS services (financially & functionally eligible), and 4. Are discharging or being diverted from Eastern or Western State Hospitals. 5. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and

	discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 6. HCS clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.
What is covered under GOSH H0044?	Services to support individuals to maintain tenancy once housing is secured, such as: 1. Early intervention for behaviors that might jeopardize housing, e.g., late rent payment, lease violations, etc. 2. Training on responsibilities and rights of tenant and landlord. 3. Coaching on relationship building with landlords, property managers, and neighbors, and assisting in dispute resolution. 4. Linking with community resources to prevent eviction
What is not covered under GOSH H0044?	1. Rent 2. Move-in-costs 3. Utilities
How much can I spend?	1. 1 unit per month (rate \$575)
Do I need to use a contracted provider?	Yes. 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH H0044?	Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization’s end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. 3. It is the responsibility of the SHPM to close the authorization for SA299, U1 and open an authorization for H0044. 4. The SHPM will update the tenancy service code, H0044, on an annual basis. If there are any concerns around client eligibility, staff with the SHPM.
When do I authorize this service?	GOSH Services should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager. Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization’s end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. Please note, the date when the tenancy service code, H0044, is opened will vary based on the terms of the SHP’s contract.



Are ETRs allowed for GOSH H0044?	No.
What about H0044 FOR Civil Transitions program?	1. H0044 should not be used for a client only eligible for the Civil Transition Program. 2. If a Supportive Housing client who was originally Civil Transition Program client ended up eligible for LTSS and secures housing use Reason Code “5440 FEFE”, which stands for 5440 Functionally Eligible Financially Eligible.

Motel Interim Stays for Transitions (MIST) SA294u2

Motel Interim Stays for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client’s chances of ending up on services in their own home. The service is authorized for up to a 6-month period.	
Who is eligible for state MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: 1. HCS Subsidy (Bridge & Acute Care Hospital) • Bridge Subsidy: HCS clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. • Acute Hospital Care (ACH) Subsidy: HCS clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. 2. GOSH Program: HCS clients who are enrolled in the Governor’s Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. 3. Other Housing Resource: • HCS clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VASH, etc. • HCS clients who have been approved for a project-based resource <u>and</u> have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. 4. In-Home Short-Term Displacement: HCS clients who have their own home and a short-term situation that requires them to temporarily vacate. Ex: pest control or eradication, fire, or flooding. 5. Experiencing Homelessness: HCS clients experiencing homelessness, at risk of homelessness or fleeing domestic violence or other unsafe

CHAPTER 6B: Interim Housing Resources (Motel Interim Stays for Transitions & Emergency Rental Assistance)

Long-Term Care Manual



	situations. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u2?	1. Payment for up to 6-month period for a Medicaid HCS client to stay at a motel/hotel. 2. Deposits. 3. Damages- (Requires HQ Approval. Please contact the Supportive Housing Program Manager).
What is not covered under MIST 294,U2?	1. Monthly payment that exceeds \$4,000.
How much can I spend?	1. Up to \$4,000 per month for a total of six months.
Do I need to use a Community Choice Guide (CCG) or GOSH Provider?	Yes. 1. The HCS/AAA CM will need to coordinate with the CCG or GOSH provider and notify them that the client has been authorized for Motel Interim Stays for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. 4. The CCG or GOSH provider can make payments, or Spokane Housing Authority can be authorized to make payments.
How do I authorize state MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM will receive an approval email with specific instructions. should open RAC 3131. 2. For instructions on how to authorize MIST payments, please see the MIST Authorization Desk Guide. 3. If you are using Spokane Housing Authority to make the MIST payments, please see the MIST Guide for Spokane Housing Authority Payments. 4. If a client is enrolled in GOSH services, HCS/AAA CM will need to select "2017 Governors Request Supportive Housing" as the reason code. If client is not enrolled in GOSH Service, please select "No reason code needed" as the reason code.
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for state MIST?	No. 1. Note: When the approved MIST amount is above \$2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Housing Subsidy - Purchasing SA294u4

Housing & Employment Stabilization Services (H&ES). These state funded services are intended to fill specific gaps to provide transitional or stabilizing supports for clients who have received a housing or Supported Employment resource or had their housing/employment coordinated through HCS to sustain community living.	
Who is eligible for state H&ES?	When an HCS client meets these qualifications: 1. Is found functionally and financially eligible and received a housing resource or had their housing coordinated through HCS; or 2. Is found functionally and financially eligible and enrolled with Supported Employment or had their employment coordinated through HCS; and 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own home, or are living in the community and need stabilization services to remain there; and 4. Do not have other programs, services, or resources to assist them with these costs; and 5. Are not eligible for federal funding.
What is covered under state H&ES?	Goods necessary to establish a residence such as essential household furnishings. 1. Items needed to help stabilize community living for a client. 2. Packing assistance. 3. Moving assistance. 4. Utility set-up fees or deposits. 5. Non-recurring health and safety assurances such as pest eradication, allergen control and/or extreme cleaning. 6. Rental deposits: all pre-tenancy payment requirements, including first month's rent, can be bundled as one deposit and reimbursed to a Community Choice Guide or a DSHS contracted Supportive Housing provider.
What is not covered under state H&ES?	1. Recreational or diversional items such as television, cable or DVD players. 2. Assistive Technology.
When do I need a provider contract?	1. A contracted provider (Community Choice Guide or GOSH SHP) will need to be authorized to complete purchases or/and payments on the behalf of the client.
How do I authorize state H&ES?	1. Open RAC 3131-LTSS Housing Stabilization. 2. Use Service Code SA294,U4 to authorize the necessary goods and services. 3. Select the appropriate reason code. Options are "In-Home Community Stabilization or Employment Stabilization"



	- Note in the Service Episode Record (SER) that the client is eligible for LTSS Housing Stabilization services and that you have Supervisory approval to authorize state only funds. - Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan. - Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615), prior to sending to DMS.
When do I authorize this service?	When an HCS client meets these qualifications: - Is found functionally and financially eligible and received a housing resource or had their housing coordinated through HCS; or - Is found functionally and financially eligible and enrolled with FCS Supported Employment or had their employment coordinated through HCS; and - Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own home, or are living in the community and need stabilization services to remain there; and - Do not have other programs, services, or resources to assist them with these costs; and - Are not eligible for federal funding.
Are ETRs allowed for state H&ES?	Yes. - An ETR will be required if the total amount of goods & services exceeds \$5000. - Select "other" for both ETR/ETP category & type. - Submit the ETR to "Committee, Housing ETR" - Note: If the amount Exceeds \$2500, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.	
Who is eligible for state ERA?	An HCS client who is facing immediate eviction due to non-payment of rent.

What is covered under state ERA?	1. A one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. 2. Late fees. 3. Other fees that are tied into the lease where client is at risk of eviction if they are not paid.
What is not covered under state ERA?	1. ERA does not include pre-tenancy deposits or move-in costs, including first month's rent.
How do I make payment?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide, GOSH Supportive Housing Provider, or Spokane Housing Authority) to make the ERA payment on the client's behalf.
How do I authorize state ERA?	1. Upon approval, the Housing Program Manager will provide instructions to authorize payment to a CCG or GOSH provider. 2. To authorize payment for Spokane Housing Authority, please see the ERA-SHA Reimbursement Guide.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Supportive Housing Program Manager. The HCS/AAA CM is only allowed to authorize the amount approved by the SHPM.
Are ETRs allowed for the state ERA?	Yes. 1. When the ERA request amount is above \$4000, this will generate an error message in CARE that will require the HCS/AAA CM to reach out to the Housing Program Manager to request an ETR and force the error. There is no formal ETR request process.

Community Choice Guide SA263

Payment for specialty services which provide assistance and support to ensure the eligible client's successful transition to the community and/or maintenance of independent housing as authorized by HCS and/or AAA staff.

CCG services may include but are not limited to the following:

- Locating and arranging appropriate, accessible housing; including working with local housing authorities and other community resource providers when applicable.
- Maintaining or assisting with obtaining affordable housing.
- When relevant, liaising among and with the client, nursing or institutional facility staff, case managers, housing providers (including AFH providers), medical personnel, legal representatives, formal caregivers, family members, informal supports and any other involved party.



- Necessary assistance to support the client's community living, including assistance in settling disputes with landlord.
- Educating client on tenant rights, expectations and responsibilities.
- Assisting client with filling out forms and obtaining needed documentation to aid in maintaining successful community living (forms may include initial and renewal voucher forms, lease agreements, etc.).
- Providing emergent assistance to avoid utility shut-off and/or eviction.
- Assisting client with locating and arranging transportation resources to effectively connect with community resources.
- Assisting client to locate and engage community integration activities.
- Training or education to client about accessing community settings or health services.
- Assisting client with finding a qualified caregiver.

Detailed instructions on how to make a CCG referral using Service Codes SA263 can be found in the [Chapter 7d](#): COPEs of the LTC Manual.

The updated CCG Activity Tracking Form can be found in the resources section of this chapter and in [Chapter 29](#): Roads to Community Living.

Related WACs:

[WAC 388-106-0270](#): What services are available under Community First Choice (CFC)?

[WAC 388-106-0030](#): Where can I receive services?

[WAC 388-106](#): Long Term Care Services

[WAC 388-106-1700](#) to [WAC 388-106-1765](#): [Supportive Housing](#)

Acronyms:

HPM/SHPM: Housing Program Manager/Supportive Housing Program Manager

LTSS: Long-Term Services and Supports

ERA: Emergency Rental Assistance

GOSH: Governor's Opportunity for Supportive Housing

FCS: Foundational Community Supports

SH: Supportive Housing

CCG: Community Choice Guide

SHA: Spokane Housing Authority

PHA: Public Housing Authority

PBV: Project Based Voucher

AMI: Area Median Income

FMR: Fair Market Rent

Forms:

[Tips for Maintaining LTSS](#)

<https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/Housing-Employment/ERAResultForm.pdf>

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/2020		Established	
8/2020		Added Chapter Section hyperlinks, Section 5B.6 GOSH and link to Supportive Housing WACs	
10/2020		Updated GOSH Pre-Tenancy service code and provided clarification around SHPM vs CM responsibility in “GOSH Client Accepted” section. Added Housing Team contacts under section 5b.11. In section 5b.4 added instruction on how to document HCS subsidy into CARE and Bridge file transition information. Added <i>Forms</i> to section 5b.11 including (2) new forms: HCS Bridge Referral and Bridge Referral and Application Process.	
2/2021		Added SA294 subsidy payment authorization information to section 5B.4. Moved GOSH Section from 5B.6 to 5B.5. Added clarification that there is no participation for Supportive Housing services. Added GOSH “Discharge Planning” and “Transition to Independent Housing” sections to 5B.5. Updated hyperlinks.	
5/2021		Deleted SA294 payment authorization process for P1. Added the need for CM support with quarterly Bridge tenancy verifications as well as annual re-certifications. Clarified steps to add “Housing subsidy (HCS/AAA)” and “Supportive Housing (HCS/AAA)” as Treatments on the Medical Screen in CARE. Added new procedure for referring to GOSH, hyperlinked to new DSHS 11-153 GOSH Referral form. Clarified GOSH eligibility and HCS and AAA CMs can refer. Clarified GOSH authorization responsibility. Hyperlinked to Chapter 30d to connect Supportive Housing service consults and consideration. Clarified on-going eligibility for GOSH clients regarding services and subsidy. Hyperlinked to Chapter 30d in the ‘How can I use CTS/CTSS/WA Roads section’. Updated PM Roles.	

8/2021		Added new staff contacts for all regions by way of link to RCL Housing Resources website. Updated Bridge Referral form, Participant Agreement and Referral and Application Process form. Added updated ERA form. Updated 811 HCS HPM role regarding DDA/DBHR referrals. Added expanded GOSH eligibility criteria.	
2/2022		Updated various links throughout the chapter. Updated HCS Subsidy P&P inserted Document. Updated Participant Agreement inserted document. Added <i>What is needed to transfer an HCS subsidy client from HCS to the AAA?</i> Section. Updated GOSH section to add protocol to staff cases with SHPM prior to closing a GOSH client and protocol related to clients with short term institutional stays (e.g., re-hospitalization or jail).	
8/2022		Added RVP eligibility and availability. Update ERA with Hotel/Motel stay information and Process. Update link to ERA form. Add info from Chapter 5a regarding WA Roads and eligibility from HCS housing resources. Updated language around HCS to AAA case transfers and Annual Assessments for GOSH. Added some hyperlinks into the GOSH Section to animated YouTube Videos: What is the Governor's Opportunity for Supportive Housing? ; You've Been Referred to GOSH – Now What? ; Governor's Opportunity for Supportive Housing (GOSH): Good Discharge Planning	
11/2022		Added more detailed payment/authorization information for ERA SA298. Added in section from Chapter 5a on how to work with individuals on HCS Housing Resources who are not currently receiving LTSS. Added language on keeping GOSH participants open who are in jail or institutional stays into the Interim Setting section. General text/grammar corrections throughout document. Added Bellingham/Whatcom and Spokane RVP resource.	
2/2023		Updated Unit Manager titles. Updated "NED" section to "permanent HUD voucher" section and added more process details. Updated Chapter Section list to include new 5b.5. Updated 811 sections with more details regarding application process. Removed old versions of forms and added updated versions (Participant Agreement, Tips for Maintaining LTSS, Chapter Version HCS Subsidy P&P and Bridge referral). Added page numbers to footer. Added links to Brochures and Video.	

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5/2023		HCS subsidy video link. Updates to Section 5b.5. Updated ERA form.	
8/2023		Updated information in the HCS Subsidy and GOSH sections related to CARE Changes. Clarified language related to ineligibility for permanent HUD vouchers.	
11/2023		Updated Emergency Rental Assistance Form. Clarified language and updated language in section 5b.5 "Working with individuals on HCS housing resources who are not currently receiving HCS LTSS". Updated GOSH Section to include new regional referral email addresses.	
1/2024		Chapter Links added and updated ERA form added	
2/2024		Added a green box in pages 14 & 24 & 29 & 34 with a process for possible no longer functionally eligible HCS clients who are already enrolled in a housing service. Added on page 33 & 34 Motel Interim Stay for Transitions (MIST) program description. Added MIST to Table of contents Page 2. Replaced Washington Roads RAC info in pages 17 & 21 & 29 with new info (RAC 3131- LTSS Housing Stabilization). Added on page 17 (1 d. and the HCS/AAA CM will extend the WA Roads RAC) & (2 i. GOSH Program Manager will end the GOSH authorization and end RAC 3131- LTSS Housing Stabilization, and HCS/AAA CM will end the WA Roads RAC). Removed from page 30 & 31 under reimbursements "while the Supportive Housing services are authorized by SHPM under the service code SA299,U1 the CM would authorize use of any CFC CTS/CTSS/WA Roads funds under a separate service code, dependent upon eligibility and funds used."	
3/27/2024		Updated Bridge documents at bottom of document with most recent versions. Page 11 & 12 amended for HCS Bridge Subsidy.	
5/7/2024		Removed Motel/Hotel language from ERA section. Corrected MIST referral email address. Added MIST Request Form. Added bullet on Civil Transition eligibility.	
6/17/2024		Added ERA email address. Updated ERA referral process. Removed "How do I make a referral for a client who I believe is eligible for ERA?" Updated MIST eligibility criteria (Bridge Subsidy, GOSH program, Civil Transitions Program, Other Housing Resource, In-Home Short-Term Displacement, & Limited Residential). Updated MIST referral Process outline. Updated &	

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		added "How is payment made for MIST?" process/procedure. Updated MIST Referral Form.	
9/3/2024		Added information regarding Bridge Subsidy waitlist, added information regarding Presumptive Eligibility, added policy information from chapter 9 regarding GOSH client unable to return to residential setting and being admitted to the hospital. Added policy information regarding if a client is incarcerated or hospitalized and how HCS pays the subsidy for up to 6 months. Added Stephen Miller contact info. Added Housing and Employment website, updated links to one pager. Updated table of contents to include Presumptive Eligibility. Added Global Leasing info. Updated GOSH eligibility criteria.	
10/2024	joana	Chapter 5b changed to Chapter 6. Chapter 6 Established	
11/2024	joana	Added information regarding the HCS Acute Care Hospital Subsidy, and the referral/process and referral.	
01/2025	joana	Edited information regarding the HCS Acute Care Hospital Subsidy	
03/2025	joana	Chapter 6 was divided up into 4 sections and renamed. Chapter 6B- Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance) established. Update policy & procedure regarding ERA. Updated OHAE background and EDAI statement. Added a chart describing all the RACs and Service Codes associated with OHAE. Updated criteria, policy & procedure for MIST.	
7/2025	Jonnie	Replaced Shawna Sampson with Jonnie Matson for MIST in the "ask the expert" section; Through chapter changed language that referenced "ALISA" to "HCS"; Added clarification of when client declines personal care, creating ineligibility for LTSS, client will not be able to receive MIST. When client becomes inactivated on LTSS, the MIST service will end; Added clarification that client must be authorized or on waitlist for CCG, GOSH or FCS-SH services; Added information on RCL and HRSN STRA and how it is used in combination with state dollars to support a client's interim HCS Subsidy.	
9/2025	Jonnie	Added HRSN utility assistance option with HRSN approved ERA. Added eligibility and instruction on using Spokane Housing Authority to make ERA and MIST payments when a provider is not available.	H25-057

**CHAPTER 6B: Interim Housing Resources (Motel
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		Removed using SA266 to reimburse CCGs for making ERA payments. Added line about providers being allowed to make an additional motel stay payment for a client without having submitted invoices for payment from a previous stay. Added section on MIST eligibility and declining personal care.	
4/2026	Joana	Removed funding chart Updated information regarding SA294,U4. Added info regarding PANs required for HRSN Added info regarding SHAs administration fee reimbursement. Removed ERA referral document.	
07/2026	Tom	Updated contact info for ERA and MIST. Added information to the Q&A section regarding Spokane Housing Authority making payments for MIST and ERA. Added Identicard information.	



Permanent Federal Vouchers

Chapter 6C outlines the policies and procedures for administering permanent housing vouchers including the 811 Project Rental Assistance (PRA) program for HCS clients. These long-term housing resources provide stable, affordable housing for individuals. This chapter details eligibility criteria, the application and referral process, case management responsibilities, and ongoing compliance requirements to ensure that clients receive and maintain appropriate housing support.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Jonnie Matson - Rental Assistance Unit Manager - jonnie.matson2@dshs.wa.gov

Or

If you have questions or need clarification regarding Permanent Federal Vouchers, please contact:

Ian Harpole - Housing Integration Unit Manager - ian.harpole@dshs.wa.gov

For additional information please visit our website: [Office of Housing and Employment](#)

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BACKGROUND

The HCS Office of Housing and Employment (OHAE) is dedicated to offering housing and supported employment resources that honor client choice. We work to eliminate barriers and expand opportunities that align with an individual's vision for their life regardless of mental health, substance use disorder, race, language, age, ability, or other status.

OHAE brings together federal, state, and local resources to create opportunities and strategies to help clients access independent housing, and in collaboration with our community partners, help build an individualized array of services to support them. This chapter provides specific guidance around Housing and Urban Development (HUD) permanent federal vouchers and can help you refer clients who are eligible for them.

Whenever possible, we can offer guidance about difficult housing situations you might encounter with your client, including tips about working with clients experiencing homelessness. Affordable housing and tenancy support are complex topics that often do not have easy or quick solutions. Please let us know about other topics or obstacles you would like to see addressed in this chapter.

PERMANENT FEDERAL HUD VOUCHERS

Starting in 2011, the HCS Housing Team began collaborating with local Public Housing Authorities (PHAs) to make Housing Choice Vouchers (HCVs) available to DSHS clients. For background, the Housing and Urban Development (HUD) agency awards these vouchers (formerly known as Section 8) to the PHAs through a competitive process called "Notice of Funding Allocations" (or NOFAs). The voucher pays for a portion of the individual's rent, and the individual is responsible for paying 30% of their monthly household toward rent.

The different types of HCVs the HCS Housing Team administers are the Non-Elderly Disabled (NED1, NED2, Mainstream Voucher [MSV]) and the Referral Voucher Program (RVP). Your regional HCS Housing Program Manager can help you understand the eligibility criteria for these vouchers and let you know where there is current availability.

What is a "Non-Elderly Disabled" (NED) voucher?

HUD defines a "Non-Elderly Disabled Family" as a family whose head of household, or sole member, is 18-61 years of age at the time of lease signing, and the qualifying person has a disability. There are three subcategories of NED vouchers that target specific groups of people with disabilities:

- **NED Category 1** vouchers are available to the qualifying person (and their family, if applicable) regardless of their current living situation.
- **NED Category 2** vouchers are available to the qualifying person (and their family, if applicable) who is currently living in an institutional setting such as Skilled Nursing Facilities, hospitals, Residential Habilitation Centers for individuals with developmental disabilities, and Psychiatric Hospitals (Eastern and Western State). The institutional settings, though, **exclude** board and

care facilities (e.g., adult homes, adult day care, adult congregate living), residential services, and community-based congregate settings. Prison is also excluded.

- **NED Mainstream** vouchers (MSV) are available to the qualifying person (and their family, if applicable) who are institutionalized (see definition above), or at risk of institutionalization, or homeless, or at risk of homelessness. Please ask your regional Housing Program Manager for more information on what are the definitions of *at risk* and *homeless*, as these may vary depending on the PHA.

What Is the Referral Voucher Program (RVP)?

The RVP is a Housing Choice Voucher (HCV) and is not considered a NED voucher. It is available to individuals regardless of setting who are receiving HCS LTSS. There is a service component for this voucher and applicants should be agreeable to receiving LTSS. This voucher is available to applicants over the age of 18.

Where are permanent HUD vouchers available?

- Region 1:
 - City of Yakima: NED2 and MSV
 - Spokane, Ferry, Stevens, Pend Oreille, Lincoln, and Whitman Counties: NED 1 and Mainstream and RVP
 - City of Kennewick: NED1 and MSV
 - Okanogan County: MSV
- Region 2:
 - Snohomish County: NED2
 - Whatcom County: RVP
- Region 3:
 - City of Tacoma/Pierce County: NED2 and MSV
 - Jefferson and Clallam Counties: NED2
 - Cowlitz, Lewis, Pacific and Wahkiakum Counties: NED2

Does an individual have to reside in the area where the voucher is available?

No. Public Housing Authorities (PHAs) allow anyone to apply for vouchers or public housing, and eligibility is not based on the current location or residence of the applicant. Applicants currently living within the service area of the PHA, however, may be given preference.

What are the basic eligibility requirements for permanent HUD vouchers?

A household must meet all criteria:

- Be very low-income. A household's income must be at, or below, 50 percent of the Area Median Income as determined by HUD. Each year, HUD publishes these income limits for every housing market across the nation:
 - <https://www.huduser.gov/portal/datasets/il.html>
- Be a citizen or a non-citizen with "eligible immigration status," and



- Be in good standing with federal housing programs. Specifically, a household must not have:
 - Been evicted from federally assisted housing for illegal drug activity within the past 3 years.
 - Been required to register as a lifetime sex offender.
 - Been convicted of producing methamphetamine in federally assisted housing.
 - A criminal history may disqualify an applicant from the voucher. On a case-by-case basis, a denial can be appealed except for the above three categories.

What are the roles and responsibilities in the eligibility process?

There is a multi-level process for determining eligibility for and processing permanent HUD vouchers. HCS, contracted providers and Housing Authorities all have a role in the process.

- **HCS Housing Program Managers (HPMs):** Are responsible for screening and referring applicants from case managers that expressed their client's need for affordable housing. All referrals are made through HCS Housing Program Managers to Public Housing Authorities; individuals contacting Public Housing Authorities outside of this process will be directed to HCS Housing Program Managers.
- **HCS Case Managers:** Make referrals for HCS housing resources, create transition plans, and authorize transition goods and services.
- **Contracted Providers** (Community Choice Guides or Supportive Housing Providers): Complete tasks and purchases authorized by the HCS Case Manager to support the client in reaching transition and/or stabilization goals.
 - **Public Housing Authorities:** After receiving the initial application packet from HCS, they will screen the applicants on their prior tenant history, conduct criminal background checks, rental history, and screen for other criteria. Each PHA is then responsible for administering their program in accordance with their housing plan.

What is the process to refer a client for permanent HUD vouchers?

- **Contact your [Regional HCS Housing Program Manager](#) (HPM) with the client's name and ACES ID**
 - HPM will prescreen the client and determine if the client is eligible to apply.
 - If client is found eligible, HPM will email the housing application to the NFCM and cc supervisor.
 - This is the time to make a CCG referral -- if one hasn't been made yet.
- **Complete the application and provide supporting documentation**
 - If the client needs support completing the application and gathering documents, this can be provided by the NFCM, SNF Social Worker, or contracted provider.
- **Submit completed application to HPM**
 - HPM will review the documents and submit them to the PHA.
 - PHAs will schedule briefing appointment with the client and/or contact.
- **HPM will work with contracted provider and PHA on housing search and lease up process.**
- **Clients must remain in the SNF until the voucher is issued by the PHA. Once client has signed the lease, a transition date can be set, and client can move.**



What is the required documentation for my client to apply?

Depending on the PHA, the required application materials can vary. However, the following is a list of common items required. Ask your Regional Housing Program Manager about the specific documents required for your client's application:

- Current state issued photo ID. PHAs will not accept expired ID.
- Copies of Social Security card(s).
- Copies of current year's Social Security award letters or other first-party income verification. In some circumstances, HPM may be able to provide income verification via ACES.
- Copies of bank statements if clients have checking or savings accounts.
- Disability verification if client is not receiving income based on their disability.

How will I know if there are permanent HUD vouchers available?

When there is immediate availability of vouchers announcements about openings are distributed statewide via regular emails to HCS supervisors, Program Managers and RCL Specialists who should disperse the information to HCS Case Managers.

Is there a waitlist for permanent HUD vouchers?

Regional HPMs maintain short waitlists of eligible applicants. When there are enough applicants on a waitlist, the HPM will no longer accept additional applications. Because the turnover in vouchers is not predictable, the HPMs will not be able to predict how long a person may need to wait for an available voucher.

811 UNITS: PROJECT BASED RENTAL ASSISTANCE (PRA)

Funding for the 811 Project Based Rental Assistance (PRA) apartment units were created by a grant from HUD. The grant provides project-based subsidies for newly built or converted housing units statewide, providing an increase in the number of permanent, affordable housing units for non-elderly clients with disabilities. HUD administers this grant through the Washington State Department of Commerce, which partners with DSHS-HCS to make referrals to the units and coordinate services for residents.

What is the definition of an "811 PRA unit"?

An [811 Project Based Rental Assistance \(PRA\)](#) unit is created through a contract between the Washington State Department of Commerce and a housing provider. The subsidy is paid to the housing provider and cannot be transferred to another apartment or otherwise follow a client when they move. When a client moves from an 811 unit, the rental assistance does not move with them to the new location. The 811 PRA units are permanent housing, and tenants may live there if they continue to meet the annual eligibility criteria and remain in compliance with their lease agreement.

What locations in Washington State have 811 PRA units?



The following areas have [811 units](#):

- Region 1:
 - Spokane County: Spokane and Spokane Valley
 - Chelan County: Wenatchee
 - Benton County: Kennewick and Richland
 - Franklin County: Pasco
 - Yakima (coming June 2026)
- Region 2:
 - King County: Seattle, Renton and Auburn
- Region 3:
 - Thurston County: Olympia
 - Clark County: Vancouver
 - Clallam County: Port Angeles

Does an individual have to live in the city or county where the 811 PRA unit is located?

No. Property managers allow eligible applicants to apply for available units regardless of an applicant's current location or residence.

What are the basic eligibility standards for 811 PRA units?

A household must meet all of the following:

- Be extremely low-income. A household's income must be at or below 30 percent of the area-wide median income as determined by HUD. Each year, HUD publishes these income limits for every housing market across the nation: <https://www.huduser.gov/portal/datasets/il.html>
- Applicant must be between the ages of 18-61 at the time of lease signing.
- Be a citizen or a non-citizen with "eligible immigration status," and
- Be in good standing with federal housing programs. Specifically, a household must not have:
 - Been evicted from federally assisted housing for illegal drug activity within 3 years.
 - Been required to register as a sex offender.
 - A felony conviction for the manufacturing or production of methamphetamine.
 - A criminal history may disqualify an applicant from an 811 unit. Denials can be appealed on a case-by-case basis except for the above three categories.
 - Applicant must be active on a DSHS caseload upon move into the unit but are not required to maintain LTSS to retain the housing.

The Housing Program Managers will process 811 client applications in the order received, and when there are multiple applications for limited units, the above priorities will apply.



- 1st priority: People living in institutional settings and those that are homeless.
- 2nd priority: Individuals wishing to move from residential settings.
- 3rd priority: In-home clients needing other housing due to safety, accessibility or rent burden issue/s.

What are HCS's and the Property Management agency's responsibilities in the 811 PRA units' eligibility process?

There is a multi-level process for determining eligibility for 811 units. Both HCS and Property Managers are responsible for determining client eligibility. Due to the complex funding strategies used to create the tax credit properties that 811 units are in, eligibility criteria may also vary by property.

- **HCS Housing Program Managers:** Are responsible for screening and referring applicants from case managers who expressed their client's need for affordable housing. All referrals are made through HCS Housing Program Managers to 811 Property Managers; individuals contacting these agencies outside of this process will be directed to HCS Housing Program Managers.
- **HCS Case Managers:** Make referrals for HCS housing resources, create transition plans, and authorize transition goods and services.
- **Contracted Providers** (Community Choice Guides or Supportive Housing Providers): Complete tasks and purchases authorized by the HCS Case Manager to support the client in reaching transition and/or stabilization goals.
- **Property Management Agencies:** After receiving initial application packets from HCS, Property Managers will screen the applicants on their prior tenant history, conduct criminal background checks, rental history, and credit history checks, and screen for other criteria. Each agency is then responsible for administering the 811 program in accordance with its tenant selection plan.

How do I make a client referral for an 811 unit?

- **Contact your [Regional HCS Housing Program Manager](#) (HPM) with the client's name and ACES ID.**
 - HPM will prescreen the client and determine if the client is eligible to apply.
 - If client is found eligible, HPM will email the housing application to the NFCM and cc Supervisor.
 - This is the time to make a CCG referral -- if one hasn't been made yet.
- **Complete the application and provide supporting documentation.**
 - If the client needs support completing the application and gathering documents, this can be provided by the HCS CM, AAA CM, SNF Social Worker, or contracted provider.
- **Submit completed application to HPM.**
 - HPM will review the documents and submit them to the Property Manager.
 - Property Managers will schedule a briefing appointment with the client and/or contact. Once client has signed the lease, a move-in date can be set, and client can move.



What is the required documentation for my client to apply?

Depending on the Property Management agency, the required application materials can vary. However, the following is a list of common items required. Ask your regional HPM for specific documents required for your client's application:

- Current state-issued photo ID. Expired ID will not be accepted.
- Copies of Social Security Card(s)
- Copies of current years Social Security award letters or other first party income verification
- Copies of bank statements if clients have checking or savings accounts.

How will I know when there is an 811 unit available?

When there is immediate 811-unit availability the openings will be announced to the field via email notifications or the [OHAE Housing SharePoint Site](#).

Is there a waitlist for 811 units?

Regional HPMs maintain waitlists of eligible applicants. HUD 811 PRA waitlist applications are submitted and maintained on the [OHAE SharePoint site](#). When there are enough applicants on a waitlist, the HPM will no longer accept additional applications. Because the turnover in 811 PRA units is not predictable, the HPMs will not be able to predict how long a person may need to wait for an available 811 PRA unit.

RESOURCES

[Housing Team Contacts](#)

[Office of Housing and Employment Website](#)

[HCS Housing Resources](#)

[Federal Vouchers One-Pager](#)

[811 Units One-Pager](#)

[LTSS One-Pager](#)

[Zero Income One-Pager](#)

[Income Discrimination Flyer: Legal Protection from Discrimination Based on Tenant's Source of Income](#)

Video: [Options for Housing Through Long-Term Care Services](#)

RAC 3132: Health Related Social Needs - Federal

Motel Interim Stays for Transitions (MIST) SA294u1

Motel Interim Stays for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period. Federal MIST is funded via the 1115 waiver in which the Washington State Health Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. This includes temporary housing.

Who is eligible for federal MIST?

HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications:

1. **HCS Subsidy (Bridge or Acute Care Hospital)**
 - Bridge Subsidy: HCS clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. Client must be required to leave their SNF for non-medical reasons; Bridge clients cannot choose to leave their SNF in order to utilize a MIST funded hotel.
 - Acute Hospital Care (ACH) Subsidy: HCS clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier.
2. **GOSH Program:** HCS clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness.
3. **Other Housing Resource:**
 - HCS clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VASH, etc.
 - HCS clients who have been approved for a project-based resource and have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency.
4. **In-Home Short-Term Displacement:** HCS clients who have their own home and a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding.
5. **Experiencing Homelessness:** HCS clients experiencing homelessness, at risk of homelessness or fleeing domestic violence or other unsafe

	situations. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u1?	1. Payment for up to 6-month period for a Medicaid HCS client to stay at a motel/hotel.
What is not covered under MIST 294u1?	1. Deposits 2. Damages (Please see RAC 3131 SA294,U2)
How much can I spend?	1. Up to \$5,000 per month for a total of six months. • Note: not to exceed six months
Do I need to use a Community Choice Guide (CCG) or GOSH provider?	Yes. 1. The HCS/AAA CM will need to coordinate with the CCG or GOSH provider and notify them that the client has been authorized for Motel Interim Stays for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. 4. The CCG or GOSH provider can make payments, or Spokane Housing Authority can be authorized to make payments.
How do I authorize federal MIST payments?	1. Upon receiving approval for MIST, the HCS/AAA CM will receive an approval email with specific instructions. should open RAC 3132. 2. For instructions on how to authorize MIST payments, please see the MIST Authorization Desk Guide . 3. If you are using Spokane Housing Authority to make the MIST payments, please see the MIST Guide for Spokane Housing Authority Payments .
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for federal MIST?	No. 1. When the approved MIST amount is above \$2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.

Federal Emergency Rental Assistance is funded via the 1115 waiver, in which the Washington State Health Related Social Needs (HRSN) Services Program will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. These includes rent.	
Who is eligible for federal ERA?	1. An HCS or AAA client who is experiencing or at risk of experiencing homelessness, including facing immediate eviction due to non-payment of rent.
What is covered under federal ERA?	1. A one-time payment made directly to landlords on behalf of an HCS or AAA client who is facing an immediate eviction due to non-payment of rent. 2. Late fees can be included.
What is not covered under federal ERA?	1. ERA does not include pre-tenancy deposits or move-in costs. 2. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent. 3. Any fees other than late fees.
How do I make payment?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide, GOSH Supportive Housing Provider, or Spokane Housing Authority) to make the ERA payment on the client's behalf.
How do I authorize federal ERA	1. Use RAC 3132. 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Housing Program Manager.
Are ETRs allowed for the federal ERA?	No. 1. Note: When the approved ERA amount is above \$4000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

RAC 3131: Long-Term Services and Supports Housing Stabilization – State Funds

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy SA299u1

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy	
Who is eligible for GOSH?	HCS/AAA clients who are receiving Medicaid long-term services who are choosing In-Home setting and: 1. Are willing to work with a Supportive Housing Provider, and 2. qualify for HCS services (financially & functionally eligible), and

	- are discharging or being diverted from Eastern or Western State Hospitals. - An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS), or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. - HCS clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by the State Hospital Discharge and Diversion (SHDD) team, and wish to live independently.
What is covered under GOSH SA299,U1?	Services that support an individual's ability to prepare for and transition to housing, including direct and collateral services: - Screening and housing assessment for individual's preferences and barriers. - Developing an individual housing support plan: identifying goals, addressing barriers, establishing approaches to meet goals, including identifying available services and resources. - Assisting with eligibility determination, housing applications, subsidy applications, and housing searches. - Identifying resources for modifications and/or one-time move-in needs. - Assisting in arranging for and supporting details of moving into housing. - Training on roles, responsibilities, and rights of tenant and landlord. - Developing housing support crisis plan. - Maintaining participant and collateral contacts, and timely completion of supportive housing deliverables as outlined in "Service Standards for Providers."
What is not covered under GOSH SA299u1?	- Rent - Move-in costs - Utilities
How much can I spend?	160 units per month
Do I need to use a contracted provider?	Yes. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH SA299u1?	Once the referral has been accepted by the SHPM:

	1. The SHPM will open RAC 3131 – LTSS Housing Stabilization and then the pre-tenancy Supportive Housing service code, SA299-U1, to open the SH authorization in CARE. 2. It is the SHPM’s responsibility to open, extend and close authorizations for service code SA299, U1.
When do I authorize this service?	1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
Are ETRs allowed for GOSH SA299u1?	No.
What about SA299,U1 for Civil Transitions Program?	1. Supportive Housing services are available through GOSH for those who meet Civil Transition Program eligibility (see Chapter 9b). 2. For clients meeting Civil Transition Program (CTP) eligibility only, use the appropriate CTP RAC and then authorize SA299u1 with the Reason Code “Civil Transitions Program”. 3. If a Civil Transition Program client ends up eligible for LTSS: • End CTP RAC • End SA299,U1 authorization, then: ○ Open RAC 3131 LTSS Housing Stabilization ○ Open SA299,U1 and use Reason Code “5440 FEFE”, which stands for 5440 Functionally Eligible Financially Eligible.

Governor’s Opportunity for Supportive Housing (GOSH) Tenancy H0044

Governor’s Opportunity for Supportive Housing (GOSH) Tenancy	
Who is eligible for GOSH?	1. HCS/AAA clients who are receiving Medicaid long-term services who: are choosing In-Home setting and: 2. Are willing to work with a Supportive Housing Provider, and 3. Qualify for HCS services (financially & functionally eligible), and 4. Are discharging or being diverted from Eastern or Western State Hospitals. 5. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 6. HCS clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.

What is covered under GOSH H0044?	Services to support individuals to maintain tenancy once housing is secured, such as: 1. Early intervention for behaviors that might jeopardize housing, e.g., late rent payment, lease violations, etc. 2. Training on responsibilities and rights of tenant and landlord. 3. Coaching on relationship building with landlords, property managers, and neighbors, and assisting in dispute resolution. 4. Linking with community resources to prevent eviction
What is not covered under GOSH H0044?	1. Rent 2. Move-in-costs 3. Utilities
How much can I spend?	1. 1 unit per month (rate \$575)
Do I need to use a contracted provider?	Yes. 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH H0044?	Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization’s end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. 3. It is the responsibility of the SHPM to close the authorization for SA299, U1 and open an authorization for H0044. 4. The SHPM will update the tenancy service code, H0044, on an annual basis. If there are any concerns around client eligibility, staff with the SHPM.
When do I authorize this service?	GOSH Services should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager. Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization’s end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. Please note, the date when the tenancy service code, H0044, is opened will vary based on the terms of the SHP’s contract.
Are ETRs allowed for GOSH H0044?	No.
What about H0044 FOR Civil Transitions program?	1. H0044 should not be used for a client only eligible for the Civil Transition Program. 2. If a Supportive Housing client who was originally Civil Transition Program client ended up eligible for LTSS and secures housing use



	Reason Code “5440 FEFE”, which stands for 5440 Functionally Eligible Financially Eligible.
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Motel Interim Stays for Transitions (MIST) SA294u2

Motel Interim Stays for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client’s chances of ending up on services in their own home. The service is authorized for up to a 6-month period.	
Who is eligible for state MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: 1. HCS Subsidy (Bridge & Acute Care Hospital) • Bridge Subsidy: HCS clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. • Acute Hospital Care (ACH) Subsidy: HCS clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. 2. GOSH Program: HCS clients who are enrolled in the Governor’s Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. 3. Other Housing Resource: • HCS clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VASH, etc. • HCS clients who have been approved for a project-based resource <u>and</u> have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. 4. In-Home Short-Term Displacement: HCS clients who have their own home and a short-term situation that requires them to temporarily vacate. Ex: pest control or eradication, fire, or flooding. 5. Experiencing Homelessness: HCS clients experiencing homelessness, at risk of homelessness or fleeing domestic violence or other unsafe situations. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.

What is covered under MIST 294u2?	1. Payment for up to 6-month period for a Medicaid HCS client to stay at a motel/hotel. 2. Deposits. 3. Damages- (Requires HQ Approval. Please contact the Supportive Housing Program Manager).
What is not covered under MIST 294u2?	1. Monthly payment that exceeds \$4,000.
How much can I spend?	1. Up to \$4,000 per month for a total of six months.
Do I need to use a Community Choice Guide (CCG) or GOSH Provider?	Yes. 1. The HCS/AAA CM will need to coordinate with the CCG or GOSH provider and notify them that the client has been authorized for Motel Interim Stays for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. 4. The CCG or GOSH provider can make payments, or Spokane Housing Authority can be authorized to make payments.
How do I authorize state MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM will receive an approval email with specific instructions. should open RAC 3131. 2. For instructions on how to authorize MIST payments, please see the MIST Authorization Desk Guide. 3. If you are using Spokane Housing Authority to make the MIST payments, please see the MIST Guide for Spokane Housing Authority Payments. 4. If a client is enrolled in GOSH services, HCS/AAA CM will need to select "2017 Governors Request Supportive Housing" as the reason code. If client is not enrolled in GOSH Service, please select "No reason code needed" as the reason code.
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for state MIST?	No. 1. Note: When the approved MIST amount is above \$2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Housing Subsidy - Purchasing SA294u4

Housing & Employment Stabilization Services (H&ES). These state funded services are intended to fill specific gaps to provide transitional or stabilizing supports for clients who have received a housing or Supported Employment resource or had their housing/employment coordinated through HCS to sustain community living.

Who is eligible for state H&ES?	When an HCS client meets these qualifications: 1. Is found functionally and financially eligible and received a housing resource or had their housing coordinated through HCS; or 2. Is found functionally and financially eligible and enrolled with Supported Employment or had their employment coordinated through HCS; and 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own home, or are living in the community and need stabilization services to remain there; and 4. Do not have other programs, services, or resources to assist them with these costs; and 5. Are not eligible for federal funding.
What is covered under state H&ES?	Goods necessary to establish a residence such as essential household furnishings. 1. Items needed to help stabilize community living for a client. 2. Packing assistance. 3. Moving assistance. 4. Utility set-up fees or deposits. 5. Non-recurring health and safety assurances such as pest eradication, allergen control and/or extreme cleaning. 6. Rental deposits: all pre-tenancy payment requirements, including first month's rent, can be bundled as one deposit and reimbursed to a Community Choice Guide or a DSHS contracted Supportive Housing provider.
What is not covered under state H&ES?	1. Recreational or diversional items such as television, cable or DVD players. 2. Assistive Technology.
When do I need a provider contract?	1. A contracted provider (Community Choice Guide or GOSH SHP) will need to be authorized to complete purchases or/and payments on the behalf of the client.
How do I authorize state H&ES?	1. Open RAC 3131-LTSS Housing Stabilization. 2. Use Service Code SA294,U4 to authorize the necessary goods and services. 3. Select the appropriate reason code. Options are "In-Home Community Stabilization or Employment Stabilization"

	- Note in the Service Episode Record (SER) that the client is eligible for LTSS Housing Stabilization services and that you have Supervisory approval to authorize state only funds. - Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan. - Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615), prior to sending to DMS.
When do I authorize this service?	When an HCS client meets these qualifications: - Is found functionally and financially eligible and received a housing resource or had their housing coordinated through HCS; or - Is found functionally and financially eligible and enrolled with FCS Supported Employment or had their employment coordinated through HCS; and - Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own home, or are living in the community and need stabilization services to remain there; and - Do not have other programs, services, or resources to assist them with these costs; and - Are not eligible for federal funding.
Are ETRs allowed for state H&ES?	Yes. - An ETR will be required if the total amount of goods & services exceeds \$5000. - Select "other" for both ETR/ETP category & type. - Submit the ETR to "Committee, Housing ETR" - Note: If the amount Exceeds \$2500, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.	
Who is eligible for state ERA?	An HCS client who is facing immediate eviction due to non-payment of rent.

What is covered under state ERA?	1. A one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. 2. Late fees. 3. Other fees that are tied into the lease where client is at risk of eviction if they are not paid.
What is not covered under state ERA?	1. ERA does not include pre-tenancy deposits or move-in costs, including first month's rent.
How do I make payment?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide, GOSH Supportive Housing Provider, or Spokane Housing Authority) to make the ERA payment on the client's behalf.
How do I authorize state ERA?	1. Upon approval, the Housing Program Manager will provide instructions to authorize payment to a CCG or GOSH provider. 2. To authorize payment for Spokane Housing Authority, please see the ERA-SHA Reimbursement Guide.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Supportive Housing Program Manager. The HCS/AAA CM is only allowed to authorize the amount approved by the SHPM.
Are ETRs allowed for the state ERA?	Yes. 1. When the ERA request amount is above \$4000, this will generate an error message in CARE that will require the HCS/AAA CM to reach out to the Housing Program Manager to request an ETR and force the error. There is no formal ETR request process.

Community Choice Guide SA263

Payment for specialty services which provide assistance and support to ensure the eligible client's successful transition to the community and/or maintenance of independent housing as authorized by HCS and/or AAA staff.

CCG services may include but are not limited to the following:

- Locating and arranging appropriate, accessible housing; including working with local housing authorities and other community resource providers when applicable.
- Maintaining or assisting with obtaining affordable housing.
- When relevant, liaising among and with the client, nursing or institutional facility staff, case managers, housing providers (including AFH providers), medical personnel, legal representatives, formal caregivers, family members, informal supports and any other involved party.

- Necessary assistance to support the client's community living, including assistance in settling disputes with landlord.
- Educating client on tenant rights, expectations and responsibilities.
- Assisting client with filling out forms and obtaining needed documentation to aid in maintaining successful community living (forms may include initial and renewal voucher forms, lease agreements, etc.).
- Providing emergent assistance to avoid utility shut-off and/or eviction.
- Assisting client with locating and arranging transportation resources to effectively connect with community resources.
- Assisting client to locate and engage community integration activities.
- Training or education to client about accessing community settings or health services.
- Assisting client with finding a qualified caregiver.

Detailed instructions on how to make a CCG referral using Service Codes SA263 can be found in the [Chapter 7d](#): COPEs of the LTC Manual.

The updated CCG Activity Tracking Form can be found in the resources section of this chapter and in [Chapter 29](#): Roads to Community Living.

Related WACs:

[WAC 388-106-0270](#): What services are available under Community First Choice (CFC)?

[WAC 388-106-0030](#): Where can I receive services?

[WAC 388-106](#): Long Term Care Services

[WAC 388-106-1700](#) to [WAC 388-106-1765](#): [Supportive Housing](#)

Acronyms:

HPM: Housing Program Manager **LTSS: Long-Term Services and Supports**

CCG: Community Choice Guide **SHA: Spokane Housing Authority**

PBV: Project Based Voucher **AMI: Area Median Income**

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
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5/2020		Established	
8/2020		Added Chapter Section hyperlinks, Section 5B.6 GOSH and link to Supportive Housing WACs	
10/2020		Updated GOSH Pre-Tenancy service code and provided clarification around SHPM vs CM responsibility in “GOSH Client Accepted” section. Added Housing Team contacts under section 5b.11. In section 5b.4 added instruction on how to document HCS subsidy into CARE and Bridge file transition information. Added <i>Forms</i> to section 5b.11 including (2) new forms: HCS Bridge Referral and Bridge Referral and Application Process.	
2/2021		Added SA294 subsidy payment authorization information to section 5B.4. Moved GOSH Section from 5B.6 to 5B.5. Added clarification that there is no participation for Supportive Housing services. Added GOSH “Discharge Planning” and “Transition to Independent Housing” sections to 5B.5. Updated hyperlinks.	
5/2021		Deleted SA294 payment authorization process for P1. Added the need for CM support with quarterly Bridge tenancy verifications as well as annual re-certifications. Clarified steps to add “Housing subsidy (HCS/AAA)” and “Supportive Housing (HCS/AAA)” as Treatments on the Medical Screen in CARE. Added new procedure for referring to GOSH, hyperlinked to new DSHS 11-153 GOSH Referral form. Clarified GOSH eligibility and HCS and AAA CMs can refer. Clarified GOSH authorization responsibility. Hyperlinked to Chapter 30d to connect Supportive Housing service consults and consideration. Clarified on-going eligibility for GOSH clients regarding services and subsidy. Hyperlinked to Chapter 30d in the ‘How can I use CTS/CTSS/WA Roads section’. Updated PM Roles.	
8/2021		Added new staff contacts for all regions by way of link to RCL Housing Resources website. Updated Bridge Referral form, Participant Agreement and Referral and Application Process form. Added updated ERA form. Updated 811 HCS HPM role regarding DDA/DBHR referrals. Added expanded GOSH eligibility criteria.	
2/2022		Updated various links throughout the chapter. Updated HCS Subsidy P&P inserted Document. Updated Participant Agreement inserted document. Added <i>What is needed to transfer an HCS subsidy client from</i>	

		<i>HCS to the AAA?</i> Section. Updated GOSH section to add protocol to staff cases with SHPM prior to closing a GOSH client and protocol related to clients with short term institutional stays (e.g., re-hospitalization or jail).	
8/2022		Added RVP eligibility and availability. Update ERA with Hotel/Motel stay information and Process. Update link to ERA form. Add info from Chapter 5a regarding WA Roads and eligibility from HCS housing resources. Updated language around HCS to AAA case transfers and Annual Assessments for GOSH. Added some hyperlinks into the GOSH Section to animated YouTube Videos: What is the Governor's Opportunity for Supportive Housing? ; You've Been Referred to GOSH – Now What? ; Governor's Opportunity for Supportive Housing (GOSH): Good Discharge Planning	
11/2022		Added more detailed payment/authorization information for ERA SA298. Added in section from Chapter 5a on how to work with individuals on HCS Housing Resources who are not currently receiving LTSS. Added language on keeping GOSH participants open who are in jail or institutional stays into the Interim Setting section. General text/grammar corrections throughout document. Added Bellingham/Whatcom and Spokane RVP resource.	
2/2023		Updated Unit Manager titles. Updated "NED" section to "permanent HUD voucher" section and added more process details. Updated Chapter Section list to include new 5b.5. Updated 811 sections with more details regarding application process. Removed old versions of forms and added updated versions (Participant Agreement, Tips for Maintaining LTSS, Chapter Version HCS Subsidy P&P and Bridge referral). Added page numbers to footer. Added links to Brochures and Video.	
5/2023		HCS subsidy video link. Updates to Section 5b.5. Updated ERA form.	
8/2023		Updated information in the HCS Subsidy and GOSH sections related to CARE Changes. Clarified language related to ineligibility for permanent HUD vouchers.	
11/2023		Updated Emergency Rental Assistance Form. Clarified language and updated language in section 5b.5 "Working with individuals on HCS housing resources who are not currently receiving HCS LTSS". Updated GOSH Section to include new regional referral email addresses.	



1/2024		Chapter Links added and updated ERA form added	
2/2024		Added a green box in pages 14 & 24 & 29 & 34 with a process for possible no longer functionally eligible HCS clients who are already enrolled in a housing service. Added on page 33 & 34 Motel Interim Stay for Transitions (MIST) program description. Added MIST to Table of contents Page 2. Replaced Washington Roads RAC info in pages 17 & 21 & 29 with new info (RAC 3131- LTSS Housing Stabilization). Added on page 17 (1 d. and the HCS/AAA CM will extend the WA Roads RAC) & (2 i. GOSH Program Manager will end the GOSH authorization and end RAC 3131- LTSS Housing Stabilization, and HCS/AAA CM will end the WA Roads RAC). Removed from page 30 & 31 under reimbursements “while the Supportive Housing services are authorized by SHPM under the service code SA299,U1 the CM would authorize use of any CFC CTS/CTSS/WA Roads funds under a separate service code, dependent upon eligibility and funds used.”	
3/27/2024		Updated Bridge documents at bottom of document with most recent versions. Page 11 &12 amended for HCS Bridge Subsidy.	
5/7/2024		Removed Motel/Hotel language from ERA section. Corrected MIST referral email address. Added MIST Request Form. Added bullet on Civil Transition eligibility.	
6/17/2024		Added ERA email address. Updated ERA referral process. Removed “How do I make a referral for a client who I believe is eligible for ERA?” Updated MIST eligibility criteria (Bridge Subsidy, GOSH program, Civil Transitions Program, Other Housing Resource, In-Home Short-Term Displacement, & Limited Residential). Updated MIST referral Process outline. Updated & added “How is payment made for MIST?” process/procedure. Updated MIST Referral Form.	
9/3/2024		Added information regarding Bridge Subsidy waitlist, added information regarding Presumptive Eligibility, added policy information from chapter 9 regarding GOSH client unable to return to residential setting and being admitted to the hospital. Added policy information regarding if a client is incarcerated or hospitalized and how HCS pays the subsidy for up to 6 months. Added Stephen Miller contact info. Added Housing and Employment website, updated links to one pager. Updated table of contents to include	



		Presumptive Eligibility. Added Global Leasing info. Updated GOSH eligibility criteria.	
10/2024	Joana	Chapter 5b changed to Chapter 6. Chapter 6 Established	
11/2024	Joana	Added information regarding the HCS Acute Care Hospital Subsidy, and the referral/process and referral.	
01/2025	Joana	Edited information regarding the HCS Acute Care Hospital Subsidy	
04/2025	Joana	Chapter 6 was divided up into 4 sections and renamed. Chapter 6C- Permanent Federal Vouchers established. Update policy & procedure regarding Housing and Employment Stabilization Services when using with clients who have been inactivated from LTSS. Updated OHAE background and EDAI statement. Added a chart describing all the RACs and Service Codes associated with OHAE.	
07/2025	WJH	Through chapter changed language that referenced "ALISA" to "HCS"; Added information on RCL and HRSN STRA and how it is used in combination with state dollars to support a client's interim HCS Subsidy.	
04/2026	Joana	Removed funding chart. Updated information regarding SA294,U4. Updated/removed language around inactivated clients	
07/2026	Tom	Added information to the Q&A section regarding Spokane Housing Authority making payments for MIST and ERA.	



Housing & Service Coordination

Chapter 6D provides guidance on working with clients experiencing homelessness, documenting housing resources in CARE, and effectively pairing Long-Term Services and Supports (LTSS) with housing assistance. This chapter outlines when the LTSS RAC can be used to authorize Goods & Services for clients accessing housing resources through HCS. Additionally, it covers best practices for integrating supportive services with housing solutions and highlights community-based housing resources that can further assist clients in achieving long-term stability.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Jonnie Matson - Rental Assistance Unit Manager - jonnie.matson2@dshs.wa.gov

Or

Samantha Thurston - Housing Integration Unit Manager - samantha.thurston1@dshs.wa.gov

For additional information please visit our website: [Office of Housing and Employment](#)

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BACKGROUND

The HCS Office of Housing and Employment (OHAE) is dedicated to offering housing and supported employment resources that honor client choice. We work to eliminate barriers and expand opportunities that align with an individual's vision for their life regardless of mental health, substance use disorder, race, language, age, ability, or other status.

OHAE brings together federal, state, and local resources to create opportunities and strategies to help clients access independent housing, and in collaboration with our community partners, help build an individualized array of services to support them. This chapter provides specific guidance around Housing and Urban Development (HUD) permanent federal vouchers and can help you refer clients who are eligible for them.

Whenever possible, we can offer guidance about difficult housing situations you might encounter with your client, including tips about working with clients experiencing homelessness. Affordable housing and tenancy support are complex topics that often do not have easy or quick solutions. Please let us know about other topics or obstacles you would like to see addressed in this chapter.

GUIDANCE ON WORKING WITH CLIENTS WHO ARE HOMELESS

The following information will assist case management staff in determining options for working with clients who are eligible for Long Term Services and Supports (LTSS) and are currently homeless or facing housing instability.

May a client receive personal care or other LTSS in a shelter, RV or other location that is outside the typical in-home setting?

Yes, *in-home* refers to settings other than institutional or licensed residential and does not require that a person reside in a house or apartment. LTSS may be provided in an alternative setting when there is a provider available to meet the client's request. If you have questions, please consult with your HPM.

[WAC 388-106-0270](#): What services are available under community first choice (CFC)?

[WAC 388-106-0030](#): Where can I receive services?

The Challenging Cases Protocol can also be used, and is often necessary, when working with clients who are experiencing homelessness. See [Chapter 5](#) for more information.

What can I do when I have assessed a client who is homeless and there are no possible in-home locations to provide personal care?



- Look into eligibility for [Foundational Community Supports \(FCS\) - Supportive Housing \(SH\)](#) or GOSH.
- Consider eligibility for [FCS-Supported Employment](#).
- If the client has access to any housing opportunities and is not FCS-SH eligible, consider authorizing a Community Choice Guide through Roads to Community Living, [COPES](#) or a state-funded service package LTSS Housing Stabilization or WA Roads.
- If the client has behavioral challenges that are affecting the establishment of LTSS, consider making a [Behavioral Supports H2019](#) (Chapter 5a) referral.
- If a client is initially declining personal care services, it is allowable to use the COPES [Wellness Newsletter](#) to keep a client open while working on a different Care Plan.
- Before closing a case for a client who is homeless but open to accepting services, consult the [Challenging Cases Protocol](#) and consider contacting your regional HPM to see if they are aware of any resources that may be available.
- Also see [Community Resources for Housing](#).

How do I document working with a client who is experiencing homelessness and declines all services?

Some clients experiencing homelessness go through the HCS assessment process multiple times as referrals for an intake are made by community providers (hospitals, shelters, etc.). It is important to document through a SER the reason the client is declining services, and the strategies used to engage the client in accepting services or locating a reasonable setting for the client to receive those services. It is also important to list any information given by collateral contacts so that the information can be referred to in future contacts with the client.

DOCUMENTING HCS HOUSING RESOURCES IN CARE

What are the changes or additions I need to make in CARE when I refer a client to an HCS housing resource?

It is important to document that your client will receive an HCS housing resource so that if/when the case transitions, the information can be communicated to the new case manager. When a client has been offered an HCS housing resource, the following additions can be made in CARE:

All SERs regarding housing should be entered using the **Housing** purpose code.

For clients utilizing the HCS Subsidy, the HCS CM must enter the following into the CARE assessment:

- Add "Housing subsidy (HCS/AAA)" as a Treatment for HCS Bridge and HCS GOSH subsidy recipients



- On the Medical Screen in CARE, choose the Program “Housing Subsidy (HCS/AAA)”
- Check “No” for Received in the Last 14 days?
- Check “Yes” for Need
- Choose “Agency” for the Provider
- Choose “PRN” for Frequency
- For Comments, type: *“Client will be receiving the HCS Housing Subsidy administered by Spokane Housing Authority.”*
- Add Spokane Housing Authority as a Paid Provider in the Care Planning section under the Supports Screen and assign the provider the task of “Housing subsidy (HCS/AAA)”

For clients utilizing a [NED voucher](#) or [811 unit](#), the CM must:

- Adding or updating the Housing Program Manager on the collateral contact screen.

For clients utilizing **Foundational Community Supports** or **GOSH Supportive Housing**, the CM must:

- Add Supportive Housing (HCS/AAA) as a Treatment in the Medical Screen and in the Care Planning section, and under supports assign the authorized Supportive Housing Provider the task of Supportive Housing (HCS/AAA) and Other (for Community Transition Services).

HOUSING & EMPLOYMENT STABILIZATION SERVICES

For HCS clients who are found functionally and financially eligible for LTSS, **and** have received a housing resource or had their housing coordinated through HCS; **or** enrolled with Supported Employment or had their employment coordinated through HCS; **and**:

- Transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own home or are living in the community and need stabilization services to remain there, and
- Does not have other programs, services, or resources to assist them with these costs, and
- Is not eligible for federal funding:
 1. Use Service Code SA294,U4 (Housing Subsidy-Purchasing) to authorize the necessary goods and services (background screening to aid housing search, paying for rental deposit and first month’s rent, utility hookup fees, purchase of furniture, purchase of essential items including needed clothing, or/and assistive technology) needed to transition or/and stabilize the client safely back to the community. Please note, an ETR will be required if the total amount of goods & services exceeds \$5000.
 2. Select the appropriate reason code. Options are “In-Home Community Stabilization” or “Employment Stabilization”
 3. When submitting an ETR, select “other” for both ETR/ETP category and type.



4. Submit the ETR for approval/denial to “Committee, Housing ETR” and email housingcommitteeetr@dshs.wa.gov to inform us about the ETR request.
5. Note in the Service Episode Record (SER) that the client is eligible for Housing & Employment Stabilization services and that you have Supervisory approval to authorize state only funds.
6. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client’s service plan.
7. Receipt(s) or/and invoice(s) for all purchases must be included in the participant’s electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615).

PAIRING SERVICES WITH HOUSING RESOURCES

Whether a client is using an HCS Housing Resource or a community housing resource, they may need Community Transition and/or Stabilization supports and/or services to be able to access or maintain housing. When a client has an opportunity to utilize a subsidy, or move into other affordable housing, these services and supports can be utilized. The following resources may be used to facilitate the moving process with the client. These resources can also be used to stabilize and sustain housing for a client to prevent a loss of affordable housing.

How can I use Supportive Housing services to assist my client with a housing resource?

Supportive Housing services are available in two ways for HCS recipients:

- Individuals who are currently residing in the community may be eligible for Supportive Housing services under “[Healthier Washington Medicaid Transformation: Foundational Community Supports \(FCS\): Supportive Housing services.](#)”
- Individuals with challenging or complex needs who are currently residing at Eastern or Western State Hospital or can be diverted from these institutions may access Supportive Housing Services through the Governor’s Opportunity for Supportive Housing (GOSH). For more information on GOSH, please see Chapter 6E.

Supportive Housing is a housing support service that can serve a client in assisting with pre- and post-tenancy tasks. The service is intended to support a client for as long as they need and want the service.

Supportive Housing services may be an option for individuals who want to live independently and have a history of unsuccessful housing episodes without coordinated, focused support services. HCS seeks to provide person-centered, responsive, low-barrier services for these individuals.

To learn more about the full spectrum of services that FCS Supportive Housing can provide, and the eligibility criteria and referral process for that program, please see [Chapter 30d](#).

How do I use Community Transition Services (CTS) or Housing & Employment Stabilization services to assist my client with a housing resource?



Clients may access HCS CTS and H&ES, depending on their eligibility criteria. To determine which services to use, please see the corresponding LTC Manual Chapters:

- Community Transition Services (CTS) through Community First Choice, see [Chapter 7b](#).
- Community Transition Services (CTS) through COPES, see [Chapter 7d](#).
- Community Transition Services (CTS) through Roads to Community Living (RCL), see [Chapter 29](#).
- Housing & Employment Stabilization Services through RAC 3131- LTSS Housing Stabilization is for clients that are only eligible for state funding and have an HCS subsidy or are enrolled with Supported employment. All goods and services can be authorized using service code SA294,U4.
- To find out more about working with Community Choice Guides or Supportive Housing Providers to provide Community Transition or Sustainability Services for clients, please see the Community Choice Guides and FCS-SH Providers section of [LTC Manual Chapter 30d: Foundational Community Supports – Supportive Housing Services](#).

Please note that individuals who are receiving an HCS Housing Resource are immediately eligible for Housing & Employment Stabilization Services and the goods and services it provides.

All clients active on LTSS and receiving an HCS Housing Resource (NED, 811, HCS Subsidy) have access to transition/stabilization services through the duration of their subsidy. Clients can access CTS/Housing & Employment Stabilization Services repeatedly for housing transition or stabilization needs. Regardless of the program through which your client can receive the transition/stabilization services, the goal of supporting clients in accessing and maintaining housing is the same. Pairing services and supports with a housing resource can provide the client a highly successful community transition and contribute to the person's housing stabilization.

***Please note:** Community First Choice, COPES, and Roads to Community Living services are always the priority programs for transition services. Housing & Employment Stabilization Services, in contrast, need supervisor approval because the services are paid for using state-only funding and may only be used when a waiver/state plan service does not address the client's need. The links above to Chapters 7b and 7d provide details on what the supports and services are, but here are a few case scenarios to help you understand how you could use the resources and services:

Scenario 1:

Doug lives in a subsidized apartment for seniors and received an eviction notice for non-payment of rent. This is the 3rd time recently that Doug has called for help with the same issue, but all the other times he was able to access a different community resource for help. This time, he has been turned down and needs \$168 to pay his portion of the rent or he will be evicted. Doug admits to having problems with his neighbors and feels like his landlord does not like him. Doug is also having a hard time keeping caregivers, and the last agency he was with has recently said they can no longer serve him.

How can CTS/Housing & Employment Stabilization Services?

- Emergency Rental Assistance can be used to pay the \$168 and prevent eviction. A CCG is used to make the payment directly to the landlord.
- Since there is a history of not paying his portion of the rent, and also some other tenancy issues with neighbors and the landlord, consider making a Foundational Community Supports - Supportive Housing referral (see [Chapter 30d](#) for eligibility criteria). A Supportive Housing provider could assist Doug with his longer-term housing stabilization needs as well as assist him with budgeting and possibly recommending a Payee and/or other community resources. A Supportive Housing provider may also be able to support Doug in caregiver retention strategies.

Scenario 2:

Louise has been rehabilitating in a SNF for the past year and is ready to transition into a community setting with in-home services. Louise lost her past housing due to a family situation and does not have a home to transition to. Louise meets the eligibility criteria for category 2 NED and has been offered an available voucher. Louise cannot remember the last time she held a lease in her name but does have some household items stored along with her personal belongings at a friend's house. Since Louise has been in the SNF, she has not received any of her monthly Supplemental Security Income and does not have any money saved, nor anyone with funds who can assist her. However, Louise knows that her friend will help her move her belongings and may be able to help her with some household furnishings. Louise does not have any other friends or family that can help her with paperwork or looking for an apartment and she feels overwhelmed at the idea of managing this transition on her own. Louise also admits that she does not know where her identification is.

How can CTS/Housing & Employment Stabilization Services?

- Louise can be referred to work with a Community Choice Guide (CCG), who can help her complete the NED2 application packet and gather the supporting documentation. The CCG can also assist her with obtaining a new identification card, including paying the fee*. Since Louise cannot remember her housing history and in order to prepare for the housing search, the CCG can also assist her in obtaining a Tenancy Background Screening Report and pay for that fee as well.
- The CCG can also assist Louise with her housing search by finding apartments and taking her to view them. Once Louise has found a unit that suits her, the CCG can assist her with the apartment application and pay the processing fee to the landlord. Once approved, the CCG can also pay the deposit and pro-rated 1st month's rent so the client can sign the lease and get a move-in date. With her move-in date established, the CCG can also assist Louise with setting up her electricity account and paying her required \$100 utility deposit since Louise has never had an account in her name.
- Louise was able to go through her stored items and she feels she has most things she needs to live independently. Her friend is helping her with a bed and dresser as well. The only basic items that Louise is missing are a lamp, bath towels and cookware. Upon CM authorization, the CCG can purchase these items for the client.
- Since Louise has not lived independently for some time, the CCG can also be tasked with helping her to create a monthly budget and helping her in finding community resources for assistance with food and utilities. The CCG can also assist Louise in determining what bus routes are close to her for her non-medical transportation needs.

*CCGs pay for approved items and then submit for reimbursement.

Coordinated Personal Care (CPC)

Background

Due to ongoing caregiver workforce shortages, some clients experience delays in accessing authorized personal care services. Historically, these delays created significant risk for clients who require assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Coordinated Personal Care was developed as a pilot program to address these service gaps. The program focuses on accelerating access to care by coordinating available caregiving resources and implementing alternative service strategies when standard provider matching is not immediately available. CPC ensures continuity of care while longer-term service arrangements are being secured.

Program Overview

Coordinated Personal Care is a client-centered service model designed to provide greater flexibility and responsiveness in care delivery. Care providers are assigned to specific geographic areas, enabling them to serve multiple clients within a defined service radius. This approach, combined with collaboration between dedicated care providers and building staff, supports more reliable and coordinated caregiving in historically hard-to-serve locations. For more information on CPC please [click here](#).

What if a client is receiving a housing service but declining personal care?

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 (to include remote caregiving), 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 declines personal care, this can cause the client to be found functionally ineligible for Long-term service and supports. Case Managers are required to offer all services a client is eligible for and inform them of what declining personal care may mean for their Medicaid medical benefits and home and community-based services and supports, including the client losing their housing subsidy.

Guidance for when a client is declining personal care

When individuals become ineligible and inactive from LTSS, they may only retain their subsidy through the end of their current lease terms. The following steps can be tried to support the client in remaining eligible for LTSS so that they can keep their subsidy.

Work with the client and others on their support team and, when appropriate, inform the team of the client's decision to decline personal care.

1. **Gather collateral information** on how the client functions and what informal or unpaid support they are receiving and ensure it is coded accurately in the assessment. See the Assessing Status (Informal Supports) section of LTC Manual Chapter [3](#).
2. **Utilize another service provider** who may have a different relationship with the client to discuss the situation with them.
3. **Consider whether the client is in crisis or decompensating.** Give the client time and opportunity to access other services to support a return to their baseline, when possible.

Offer **all services** the client is eligible for.

Make sure **LTC Manual chapter guidelines** are followed for the benefit package the client is functionally and financially eligible for and enrolled in. For the benefit packages below, clients may receive a service or item they are eligible for, with or without personal care services authorized. **Please note, this does not apply if the client is declining personal care services.**

- Community First Choice (CFC), LTC [Chapter 7b](#) states a CFC client may receive any CFC service or item they are eligible for, with or without personal care in place.
 - A **CFC** client who is eligible for and needs/wants a PERS unit, does not need to be authorized for personal care services to receive the CFC benefit of PERS service.
 - Please note, 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.
- When an individual is found eligible for CFC+**COPES**, there are many additional COPES waiver services a client can choose from that are found in [Chapter 7d](#).
 - As an example, a COPES eligible client can choose to receive the Wellness Newsletter if they are eligible and do not need to be authorized for personal care services to receive the waiver benefit.
- Roads to Community Living (**RCL**) [Chapter 29](#)
 - Individuals who are enrolled in **RCL** have many service options beyond personal care and can be found in the chapter link.
 - If you are working with a client who is on **RCL**, please contact an **RCL** Enrollment Specialist prior to inactivating services. DSHSALTSARCLReferrals@dshs.wa.gov
- If the individual is Medicaid Personal Care (**MPC**) eligible, as this LTSS program is limited to personal care services (see [Chapter 7c](#)), a client who is not declining personal care may access services through a state-funded benefit package. Examples include:
 - Community Choice Guide through Housing Stability RAC 3131
 - GOSH Supportive Housing Service
 - Client Training: Behavior Support through WA Roads (RAC 3120)

Offer **Remote Caregiving** when and where available.

The delivery of personal care services, using remote caregiving assistance, can be used for tasks that don't require hands-on assistance, stand-by, and/or physical set-up, alone or in combination with an in-person caregiver.

- Remote Caregiving [SharePoint](#)
- DSHS Remote Caregiving [Website](#)
- For questions RemoteCaregiving@dshs.wa.gov

Staff client's case with supervisor and utilize **Targeted Case Management** in [Chapter 5](#).

Contact the [Housing Program Manager](#) for assistance.

Use the **Challenging Cases Protocol** in [Chapter 5](#).

The purpose of the Challenging Cases Protocol is to promote statewide consistency in working with complex clients before denying or terminating services. Service termination does not abdicate standard case management practice. The protocol recognizes the client's preferences of care, services, and life choices. Every effort must be made toward resolution of issues that may lead to denial or termination of services.

Staff the situation in either a Complex Care Case Staffing meeting or the **Housing Supports Case Staffing** meeting.

For an invitation to the Housing Supports Case Staffing meeting. Please contact your regional [Housing Program Manager](#).

If the client's assessment is in current status, and the client decides they do not want to receive personal care (declines personal care), do I need to complete another assessment?

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". An interim assessment is used to report information about the client that is **not** related to a change in the client's condition.

See LTC Manual [Chapter 3](#), *When do I perform an interim assessment?*, for more information.

If a client declining personal care results in them being ineligible for LTSS, a Significant Change assessment must be completed prior to inactivating the case. See LTC Manual [Chapter 3](#).

Steps to follow when the AAA sends a case back for no personal care services authorized.

- **Make sure file meets minimum requirements** for transfer per [Chapter 3](#).
 - Clients are not required to have a personal care authorization to be transferred and case managed by the AAA. (see [chapter 3](#))
- **Follow Transfer Protocol** per [Chapter 5](#).

- **Consider a case staffing amongst offices.** If needed, escalate to the appropriate HQ expert listed in chapters [3](#) or [5](#).

Follow the process of **terminating** services.

- See [Chapter 3](#) of LTC Manual.

Follow **best practices** in documentation.

- See [Chapter 5](#) of the LTC Manual.
- See [Chapter 27](#) for Notices

HOW DO I EXIT A CLIENT WHO HAS AN HCS SUBSIDY BUT IS NO LONGER ELIGIBLE FOR LTSS?

- The HCS/AAA case manager will communicate the following to the client “Due to your Long-Term Services and Supports being terminated, your housing subsidy/rent assistance is also being terminated at the end of your current lease. You will then be responsible for the full rent amount.”
- The HCS/AAA case manager will hold the case for up to 90 days from the date the client is no longer eligible for services.
 - If the client cannot afford the full rental amount without subsidy support, this transition period allows time to identify and secure affordable housing, apply for alternative programs, and coordinate relocation as needed. This process helps prevent housing instability and reduces the risk of homelessness prior to case closure.
 - If the client has a GOSH provider, they can continue working with the client for the 90-day period to work on alternatives. Please see Chapter 6E for more information, including guidance on GOSH termination PANs.
 - If the client wants support in finding housing alternatives, a Community Choice Guide (CCG) can be authorized for 90 days through RAC 3131- LTSS Housing Stabilization. Since the HCS subsidy is a state paid service, no PAN is required. Please reach out to HPM to notify them that the client will become inactive.
 - The HCS/AAA case manager will offer the client alternatives (Foundational Community Support referral, resource list, etc.).
- The HCS/AAA Case manager will notify the assigned Housing Program Manager when the client has been found not eligible for services.
- The HCS/AAA will need to verify that all Contracted Providers working with the client have been reimbursed before inactivating the case.



- If there is a determination that the individual needs and wants LTSS within the 90-day period, the HCS/AAA case manager should contact the HCS office for an Initial/Reapply assessment. Once the Initial/Reapply assessment is complete, the case is transferred back to the AAA.

WHEN CAN A CLIENT'S HCS SUBSIDY BE TERMINATED?

- When they refuse to complete an Initial, Annual or Significant Change CARE Assessment, or
- They do not meet functional and/or financial eligibility for HCS Long-Term Services and Supports, or
- They decline personal care services, or
- They refuse to apply for an available permanent housing voucher or other permanent affordable housing, including waitlists, in their area, or
- They are absent from your HCS-subsidized unit for more than 180 continuous days, or
- They do not allow the required, biannual housing inspection, or
- They no longer live in their unit, or
- Their actions have created an unsafe or illegal situation in their subsidized unit, or
- They accept a different subsidy or move into a permanently subsidized apartment.

HOUSING RESOURCES THROUGH CIVIL TRANSITIONS

Yes, a Civil Transitions Program recipient can access a specific housing resource through HCS. Participants in the Civil Transitions Program are eligible for HCS housing resources regardless of LTSS eligibility status. The Civil Transitions Program relates to individuals deemed by the court not competent to stand trial and not restorable due to a diagnosis of dementia, traumatic brain injury (TBI), or an intellectual or development disability (IDD).

Eligibility Criteria:

A Civil Transitions Program recipient that is referred to a housing resources, is eligible to access a housing resource without having to be functionally, or/and financially eligible for LTSS.

Which housing resources can a Civil Transitions Program Recipients Access:

They can access the following resources:

- Motel Interim Stay for Transitions (See [Chapter 6B](#))
- Housing and Employment Stabilization Services (See [Chapter 6D](#))



- Supportive Housing Services (see [Chapter 30D](#))

COMMUNITY RESOURCES FOR HOUSING

There are other community resources for housing that may be available to your client. The [Roads to Community Living internet site](#) contains regional information for community housing resources.

Additional Housing Resources are available for clients. Please visit [Housing Openings](#) to learn about waitlist openings for Project Based/ Mainstream/Housing Choice Vouchers.

RESOURCES

[Housing Team Contacts](#)

[Office of Housing and Employment SharePoint](#)

[HCS Housing Resources](#)

[Federal Vouchers One-Pager](#)

[811 Units One-Pager](#)

[LTSS One-Pager](#)

[Global Leasing One-Pager](#)

[Civil Transitions Program One-Pager](#)

[Zero Income One-Pager](#)

[Income Discrimination Flyer: Legal Protection from Discrimination Based on Tenant's Source of Income](#)

[HCS Bridge Subsidy Brochure](#)

[Governor's Opportunity for Supportive Housing One-Pager](#)

[MIST Field One-Pager](#)

Video: [Options for Housing Through Long-Term Care Services](#)

RAC 3132: Health Related Social Needs - Federal

Motel Interim Stays for Transitions (MIST) SA294u1

Motel Interim Stays for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period. Federal MIST is funded via the 1115 waiver in which the Washington State Health

Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. This includes temporary housing.	
Who is eligible for federal MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: HCS Subsidy (Bridge or Acute Care Hospital) - Bridge Subsidy: HCS clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. Client must be required to leave their SNF for non-medical reasons; Bridge clients cannot choose to leave their SNF in order to utilize a MIST funded hotel. - Acute Hospital Care (ACH) Subsidy: HCS clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. GOSH Program: HCS clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. Other Housing Resource: - HCS clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VASH, etc. - HCS clients who have been approved for a project-based resource <u>and</u> have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. In-Home Short-Term Displacement: HCS clients who have their own home <u>and</u> a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding. Experiencing Homelessness: HCS clients experiencing homelessness, at risk of homelessness or fleeing domestic violence or other unsafe situations. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u1?	Payment for up to 6-month period for a Medicaid HCS client to stay at a motel/hotel.
What is not covered under MIST 294u1?	- Deposits - Damages (Please see RAC 3131 SA294,U2)
How much can I spend?	- Up to \$5,000 per month for a total of six months. - Note: not to exceed six months

Do I need to use a Community Choice Guide (CCG) or GOSH provider?	Yes. 1. The HCS/AAA CM will need to coordinate with the CCG or GOSH provider and notify them that the client has been authorized for Motel Interim Stays for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. 4. The CCG or GOSH provider can make payments, or Spokane Housing Authority can be authorized to make payments.
How do I authorize federal MIST payments?	1. Upon receiving approval for MIST, the HCS/AAA CM will receive an approval email with specific instructions. should open RAC 3132. 2. For instructions on how to authorize MIST payments, please see the MIST Authorization Desk Guide. 3. If you are using Spokane Housing Authority to make the MIST payments, please see the MIST Guide for Spokane Housing Authority Payments.
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for federal MIST?	No. 1. When the approved MIST amount is above \$2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially. Federal Emergency Rental Assistance is funded via the 1115 waiver, in which the Washington State Health Related Social Needs (HRSN) Services Program will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. These includes rent.	
Who is eligible for federal ERA?	1. An HCS or AAA client who is experiencing or at risk of experiencing homelessness, including facing immediate eviction due to non-payment of rent.

What is covered under federal ERA?	1. A one-time payment made directly to landlords on behalf of an HCS or AAA client who is facing an immediate eviction due to non-payment of rent. 2. Late fees can be included.
What is not covered under federal ERA?	1. ERA does not include pre-tenancy deposits or move-in costs. 2. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent. 3. Any fees other than late fees.
How do I make payment?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide, GOSH Supportive Housing Provider, or Spokane Housing Authority) to make the ERA payment on the client's behalf.
How do I authorize federal ERA	1. Use RAC 3132. 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Housing Program Manager.
Are ETRs allowed for the federal ERA?	No. 1. Note: When the approved ERA amount is above \$4000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

RAC 3131: Long-Term Services and Supports Housing Stabilization – State Funds

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy SA299u1

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy	
Who is eligible for GOSH?	HCS/AAA clients who are receiving Medicaid long-term services who are choosing In-Home setting and: 1. Are willing to work with a Supportive Housing Provider, and 2. qualify for HCS services (financially & functionally eligible), and 3. are discharging or being diverted from Eastern or Western State Hospitals. 4. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS), or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order.

	HCS clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by the State Hospital Discharge and Diversion (SHDD) team, and wish to live independently.
What is covered under GOSH SA299,U1?	Services that support an individual's ability to prepare for and transition to housing, including direct and collateral services: - Screening and housing assessment for individual's preferences and barriers. - Developing an individual housing support plan: identifying goals, addressing barriers, establishing approaches to meet goals, including identifying available services and resources. - Assisting with eligibility determination, housing applications, subsidy applications, and housing searches. - Identifying resources for modifications and/or one-time move-in needs. - Assisting in arranging for and supporting details of moving into housing. - Training on roles, responsibilities, and rights of tenant and landlord. - Developing housing support crisis plan. - Maintaining participant and collateral contacts, and timely completion of supportive housing deliverables as outlined in "Service Standards for Providers."
What is not covered under GOSH SA299u1?	- Rent - Move-in costs - Utilities
How much can I spend?	160 units per month
Do I need to use a contracted provider?	Yes. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH SA299u1?	Once the referral has been accepted by the SHPM: - The SHPM will open RAC 3131 – LTSS Housing Stabilization and then the pre-tenancy Supportive Housing service code, SA299-U1, to open the SH authorization in CARE. - It is the SHPM's responsibility to open, extend and close authorizations for service code SA299, U1.
When do I authorize this service?	After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
Are ETRs allowed for GOSH SA299u1?	No.

What about SA299,U1 for Civil Transitions Program?	1. Supportive Housing services are available through GOSH for those who meet Civil Transition Program eligibility (see Chapter 9b). 2. For clients meeting Civil Transition Program (CTP) eligibility only, use the appropriate CTP RAC and then authorize SA299u1 with the Reason Code “Civil Transitions Program”. 3. If a Civil Transition Program client ends up eligible for LTSS: • End CTP RAC • End SA299,U1 authorization, then: ○ Open RAC 3131 LTSS Housing Stabilization ○ Open SA299,U1 and use Reason Code “5440 FEFE”, which stands for 5440 Functionally Eligible Financially Eligible.
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Governor’s Opportunity for Supportive Housing (GOSH) Tenancy H0044

Governor’s Opportunity for Supportive Housing (GOSH) Tenancy	
Who is eligible for GOSH?	1. HCS/AAA clients who are receiving Medicaid long-term services who: are choosing In-Home setting and: 2. Are willing to work with a Supportive Housing Provider, and 3. Qualify for HCS services (financially & functionally eligible), and 4. Are discharging or being diverted from Eastern or Western State Hospitals. 5. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 6. HCS clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.
What is covered under GOSH H0044?	Services to support individuals to maintain tenancy once housing is secured, such as: 1. Early intervention for behaviors that might jeopardize housing, e.g., late rent payment, lease violations, etc. 2. Training on responsibilities and rights of tenant and landlord. 3. Coaching on relationship building with landlords, property managers, and neighbors, and assisting in dispute resolution. 4. Linking with community resources to prevent eviction
What is not covered under GOSH H0044?	1. Rent 2. Move-in-costs

	3. Utilities
How much can I spend?	1. 1 unit per month (rate \$575)
Do I need to use a contracted provider?	Yes. 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH H0044?	Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization’s end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. 3. It is the responsibility of the SHPM to close the authorization for SA299, U1 and open an authorization for H0044. 4. The SHPM will update the tenancy service code, H0044, on an annual basis. If there are any concerns around client eligibility, staff with the SHPM.
When do I authorize this service?	GOSH Services should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager. Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization’s end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. Please note, the date when the tenancy service code, H0044, is opened will vary based on the terms of the SHP’s contract.
Are ETRs allowed for GOSH H0044?	No.
What about H0044 FOR Civil Transitions program?	1. H0044 should not be used for a client only eligible for the Civil Transition Program. 2. If a Supportive Housing client who was originally Civil Transition Program client ended up eligible for LTSS and secures housing use Reason Code “5440 FEFE”, which stands for 5440 Functionally Eligible Financially Eligible.

Motel Interim Stays for Transitions (MIST) SA294u2

Motel Interim Stays for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the

client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period.	
Who is eligible for state MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: HCS Subsidy (Bridge & Acute Care Hospital) - Bridge Subsidy: HCS clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. - Acute Hospital Care (ACH) Subsidy: HCS clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. GOSH Program: HCS clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. Other Housing Resource: - HCS clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VASH, etc. - HCS clients who have been approved for a project-based resource <u>and</u> have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. In-Home Short-Term Displacement: HCS clients who have their own home and a short-term situation that requires them to temporarily vacate. Ex: pest control or eradication, fire, or flooding. Experiencing Homelessness: HCS clients experiencing homelessness, at risk of homelessness or fleeing domestic violence or other unsafe situations. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u2?	- Payment for up to 6-month period for a Medicaid HCS client to stay at a motel/hotel. - Deposits. - Damages- (Requires HQ Approval. Please contact the Supportive Housing Program Manager).
What is not covered under MIST 294u2?	Monthly payment that exceeds \$4,000.
How much can I spend?	Up to \$4,000 per month for a total of six months.
Do I need to use a Community Choice Guide (CCG) or GOSH Provider?	Yes. The HCS/AAA CM will need to coordinate with the CCG or GOSH provider and notify them that the client has been authorized for Motel Interim Stays for Transitions for a period of up to 6 months.

	2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. 4. The CCG or GOSH provider can make payments, or Spokane Housing Authority can be authorized to make payments.
How do I authorize state MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM will receive an approval email with specific instructions. should open RAC 3131. 2. For instructions on how to authorize MIST payments, please see the MIST Authorization Desk Guide. 3. If you are using Spokane Housing Authority to make the MIST payments, please see the MIST Guide for Spokane Housing Authority Payments. 4. If a client is enrolled in GOSH services, HCS/AAA CM will need to select “2017 Governors Request Supportive Housing” as the reason code. If client is not enrolled in GOSH Service, please select “No reason code needed” as the reason code.
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for state MIST?	No. 1. Note: When the approved MIST amount is above \$2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Housing Subsidy - Purchasing SA294u4

Housing & Employment Stabilization Services (H&ES). These state funded services are intended to fill specific gaps to provide transitional or stabilizing supports for clients who have received a housing or Supported Employment resource or had their housing/employment coordinated through HCS to sustain community living.

Who is eligible for state H&ES?	When an HCS client meets these qualifications: 1. Is found functionally and financially eligible and received a housing resource or had their housing coordinated through HCS; or 2. Is found functionally and financially eligible and enrolled with Supported Employment or had their employment coordinated through HCS; and 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own
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	home, or are living in the community and need stabilization services to remain there; and - Do not have other programs, services, or resources to assist them with these costs; and - Are not eligible for federal funding.
What is covered under state H&ES?	Goods necessary to establish a residence such as essential household furnishings. - Items needed to help stabilize community living for a client. - Packing assistance. - Moving assistance. - Utility set-up fees or deposits. - Non-recurring health and safety assurances such as pest eradication, allergen control and/or extreme cleaning. - Rental deposits: all pre-tenancy payment requirements, including first month's rent, can be bundled as one deposit and reimbursed to a Community Choice Guide or a DSHS contracted Supportive Housing provider.
What is not covered under state H&ES?	- Recreational or diversional items such as television, cable or DVD players. - Assistive Technology.
When do I need a provider contract?	A contracted provider (Community Choice Guide or GOSH SHP) will need to be authorized to complete purchases or/and payments on the behalf of the client.
How do I authorize state H&ES?	- Open RAC 3131-LTSS Housing Stabilization. - Use Service Code SA294,U4 to authorize the necessary goods and services. - Select the appropriate reason code. Options are "In-Home Community Stabilization or Employment Stabilization" - Note in the Service Episode Record (SER) that the client is eligible for LTSS Housing Stabilization services and that you have Supervisory approval to authorize state only funds. - Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan. - Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615), prior to sending to DMS.
When do I authorize this service?	When an HCS client meets these qualifications: Is found functionally and financially eligible and received a housing resource or had their housing coordinated through HCS; or

	- Is found functionally and financially eligible and enrolled with FCS Supported Employment or had their employment coordinated through HCS; and - Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own home, or are living in the community and need stabilization services to remain there; and - Do not have other programs, services, or resources to assist them with these costs; and - Are not eligible for federal funding.
Are ETRs allowed for state H&ES?	Yes. - An ETR will be required if the total amount of goods & services exceeds \$5000. - Select “other” for both ETR/ETP category & type. - Submit the ETR to “Committee, Housing ETR” - Note: If the amount Exceeds \$2500, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.	
Who is eligible for state ERA?	An HCS client who is facing immediate eviction due to non-payment of rent.
What is covered under state ERA?	- A one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. - Late fees. - Other fees that are tied into the lease where client is at risk of eviction if they are not paid.
What is not covered under state ERA?	ERA does not include pre-tenancy deposits or move-in costs, including first month’s rent.
How do I make payment?	The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide, GOSH Supportive Housing Provider, or Spokane Housing Authority) to make the ERA payment on the client’s behalf.

How do I authorize state ERA?	1. Upon approval, the Housing Program Manager will provide instructions to authorize payment to a CCG or GOSH provider. 2. To authorize payment for Spokane Housing Authority, please see the ERA-SHA Reimbursement Guide.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Supportive Housing Program Manager. The HCS/AAA CM is only allowed to authorize the amount approved by the SHPM.
Are ETRs allowed for the state ERA?	Yes. 1. When the ERA request amount is above \$4000, this will generate an error message in CARE that will require the HCS/AAA CM to reach out to the Housing Program Manager to request an ETR and force the error. There is no formal ETR request process.

Community Choice Guide SA263

Payment for specialty services which provide assistance and support to ensure the eligible client's successful transition to the community and/or maintenance of independent housing as authorized by HCS and/or AAA staff.

CCG services may include but are not limited to the following:

- Locating and arranging appropriate, accessible housing; including working with local housing authorities and other community resource providers when applicable.
- Maintaining or assisting with obtaining affordable housing.
- When relevant, liaising among and with the client, nursing or institutional facility staff, case managers, housing providers (including AFH providers), medical personnel, legal representatives, formal caregivers, family members, informal supports and any other involved party.
- Necessary assistance to support the client's community living, including assistance in settling disputes with landlord.
- Educating client on tenant rights, expectations and responsibilities.
- Assisting client with filling out forms and obtaining needed documentation to aid in maintaining successful community living (forms may include initial and renewal voucher forms, lease agreements, etc.).
- Providing emergent assistance to avoid utility shut-off and/or eviction.
- Assisting client with locating and arranging transportation resources to effectively connect with community resources.
- Assisting client to locate and engage community integration activities.
- Training or education to client about accessing community settings or health services.
- Assisting client with finding a qualified caregiver.

Detailed instructions on how to make a CCG referral using Service Codes SA263 can be found in the [Chapter 7d](#): COPEs of the LTC Manual.

The updated CCG Activity Tracking Form can be found in the resources section of this chapter and in [Chapter 29](#): Roads to Community Living.

Related WACs:

[WAC 388-106-0270](#): What services are available under Community First Choice (CFC)?

[WAC 388-106-0030](#): Where can I receive services?

[WAC 388-106](#): Long Term Care Services

[WAC 388-106-1700](#) to [WAC 388-106-1765](#): Supportive Housing

Acronyms:

HPM: Housing Program Manager

LTSS: Long-Term Services and Supports

ERA: Emergency Rental Assistance

GOSH: Governor's Opportunity for Supportive Housing

FCS: Foundational Community Supports

SH: Supportive Housing

CCG: Community Choice Guide

SHA: Spokane Housing Authority

PHA: Public Housing Authority

PBV: Project Based Voucher

AMI: Area Median Income

FMR: Fair Market Rent

Forms:

[GOSH Referral Form](#)

[Tips for Maintaining LTSS](#)

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/2020		Established	
8/2020		Added Chapter Section hyperlinks, Section 5B.6 GOSH and link to Supportive Housing WACs	

10/2020		Updated GOSH Pre-Tenancy service code and provided clarification around SHPM vs CM responsibility in “GOSH Client Accepted” section. Added Housing Team contacts under section 5b.11. In section 5b.4 added instruction on how to document HCS subsidy into CARE and Bridge file transition information. Added <i>Forms</i> to section 5b.11 including (2) new forms: HCS Bridge Referral and Bridge Referral and Application Process.	
2/2021		Added SA294 subsidy payment authorization information to section 5B.4. Moved GOSH Section from 5B.6 to 5B.5. Added clarification that there is no participation for Supportive Housing services. Added GOSH “Discharge Planning” and “Transition to Independent Housing” sections to 5B.5. Updated hyperlinks.	
5/2021		Deleted SA294 payment authorization process for P1. Added the need for CM support with quarterly Bridge tenancy verifications as well as annual re-certifications. Clarified steps to add “Housing subsidy (HCS/AAA)” and “Supportive Housing (HCS/AAA)” as Treatments on the Medical Screen in CARE. Added new procedure for referring to GOSH, hyperlinked to new DSHS 11-153 GOSH Referral form. Clarified GOSH eligibility and HCS and AAA CMs can refer. Clarified GOSH authorization responsibility. Hyperlinked to Chapter 30d to connect Supportive Housing service consults and consideration. Clarified on-going eligibility for GOSH clients regarding services and subsidy. Hyperlinked to Chapter 30d in the ‘How can I use CTS/CTSS/WA Roads section’. Updated PM Roles.	
8/2021		Added new staff contacts for all regions by way of link to RCL Housing Resources website. Updated Bridge Referral form, Participant Agreement and Referral and Application Process form. Added updated ERA form. Updated 811 HCS HPM role regarding DDA/DBHR referrals. Added expanded GOSH eligibility criteria.	
2/2022		Updated various links throughout the chapter. Updated HCS Subsidy P&P inserted Document. Updated Participant Agreement inserted document. Added <i>What is needed to transfer an HCS subsidy client from HCS to the AAA?</i> Section. Updated GOSH section to add protocol to staff cases with SHPM prior to closing a	

		GOSH client and protocol related to clients with short term institutional stays (e.g., re-hospitalization or jail).	
8/2022		Added RVP eligibility and availability. Update ERA with Hotel/Motel stay information and Process. Update link to ERA form. Add info from Chapter 5a regarding WA Roads and eligibility from HCS housing resources. Updated language around HCS to AAA case transfers and Annual Assessments for GOSH. Added some hyperlinks into the GOSH Section to animated YouTube Videos: What is the Governor's Opportunity for Supportive Housing? ; You've Been Referred to GOSH – Now What? ; Governor's Opportunity for Supportive Housing (GOSH): Good Discharge Planning	
11/2022		Added more detailed payment/authorization information for ERA SA298. Added in section from Chapter 5a on how to work with individuals on HCS Housing Resources who are not currently receiving LTSS. Added language on keeping GOSH participants open who are in jail or institutional stays into the Interim Setting section. General text/grammar corrections throughout document. Added Bellingham/Whatcom and Spokane RVP resource.	
2/2023		Updated Unit Manager titles. Updated "NED" section to "permanent HUD voucher" section and added more process details. Updated Chapter Section list to include new 5b.5. Updated 811 sections with more details regarding application process. Removed old versions of forms and added updated versions (Participant Agreement, Tips for Maintaining LTSS, Chapter Version HCS Subsidy P&P and Bridge referral). Added page numbers to footer. Added links to Brochures and Video.	
5/2023		HCS subsidy video link. Updates to Section 5b.5. Updated ERA form.	
8/2023		Updated information in the HCS Subsidy and GOSH sections related to CARE Changes. Clarified language related to ineligibility for permanent HUD vouchers.	
11/2023		Updated Emergency Rental Assistance Form. Clarified language and updated language in section 5b.5 "Working with individuals on HCS housing resources who are not currently receiving HCS LTSS". Updated GOSH Section to include new regional referral email addresses.	
1/2024		Chapter Links added and updated ERA form added	



2/2024		Added a green box in pages 14 & 24 & 29 & 34 with a process for possible no longer functionally eligible HCS clients who are already enrolled in a housing service. Added on page 33 & 34 Motel Interim Stay for Transitions (MIST) program description. Added MIST to Table of contents Page 2. Replaced Washington Roads RAC info in pages 17 & 21 & 29 with new info (RAC 3131- LTSS Housing Stabilization). Added on page 17 (1 d. and the HCS/AAA CM will extend the WA Roads RAC) & (2 i. GOSH Program Manager will end the GOSH authorization and end RAC 3131- LTSS Housing Stabilization, and HCS/AAA CM will end the WA Roads RAC). Removed from page 30 & 31 under reimbursements “while the Supportive Housing services are authorized by SHPM under the service code SA299,U1 the CM would authorize use of any CFC CTS/CTSS/WA Roads funds under a separate service code, dependent upon eligibility and funds used.”	
3/27/2024		Updated Bridge documents at bottom of document with most recent versions. Page 11 &12 amended for HCS Bridge Subsidy.	
5/7/2024		Removed Motel/Hotel language from ERA section. Corrected MIST referral email address. Added MIST Request Form. Added bullet on Civil Transition eligibility.	
6/17/2024		Added ERA email address. Updated ERA referral process. Removed “How do I make a referral for a client who I believe is eligible for ERA?” Updated MIST eligibility criteria (Bridge Subsidy, GOSH program, Civil Transitions Program, Other Housing Resource, In-Home Short-Term Displacement, & Limited Residential). Updated MIST referral Process outline. Updated & added “How is payment made for MIST?” process/procedure. Updated MIST Referral Form.	
9/3/2024	Joana	Added information regarding Bridge Subsidy waitlist, added information regarding Presumptive Eligibility, added policy information from chapter 9 regarding GOSH client unable to return to residential setting and being admitted to the hospital. Added policy information regarding if a client is incarcerated or hospitalized and how HCS pays the subsidy for up to 6 months. Added Stephen Miller contact info. Added Housing and Employment website, updated links to one pager. Updated table of contents to include	



		Presumptive Eligibility. Added Global Leasing info. Updated GOSH eligibility criteria.	
10/2024	Joana	Chapter 5b changed to Chapter 6. Chapter 6 Established	
11/2024	Joana	Added information regarding the HCS Acute Care Hospital Subsidy, and the referral/process and referral.	
01/2025	Joana	Edited information regarding the HCS Acute Care Hospital Subsidy	
03/2025	Joana	Chapter 6 was divided up into 4 sections and renamed. Chapter 6D- Housing & Service Coordination established. Update policy & procedure regarding Housing and Employment Stabilization Services. Updated OHAE background and EDAI statement. Added a chart describing all the RACs and Service Codes associated with OHAE. Added information regarding the Civil Transitions Program and relation to Housing Resources.	
07/2025	WJH	Removed Whitney Joy Howard under “ask the expert” section; Through chapter changed language that referenced “ALISA” to “HCS”; Added in section on use of Housing & Employment Stabilization Services (SA294u4); Added in a section on the Civil Transition Program housing resources; Added information on RCL and HRSN STRA and how it is used in combination with state dollars to support a client’s interim HCS Subsidy.	
9/2025	Jonnie	Added section on How to Work with Clients Declining Personal Care.	
03/2026	Joana	Added section how to work with a client who is declining pc. Added section regarding how a client can lose their HCS Subsidy. Added section on how to exit a client from the HCS Subsidy	
04/2026	Jonnie	Remove funding chart. Updated information regarding SA294,U4.	
07/2026	Tom	Added information to the Q&A section regarding Spokane Housing Authority making payments for MIST and ERA.	



Introduction to Medicaid, State Plans, and 1915c Waivers

Chapter 7 provides an overview of Medicaid, the Medicaid State Plan, and 1915c Waivers. It will also introduce the core Home and Community Services (HCS) programs that enable individuals to remain in or return to their own communities through the provision of coordinated, comprehensive and economical home and community-based services.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Becca Howard

HCBS Waiver Program Manager

564.263.0839

Rebecca.Howard@dshs.wa.gov

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BACKGROUND

The purpose of the HCS Division is to promote, plan, develop, and provide long-term care services responsive to the needs of adults with disabilities and the elderly with priority attention to low-income individuals and families. We help people with disabilities and their families obtain appropriate quality services to maximize independence, dignity, and quality of life.

HCS programs are funded by Medicaid and/or state funds and administered by the Home and Community Living Administration (HCLA). To be eligible for all HCLA-funded programs, the applicant must meet the target population, functional, and financial criteria.

MEDICAID

Medicaid, Title XIX of the Social Security Act (SSA), is a needs-based entitlement program that provides medical assistance for certain individuals and families with low incomes and few resources. The Medicaid program became law in 1965 as a jointly funded, cooperative venture between the Federal and State governments to assist states in the provision of adequate medical care to eligible needy persons.

Medicaid is the foundation on which HCS and the Developmental Disabilities Community Services (DDCS) build home and community-based programs. Most of the core programs are funded through either the Medicaid State Plan or a Medicaid 1915(c) waiver. The costs of providing Medicaid services are shared between the Federal and State government.

The portion paid by the Federal government is known as the Federal Medical Assistance Percentage or FMAP. Each state's FMAP is determined annually using a formula that compares the state's average per capita income with the national average. FMAP cannot be lower than 50% or higher than 83%. States with a higher per capita income receive a lower FMAP. Washington State's FMAP is about 50%.

Rules and policies that govern Medicaid are found in the SSA, the Code of Federal Regulations (CFR), and the Centers for Medicare and Medicaid Services (CMS) Medicaid Manual.

Medicaid State Plan

Section 1905 of the SSA requires States that administer the Medicaid program to describe how they will meet the mandatory Medicaid requirements and the optional services they will provide. This is done through the development of a Medicaid State Plan (also known as the State Plan). It is Washington's agreement with CMS that our state will adhere to the requirements of the SSA and the official issuances of the Department of Health and Human Services (DHHS).

The State Plan is "owned" by the Health Care Authority which is Washington's Medicaid State Agency. HCS and DDCS are considered operating agencies for some of the state plan services such as Medicaid Personal Care (MPC) and Community First Choice (CFC).



State Plan Approval

Once approved by CMS, the State Plan deems Washington eligible to receive federal funding or federal matching funds for providing Medicaid services. State Plan services must be offered statewide, and the state cannot set limits on the number of people who will be served or the dollar amount that will be spent. Federal rules require that state plan services should be used before using 1915(c) waiver funds. This is why state plan programs are considered priority programs. By utilizing State Plan services first, Home and Community Based Services (HCBS) waiver capacity is reserved for clients whose amount, duration, or scope of service need is beyond what the state plan programs can provide.

Components

All state plans are different. Each state defines Medicaid eligibility differently and not all states offer some of the optional Medicaid services (like MPC). The State Plan describes:

- Who is eligible;
- What services will be offered including the:
 - amount (how often),
 - duration (for how long), and
 - scope (exact nature of what is provided);
- Who are the qualified providers for each service and what are the specific qualifications for each type of provider;
- How the state sets the rate of payment for services and how payment is made; and
- How the program is administered.

Below is a list of State Plan programs operated by HCS and DDOS:

- [Community First Choice \(CFC\)](#)
- [Medicaid Personal Care \(MPC\)](#)
- Program of All-Inclusive Care for the Elderly (PACE) – HCS Only
- [Private Duty Nursing](#)

HCBS 1915c Waiver

Section 1915(c) of the Social Security Act describes the regulations for obtaining and operating a 1915(c) HCBS waiver. These waivers are Medicaid's alternative to providing long-term care in institutional settings. HCBS waiver rules allow states to “waive” Medicaid State Plan rules in order to provide services to individuals in their local communities instead of in an institution such as a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/ID).

The state plan rules that can be waived include:

- Income and Resources (the financial eligibility criteria)
- Comparability (targeting a specific population)
- State wideness (targeting a specific geographic area)

States also have more flexibility in adding additional, optional services to a 1915(c) waiver than to a State Plan.



HCBS waivers operated by HCS include:

- Community Options Program Entry System (COPES)
- New Freedom
- Residential Support Waiver (RSW)

DDCS operates the following HCBS waivers:

- Basic Plus
- Core
- Community Protection (CP)
- Children with Intensive In-home Behavioral Supports (CIIBS)
- Individual and Family Services (IFS)

PROGRAM DETERMINATION

Before authorizing initial services or reauthorize ongoing services, clients must be determined both financially and functionally eligible for the program that provides the services they need. For information about financial eligibility for services, see [Chapter 7a](#) of the LTC manual.

Initial determination for HCS-funded services is made by the HCS Division. Program eligibility for our target population (aged, blind or physically disabled per SSA criteria) is based on a CARE assessment of an individual's functional unmet needs and a Medicaid financial determination. Functional and financial determinations occur at the same time.

Upon completion of a CARE assessment, the case manager determines program eligibility based on functional eligibility for the programs listed in the drop-down menu on the care plan screen in CARE. Program selection is based on the following items:

- Financial and functional program eligibility;
- Program rules; and
- Client's choice of eligible programs and providers.

Hierarchy

Determine the appropriate program selection based on the following general hierarchy:

- Roads To Community Living (RCL); then
 - ↳ Medicaid State Plan programs – CFC or
– MPC; then
 - ↳ Home and Community-Based Services (HCBS) waivers; then
 - ↳ State-funded Medical Care Services (MCS); then
 - ↳ State-funded LTC for Non-Citizens; then
 - ↳ Washington Roads

Required Form

Clients who are functionally and financially eligible for the waiver programs can choose to receive their care in an institution or in the community. The Acknowledgment of Services form [DSHS 14-225](#) for CFC



and HCS waiver programs is the documentation that all of the program choices have been explained to the client and the client has acknowledged their choice of CFC or waiver services instead of nursing home care. DDOS uses the Voluntary Participation Form [DSHS 10-424](#).

1. This form is a federal requirement.
 - a) CFC and waiver services cannot be authorized without the client's signature and signature date on this form.
 - b) This document indicates the client's choice of Home & Community-based waiver and CFC services (CFC and/or COPES, New Freedom, or Residential Support Waiver).
2. If the client enters the nursing facility, home and community-based services are terminated on that date.
 - a) A new 14-225 is not required if the stay is short-term (e.g. 30 days or less, recipient is attending rehabilitation and will be returning to place of residence.)
 - b) If the stay in the nursing home is more than 30 days, a new Acknowledgment of Services form is required if the client wants to return to the community on CFC and/or waiver services. The 14-225 is documentation of the client's choice to receive services outside of the nursing home.
3. Two signed copies are required - one copy is given to the client, and one copy is placed in the client record by sending it to the HCS Imaging Unit.

Excluded Services

Assess and document client goals and services within CARE regardless of funding source. When service planning, you may need to look at funding resources other than HCS and DDOS. Excluded services are found in [WAC 388-106-0020](#). For example, core programs do not cover the following services:

1. For Chore and MPC only:
 - Teaching, including teaching how to perform personal care tasks;
 - Development of social, behavioral, recreational, communication, or other types of community living skills;
 - Nursing care.
- Personal care services provided outside of the client's residence in your place of employment or while accessing community services, that are NOT identified and authorized in your written service plan;
2. Respite (HCS/AAA only);
3. Child care;
4. Animal care, unless for service animals when receiving services through New Freedom;
5. Sterile procedures, administration of medications, or other tasks requiring a licensed health professional, unless authorized as an approved nursing delegation task, client self-directed care task (excludes agency providers), or provided by a family member;
6. Services provided over the telephone;
7. Chore services provided outside the state of Washington;
8. Any services provided outside of the United States;
9. Services to any person who has not been authorized by the department to receive them;
10. Yard care;
11. Assistance with managing finances unless receiving services through New Freedom.



RESOURCES

Related WAC

[WAC 388-106-0020](#) Excluded Services

Acronyms

AAA	Area Agency on Aging
CFC	Community First Choice
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
COPES	Community Options Program Entry System
DDCS	Developmental Disability Community Services
DHHS	Department of Health and Human Services
FMAP	Federal Medical Assistance Percentage
HCBS	Home and Community Based Services
HCLA	Home and Community Living Administration
HCS	Home and Community Services
MCS	Medical Care Services
MPC	Medicaid Personal Care
SSA	Social Security Act

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
4/2026	Becca Howard	Update contact	
7/2025	Annie Moua	Update ALTSA to HCLA and DDA to DDCS	TBD
10/1/2023	Anne Moua	Update contact	
	Beth Adams	Moved to new template; rearranged content order	



Financial Eligibility for Core Programs

Chapter 7a describes the financial eligibility for HCS programs that provide services that enable individuals to remain in, or return to, their own communities through the provision of coordinated, comprehensive, and economical home and community-based services.

HCS programs are funded by Title XIX Medicaid, Title XXI Children’s Health Insurance Program (CHIP), or by the state, and administered by Home and Community Living Administration (HCLA). To be eligible for all HCLA-funded programs, the applicant must meet the target population, functional, and financial criteria.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Tania Gariano Unit Manager - Financial Eligibility and Policy
564-200-4915 tania.gariano@dshs.wa.gov

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BACKGROUND

Medicaid, Title XIX of the Social Security Act (the Act), is a program that provides medical assistance for certain individuals and families that meet categorical and financial eligibility requirements. The Medicaid program became law in 1965 as a jointly funded, cooperative venture between the Federal and State governments to assist states in the provision of adequate medical care to eligible, needy individuals. Long Term Services and Supports (LTSS) is an umbrella term that includes both services provided through institutional rules and waivers, and services provided under the State Plan. A subset of LTSS is called long-term care (LTC). LTC refers to programs that use institutional Medicaid rules to determine financial eligibility.

State Plan

Section 1902 of the Act requires states that administer the Medicaid program to describe how they will meet the mandatory Medicaid requirements and the optional services they will provide. This is what we call our state plan. The state plan:

- Establishes eligibility standards;
- Determines the amount (how often), duration (for how long), and scope (exact nature of what is provided) of services;
- Sets the rate of payment for services; and
- Defines program administration.

The State Plan is Washington's agreement that our state will adhere to the requirements of the Act and the official issuances of the Department of Health and Human Services (HHS). The State Plan deems Washington eligible to receive federal funding or federal matching funds for providing Medicaid services.

All state plans are different – each state defines Medicaid eligibility differently and eligibility is not the same across state lines.

Home & Community Based Services (HCBS) Waivers

Granted under Section 1915(c) of the Act, an HCBS waiver is Medicaid's alternative to providing long-term care in institutional settings. The terms waiver, HCBS waiver, 1915(c) waiver, and HCS waiver all refer to HCS waivers granted under Section 1915(c) of the Act. Developmental Disabilities Administration (DDA) also has 1915(c) waivers.

Programs that Use HCBS Waiver Rules for Financial Eligibility

Program of All-Inclusive Care for the Elderly

[Medicaid manual link](#)

Program of All-inclusive Care for the Elderly (PACE) is a managed care LTSS option for individuals living within the PACE service area. Though PACE is a state plan option, HCBS waiver rules are used to determine both eligibility and post eligibility. There is one exception; however, PACE eligible clients are



not subject to transfer of asset rules. For all other financial eligibility criteria, see the [HCBS Waiver section](#).

Roads to Community Living

[Medicaid manual link](#)

Roads to Community Living (RCL) is a demonstration project funded by the Money Follows the Person grant. It is meant to transition Medicaid eligible persons out of institutions into the community, excluding Adult Family Homes. Eligibility for RCL is dependent on institutional Medicaid eligibility – if a person is receiving Medicaid on the day of discharge from an institution, after a qualifying stay, that person is eligible for RCL. RCL guarantees 365 days of categorically needy (CN) medical coverage. However, for post eligibility, RCL uses the same rules as HCBS waivers (unless the client is eligible under a MAGI-based program). See the [HCBS Waiver Post Eligibility](#) section information regarding this.

NOTE: Although HCBS waiver post eligibility is used throughout the RCL demonstration period, many RCL persons will be placed on non-RCL services at the end of the demonstration period. Eligibility for RCL does not necessarily guarantee eligibility for these services. Be sure to contact the Public Benefits Specialist (PBS) if it is anticipated an RCL recipient will transition to non-RCL HCBS services.

State-Funded Long-Term Care for Non-Citizens

[Medicaid manual link](#)

The State-funded LTC program for non-Citizens is for individuals in need of LTSS, but not eligible for federally funded Medicaid or Medical Care Services (MCS). This program is funding limited and currently has a limited number of “slots.” Eligibility for residential or at-home settings follows HCBS waiver rules. Availability of a slot is coordinated with HCLA headquarters. See the [HCBS Waivers](#) eligibility section for financial eligibility.

FINANCIAL FUNDAMENTALS FOR CLASSIC MEDICAID RECIPIENTS

Timeframes & Responsibilities

The PBS has 45 days from receipt of application to determine eligibility, and 60 days where a disability determination is needed, unless there is good cause to extend the timeline.

HCS PBS staff are responsible for the medical eligibility for non-MAGI based programs when the person is applying for or receiving HCS services.

DDA PBS staff are responsible for the medical eligibility for non-MAGI based programs when the person is applying for or receiving DDA services, Healthcare for Workers with Disabilities (HWD), hospice, children and family institutional medical, and behavioral health organization (BHO) alternate living facility (ALF) placements.

An overview of what agency is responsible for Medicaid eligibility determinations is found [here](#).



Communicating with HCS Public Benefits Specialists (PBS)

- The HCS Financial / Social Services Communication form ([14-443](#)) is used to communicate with PBS staff when initially authorizing HCBS services and at each annual review or significant change if services are extended for a year.
- The 14-443 is available in an electronic format through DMS within the Barcode system.
- Once submitted, the electronic 14-443 is automatically assigned to the PBS of record.

Communicating with DDA PBS

- The Public Benefits Specialist /DDA Case Resource Manager Communication form (15-345) is used to communicate with PBS staff when initially authorizing HCBS services and at each annual review or significant change if services are extended for a year.
- The 15-345 is no longer a paper form but is available in an electronic format through DMS within the Barcode system.
- Once submitted, the electronic 15-345 is automatically assigned to the PBS of record.

Medical Income and Resource Standards

The Health Care Authority (HCA) updates and distributes the [Washington Apple Health Income and Resource Standards](#) document. This document lists most financial income and resource standards, plus standards used in determining institutional eligibility and participation such as personal needs allowance (PNA), maintenance needs, community spouse allocation, and housing maximum amounts. Most standards change annually, but changes are staggered at each calendar quarter.

SSI Recipients Applying for HCBS Waiver, or HCBS Waiver-Rule-Based Services

The Act requires all LTC applicants, including SSI recipients, to submit an application for programs that use institutional financial eligibility rules. Those programs include services in a medical institution, an HCBS waiver service, or services based on HCBS waiver rules. SSI recipients in Washington are categorically eligible for Medicaid but may not be financially eligible for these services. To be eligible for these services, a recipient must:

- Not have transferred an asset for less than fair market value (does not apply to PACE or hospice as a program);
- Not have equity interest in a home that is greater than the standard. See WAC 182-513-1350; and
- Have annuities that meet the requirements in Chapter 182-516 WAC, if any annuities are owned.

SSI recipients or their representatives must complete the Eligibility Review for Long-term Care Benefits ([DSHS 14-416](#)) when requesting LTC services unless a signed application less than one year old is in the client's Electronic Client Record (ECR). This form contains a question about annuities, transfer of assets, and home equity. They may also apply online at <https://www.washingtonconnection.org/home/>. Once a signed application or eligibility review is received, another one will not be required, even if there is a break in LTC services. **Do not delay services while obtaining the application or eligibility review.**



An eligibility review or application is required if SSI eligibility ends. Generally, DSHS is responsible to redetermine Medicaid eligibility when a person's SSI stops. If you have any questions about SSI eligibility, talk with the Public Benefits Specialist.

Fast Track

Fast Track is a process that allows the authorization of HCS services prior to a financial eligibility determination when staff can reasonably conclude that the client will be financially eligible. Clients receiving services during the Fast Track period will not receive a Medicaid Services Card until financial eligibility is established. Fast Track is available for CFC, Community Options Program Entry System (COPES), and Medicaid Personal Care (MPC), when authorized by HCS. Further, CFC together with COPES can also be Fast Tracked. Do not use Fast Track for non-citizens unless you know that they will qualify for a CN or MN program.

If a client is found not financially eligible during a Fast Track service month, the services are state-funded, and there is no overpayment responsibility. Any expenditures are recovered through the Estate Recovery process. If the client is found financially eligible, the Fast Track services are federally funded once the Medicaid program is in place.

Ensure you communicate with the PBS regarding a person's potential for Fast Track services.

For specific instructions on the Fast Track process please refer to the [Social Service Authorization Manual](#).

Presumptive Eligibility (PE)

Medicaid Transformation Project (MTP), Long-Term Services and Supports Presumptive Eligibility (LTSS PE), approved under the 1115 waiver, is a package of services that allows the state to waive certain Medicaid requirements. LTSS PE provides individuals with an opportunity for expedited access to both home and community-based services in their own home and Medicaid (Apple Health) medical coverage benefits while full functional and financial eligibility are being determined.

The LTSS PE assessment will be used in CARE to gather preliminary information for LTSS PE eligibility. For PE-eligible recipients, HCLA/HCS will provide a limited benefit package during the PE period, through phases, for individuals residing in their own home and who plan to enroll in one of the following Washington State programs:

- Medicaid Personal Care (MPC)
- Community First Choice (CFC)
- CFC + Community Options Program Entry System (COPES)

Rules governing LTSS PE can be found in WAC 388-106-1800 through 388-106-1855. LTSS PE description and requirements are located in [Chapter 30e](#).

Third Party Resources

Generally, if a person has a third-party resource (TPR), they are required to contribute this resource toward their cost of care. Generally, a TPR is a source of funds that does not meet the definition of income (anything a person receives that can be used for food or shelter). Some sources of TPR are veteran's pensions, LTC insurance, or other third-party insurance. More information on financial eligibility and TPR can be found in the [Medicaid Manual](#).

SERVICES

Community First Choice

[Medicaid manual link](#)

Community First Choice (CFC) is a state plan option granted under 1915(k) of the Act. Individuals are financially eligible for CFC if they are eligible for categorically needy (CN) or Alternate Benefit Plan (ABP) scope of care in the community. This includes both non-institutional medical coverage groups and CN coverage through an HCBS waiver. The financial eligibility rules are located in WAC 182-513-1210 through WAC 182-513-1220.

An SSI recipient is financially eligible for CFC.

One benefit of CFC is if an SSI-related married person is found functionally eligible for CFC, and their spouse is not in a medical institution, the CFC eligible person can utilize the financial benefits of spousal impoverishment protections in eligibility for non-institutional Medicaid. Essentially, this means that for both single and married individuals (where the spouse is not in a medical institution):

- Countable income in the name of the CFC eligible person must be at or below the 1-person categorically needy income level (CNIL); and
- Combined resources must be at or below the state resource standard plus \$2000.00.

In the case of a functionally CFC eligible SSI-related person residing in an alternate living facility (ALF), as defined in WAC 182-500-0050, contact the PBS to determine whether non-institutional Medicaid or HCBS waiver rules will be used for financial eligibility. A person residing in an ALF has a different income standard for non-institutional Medicaid.

NOTE: If a CFC eligible person lives in an ALF, and their countable income is above the CNIL for their household size, this person not only pays Room & Board, but also contributes their remaining income after their PNA and Room & Board are deducted. The combination of Room & Board and their remaining income is considered "total client responsibility."

In the case of a functionally CFC eligible SSI-related person who is working and age 16 or older, contact the PBS to determine whether the Healthcare for Workers with Disabilities (HWD) program is more beneficial than other SSI-related programs. The HWD program has a higher income limit and no asset test.

In the case of MAGI-based methodologies, there are no spousal impoverishment protections, and individuals must be eligible for a federally funded CN or ABP scope of care medical program. There is no asset test for MAGI-based methodologies.

For a complete list of medical coverage groups eligible for CFC, see the [Medicaid Programs - LTSS Chart](#).



CFC Financial Eligibility

Use the steps below in ACES Online to verify CFC financial eligibility. You are looking for an *active* medical coverage group where the person is a *recipient*. If you are unsure of the information in ACES, check with the PBS.

- 1) Look for any of the non-institutional CN or ABP coverage groups listed on the [Medicaid Programs - LTSS Chart](#) ;
 - a) If a person is a recipient in an active assistance unit (AU) where CFC is available, this person is eligible for CFC services;
- 2) If the person is not eligible under (1), and the person receives SSI, the person is eligible for CFC. The PBS will update the medical coverage group upon notification from you. Examples include:
 - a) Persons discharging from institutions (L01 or L41 – PACE/hospice in an institution);
 - b) Persons ending their Roads to Community Living (RCL) demonstration (L41); and
 - c) Persons withdrawing from PACE (L31);
- 3) If the person is not eligible under (2), but is in a medical institution, coordinate with your PBS to establish eligibility;
- 4) If the person is not eligible under (3), and the person lives in an ALF, coordinate with your PBS to establish eligibility. A financial application may be needed;
- 5) If the person is not eligible under (4), and the person needs to use HCBS waiver rules to access CFC in any setting, coordinate with your PBS to establish eligibility. Also see the [HCBS Waiver](#) section. A financial application will be needed;
- 6) If the person is not eligible under (5), or you are unsure of a person's Medicaid status, contact the PBS;
- 7) If the person is not an active recipient in any AU, a financial application is required.

NOTE: If you determine a Medicare-entitled SSI-related person is eligible for CFC without using HCBS waiver rules, there could be financial advantages to accessing an HCBS waiver service anyway. One such advantage is that a Medicare-Medicaid entitled person has their Medicare Part D prescription copayments waived when receiving HCBS waiver services, whereas a CFC-only person does not. Be sure to ask the PBS if you have questions about CFC only versus HCBS waiver plus CFC.

CFC Post Eligibility

- A CFC-only person (i.e., without HCBS waiver services) does not participate towards their cost of care. If living in an ALF, they pay only Room & Board. However, if SSI-related, living in an ALF, and their income is above the CNIL for their household size, they contribute their total client responsibility towards their cost of care. This does not apply to HWD – see last bullet below.
- A CFC eligible person who also receives HCBS waiver services participates towards their cost of care. If living in an ALF, they pay participation along with Room & Board.
- A CFC eligible person who used HCBS waiver rules to access hospice services participates towards their cost of care. If living in an ALF, they pay participation along with Room & Board.
- A CFC eligible person who is CN eligible through the HWD program continues to pay their HWD premium, along with Room & Board if in an ALF.

HCBS Waivers (COPES, New Freedom, Residential Support)

[Medicaid manual link](#)

HCBS waivers allow clients the choice of receiving institutional services in the community instead of in a medical institution. These waivers are granted under section 1915(c) of the Act. All HCS HCBS waivers follow the same financial eligibility rules described in Chapter 182-515 WAC. However, some HCBS waivers may only be offered in certain settings. See LTC Manual Chapter 7 for more information regarding settings.

DDA HCBS waivers also follow the same financial eligibility rules in Chapter 182-515 WAC; however, there is one key difference in financial eligibility between HCS and DDA HCBS waivers:

Income eligibility for DDA HCBS waivers is capped at the special income level (SIL), whereas HCS HCBS waiver recipients can have income above the SIL. This is referred to as Mega COPES.

HCBS Waiver Eligibility

Core eligibility: a person must either be receiving SSI or be SSI-related. MAGI-based medical coverage groups are not eligible for HCBS waiver services, though they may apply, and be related to SSI via a non-grant medical assistance (NGMA) determination (a disability / blindness determination).

HCBS Waiver Eligibility by Medical Coverage Group

Generally, an HCBS waiver recipient will always be placed on the L21 or L22 medical coverage group once financial eligibility and functional eligibility are established. For individuals in a medical institution active on Medicaid (L01 or L02), they are financially eligible for HCBS waiver services upon transition to the community. For individuals on L95 or L99, coordinate with the PBS because their income may be too high for HCBS waiver services.

There are a few other medical coverage groups that a person will be an active recipient on where they can receive HCBS waiver services. These medical coverage groups are:

Group	Description
S08	HWD
D01/D02*/D26*	Foster Care

*Coordinate HCBS waiver eligibility with your PBS and HCA

For all other SSI and SSI-related medical coverage groups, if an active recipient, a person has met most financial eligibility criteria, but the PBS will need to verify the following three criteria:

- No uncompensated transfers that may incur a penalty period;
- No equity interest in a home that exceeds the standard. See WAC 182-513-1350; and
- All annuities owned by the client or spouse meet the annuity requirements of Chapter 182-516 WAC.



Persons active only on a Medicare savings program (MSP) – S03, S04, S05, or S06 – are not eligible under the group discussed above. Coordinate with the PBS to determine these individuals' eligibility.

HCBS Waiver Eligibility via Application

Financial and functional eligibility for HCBS waiver is completed concurrently. Consider Fast Track where it is reasonably determined that a person may be financially eligible for HCBS waiver. Coordinate Fast Track with the PBS. Please note – Fast Track for New Freedom or DDA HCBS waivers is not allowed. Refer to the [Fast Track](#) section for services that can be Fast Tracked.

Income – For both single and married persons, income eligibility is only based on income in the name of the HCBS waiver applicant, and one-half of any community income (if married). Generally, a person's income can be significant, and they are still income eligible for HCBS waiver. The monthly state nursing facility rate, medically needy income disregards, along with recurring medical expenses are subtracted from a person's income before comparing it to the 1-person medically needy income level (MNIL).

For example, this means that as of 01/01/2026, a person can have countable income approximately as high as \$11,503 and still be income eligible for HCS HCBS waiver.

Note: This calculation does not apply to DDA HCBS waivers.

Resources - For both single and married individuals, the resource limit is \$2000.00. However, if married, a person can allocate up to the state spousal resource standard to their spouse before counting resources towards this \$2000.00 limit. This can only occur when the spouse is not in a medical institution. Further, any resources above the standard can be reduced by medical expenses. Other resource considerations –

- A person with an equity interest in their home above the standard is not eligible for HCBS waiver. See WAC 182-513-1350;
- A person (and their spouse if married) must disclose their interest in any annuities, and the annuities must meet the requirements of Chapter 182-516 WAC; and
- HCBS waiver services are subject to transfer of asset considerations. If the person, or their spouse, has transferred an asset in the five years prior to their application, coordinate with your PBS to determine whether eligibility, or a transfer penalty, will be established.

HCBS Waiver Post Eligibility

A person otherwise eligible for non-institutional CN in the community, described in WAC 182-515-1507, does not participate towards their cost of care. If living in an ALF, the person is responsible for Room & Board. If eligible for HWD, a person continues to pay their HWD premium, along with Room & Board if in an ALF.



A person eligible for HCBS waiver under WAC 182-515-1508 does participate toward their cost of care. If living in an ALF, the person is responsible for Room & Board in addition to participation.

A person only participates up to their total cost of care for services that month. If HCBS waiver rules are required to determine eligibility for CFC, a person participates towards the cost of both their HCBS waiver services and CFC services.

The rules regarding post eligibility and participation are found in WAC 182-515-1509 for HCS HCBS waivers and WAC 182-515-1514 for DDA HCBS waivers.

If a person is Fast Tracked, participation must be estimated. Coordinate with the PBS to complete this.

Medicaid Personal Care

[Medicaid manual link](#)

MPC is a state plan entitlement similar to CFC. However, access to MPC services is through a non-institutional CN or ABP medical program. Unlike CFC, individuals who access CN through an HCBS waiver are not eligible for MPC. Financial eligibility for MPC is described in WAC 182-513-1225.

An SSI recipient is financially eligible for MPC.

Generally, for SSI-related individuals, the income and resource standards for non-institutional CN are as follows:

- Countable income for a one-person household is no greater than the 1-person CNIL. Countable income for a married person living with their spouse is no greater than the 2-person CNIL.
- Countable resources for a one-person household are no greater than \$2000.00. Countable resources for a married person living with their spouse are no greater than \$3000.00.

In the case of a functionally MPC eligible SSI-related person residing in an Alternate Living Facility (ALF), contact the PBS to determine whether the person is eligible for non-institutional CN. A person residing in an ALF has a different income standard for non-institutional CN.

NOTE: If an MPC eligible person lives in an ALF, and their countable income is above the CNIL for their household size, this person not only pays Room & Board, but also contributes their remaining income after their PNA and Room & Board are deducted. The combination of Room & Board and their remaining income is considered "total client responsibility."

In the case of a functionally MPC eligible SSI-related person who is working, and 16 years old or older, contact the PBS to determine whether the HWD program will get the person access to non-institutional CN. The HWD program has a higher income limit and no asset test.

In the case of MAGI-based methodologies, individuals must be eligible for a federally funded CN or ABP scope of care. There is no asset test for MAGI-based methodologies.

For a complete list of medical coverage groups eligible for MPC, see the [Medicaid Programs - LTSS Chart](#).



MPC Eligibility

Use the steps below in ACES Online to verify MPC financial eligibility. You are looking for an *active* medical coverage group where the person is a *recipient*. If you are unsure of the information in ACES, check with your PBS.

- 1) Look for any of the non-institutional CN or ABP coverage groups listed on the [Medicaid Programs - LTSS Chart](#);
 - a) If a person is a recipient in an active AU where MPC is available, this person is eligible for MPC services;
- 2) If the person is not eligible under (1), and the person receives SSI, the person is eligible for MPC. The PBS will update the medical coverage group upon notification from you. Examples include:
 - a) Persons discharging from institutions (L01 or L41 – PACE/hospice in an institution);
 - b) Persons ending their Roads to Community Living (RCL) demonstration (L41); and
 - c) Persons withdrawing from PACE (L31);
- 3) If the person is not eligible under (2), but is in a medical institution, coordinate with your PBS to establish eligibility;
- 4) If the person is not eligible under (3), and the person lives in an ALF, coordinate with your PBS to establish eligibility. A financial application may be needed;
- 5) If the person is not eligible under (4), or you are unsure of a person's Medicaid status, contact the PBS;
- 6) If the person is not an active recipient in any AU, a financial application is required.

MPC Post Eligibility

A person on MPC does not participate toward their cost of care. If living in an ALF, they pay only Room & Board. However, if SSI-related, living in an ALF, and their income is above the CNIL for their household size, they contribute their total client responsibility towards their cost of care.

An MPC eligible person who is CN eligible through the HWD program continues to pay their HWD premium, along with Room & Board if in an ALF.

Medical Care Services

[Medicaid manual link](#)

Medical Care Services (MCS) is a state-funded medical program where eligibility is driven by a person's eligibility for the Aged, Blind, Disabled (ABD) cash program; or eligibility for the Housing and Essential Needs (HEN) program.

In order to be eligible for MCS, a person must be eligible for ABD cash or a HEN referral (but not necessarily receiving a cash grant). Further, the person must not be eligible for any federally funded medical assistance solely due to their citizenship or immigration status. In essence, MCS serves the population of individuals who are qualified aliens that are subject to and within their five-year bar for Medicaid eligibility; and those persons who are lawfully present, but never able to become eligible for Medicaid (i.e., "nonqualified alien").



Eligibility for Residential Services under MCS

Use the steps below in ACES Online to verify residential services eligibility under MCS. You are looking for a medical coverage group where the person is a *recipient*. If you are unsure of the information in ACES, check with your PBS.

- 1) Look for an *active recipient* of an A01 or A05 medical coverage group. See the [Medicaid Programs - LTSS Chart](#) for information on these medical coverage groups;
- 2) If not eligible under (1), but eligible in a medical coverage group that is specific to non-citizens, or another state-funded program, coordinate eligibility with your PBS. An application for cash through DSHS is required;
- 3) If not eligible under (2), an application for cash through DSHS is required.

Post Eligibility for Residential Services under MCS

No cost of care letters are sent to individuals eligible for residential services under the MCS program. They are responsible for Room & Board. To calculate Room & Board, subtract a person's PNA from their countable income. The remaining income is contributed up to the Room & Board standard.

Chore

Chore is an HCS program using state-only funds. Chore is not available to new applicants as of August 2001. Current Chore clients have been grandfathered into the program. If terminated from Chore, individuals will never be financially eligible for Chore again.

HCS financial does not determine financial eligibility for Chore. Financial eligibility for Chore is in WAC 388-106-0610.

Chore Eligibility

Financial eligibility is determined by the social services case worker at least annually, or at an income change. This is accomplished by:

- Completing a CHORE PROGRAM INCOME AND RESOURCES DECLARATION form (DSHS 14-404) to determine financial eligibility and calculate participation;
- Giving a copy to the client
- Placing the original signed copy in the file through DMS

NOTE: If the client does not have an ACES number you will need to work with HCS HQ staff to create a "negative" ACES number which will enable you to create an electronic client record in Barcode.

To remain financially eligible for Chore, a person must:

- Have income that does not exceed the cost of Chore services and not exceed 100% of the Federal Poverty Level (FPL) for their household size;
- Have resources no greater than \$10,000 (one person), \$15,000 (two-person family). An additional \$1,000 is added to the two-person standard for each additional family member; and
- Have not transferred an asset for less than fair market value on or after November 1, 1995.



Chore Post Eligibility

HCS financial does not determine Chore post eligibility. A person's contribution toward their cost of care for Chore services is very different than for HCBS waivers and is calculated by the case manager/social services specialist. For post eligibility, see WAC [388-106-0625](#).

Healthcare for Workers with Disabilities

[Medicaid manual link](#)

HWD is a unique program, in that it is SSI-related, however:

- There is no asset test like other SSI and SSI-related programs;
- Disability determinations are not subject to substantial gainful activity concerns;
- Income limits are much higher than other SSI-related programs; and
- An HWD eligible person is financially eligible for CFC, HCBS waiver, and MPC;
 - For CFC or CFC plus HCBS waiver, coordinate with your PBS to ensure the person meets the home equity requirements in WAC 182-513-1350, and the person disclosed interest in any annuities; and
 - For HCBS waiver, coordinate with your PBS to ensure the person is not subject to a transfer of asset penalty.

HWD Eligibility

Determine if a person is an active recipient of an S08 AU. If not, and the person meets (or may meet) the following criteria, contact your local HCS HWD specialist:

- a) Be at least age 16;
- b) Meet the federal disability requirements; and
- c) Be employed full or part-time (including self-employment);

Your local HCS HWD specialist can be found [here](#).

HWD Post Eligibility

A person on HWD does not participate, regardless of service or setting. In all cases, the person must continue to pay their HWD premium to remain eligible for HWD. If living in an ALF, the person is responsible for Room & Board along with their HWD premium.

Note: HWD premiums for American Indians or Alaska Natives are waived.

Children's Health Insurance Program (CHIP)

CHIP is healthcare coverage for children funded under Title XXI of the Act. It provides coverage to children up to the age of 19 who are not eligible for Medicaid (Title XIX) because family income exceeds



the Medicaid standard (215% FPL). Once a child is determined eligible for CHIP, the child remains continuously eligible for 12 full months of coverage.

Income eligibility for CHIP

Families pay a premium for coverage in CHIP that is based on net income of the medical assistance unit that includes the child. The maximum income limit is 317% FPL. Coverage is based on MAGI methodologies and families apply for coverage through the Health Benefit Exchange.

Premium requirements

Households with income between 215% and 265% FPL pay a premium of \$20 per child per month (maximum \$40 per month) and households with income between 265% FPL and 317% pay a premium of \$30 per child per month (maximum \$60 per month). Premiums are waived for American Indian/Alaskan Native clients and pregnant women.

Eligibility for HCS/DDA services

DDA provides services to children; however, HCS does not provide services until a child turns 18. Since CHIP provides coverage through a child's 19th birthday, it is possible that a CHIP eligible child will qualify for HCS services. HCS can authorize services, which are equivalent to Medicaid's MPC and CFC, to a child on CHIP coverage – the difference is the funding source used to pay for the services. A child on CHIP is eligible under the ACES coverage group N13 and has special CHIP functional RACs which must be used for correct authorizations.

<u>Service</u>	<u>HCS</u>	<u>DDA</u>
Personal Care (CFC-lookalike)	3251	3521
Personal Care (MPC-lookalike)	3250	3520

Children on CHIP coverage are not eligible for HCBS waiver services. A child on CHIP who needs waiver services must be transitioned to the L22 coverage group and disability must be established.

State-Funded CHIP

Washington State also administers a state-funded CHIP program for children who do not meet the citizenship criteria for the federal program. The eligibility for the program mirrors the federal program; however, eligibility will be under the ACES coverage group N33. These children are eligible for state-funded services that mirror the Medicaid's MPC and CFC services. The functional RACs that must be approved to authorize state-funded services are below.

<u>Service</u>	<u>HCS</u>	<u>DDA</u>
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Personal Care (CFC-lookalike)	3350	3910
Personal Care (MPC-lookalike)	3351	3911

RESOURCES

[Medicaid 101.pptx](#)

[Medicaid Programs - LTSS Chart 7.2023.doc](#)

[Apple Health Medicaid Manual](#)

[Eligibility A-Z Manual \(Cash & Food\)](#)

[ACES Manual - Inquiry Search Information](#)

[Title 182 WAC \(Health Care Authority\)](#)

[Chapter 182-500 WAC Definitions](#)

[LTSS Definitions WAC](#)

[Financial Eligibility & Policy SharePoint \(Available to State Employees Only\)](#)

Acronyms

ABD	Aged, Blind, Disabled
ABP	Alternate Benefit Plan
ALF	Alternate Living Facility
AU	Assistance Unit
BHO	Behavioral Health Organization
CFC	Community First Choice
CHIP	Children's Health Insurance Program
CN	Categorically Needy
CNIL	Categorically Needy Income Level
COPEs	Community Options Program Entry System
DDA	Developmental Disabilities Administration
DMS	Document Management System
ECR	Electronic Case Record
FPL	Federal Poverty Level
HCA	Health Care Authority
HCBS	Home and Community Based Services
HCLA	Home and Community Living Administration
HCS	Home and Community Services
HEN	Housing and Essential Needs
HHS	Health and Human Services



HWD	Healthcare for Workers with Disabilities
LTC	Long-term Care
LTSS	Long Term Services and Supports
MCS	Medical Care Services
MNIL	Medically Needy Income Level
MPC	Medicaid Personal Care
MSP	Medicare Savings Program
NGMA	Non-Grant Medical Assistance
PACE	Program of All-Inclusive Care for the Elderly
PBS	Public Benefits Specialist
PE	Presumptive Eligibility
PNA	Personal Needs Allowance
RCL	Roads to Community Living
SIL	Special Income Level
TPR	Third-Party Resource

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
9/2/2026	T Gariano	Updated for chapter publication	

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).



Community First Choice

Ask the Expert

If you have questions or need clarification, please contact:

For Home and Community Services (HCS) and Area Agency on Aging (AAA):

Victoria Nuesca HCS CFC Program Manager
360.725.2393 victoria.nuesca@dshs.wa.gov

For Developmental Disabilities Administration (DDA):

Sue Halle DDA CFC Program Manager
360.764.3561 suzan.halle@dshs.wa.gov

Peggy Dotson DDA Assistive Technology Program Manager
360.407.1563 peggy.dotson@dshs.wa.gov

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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)

Developmental Disabilities Administration (DDA)

Nursing Facility Level of Care (NFLOC)

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 (<i>when sole source of heat</i>) 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.
 - o 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.
 - o **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 <i>only</i> :	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](#).
- 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.

Use [Carina](#) or [the CDE](#) to help clients locate IPs.

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

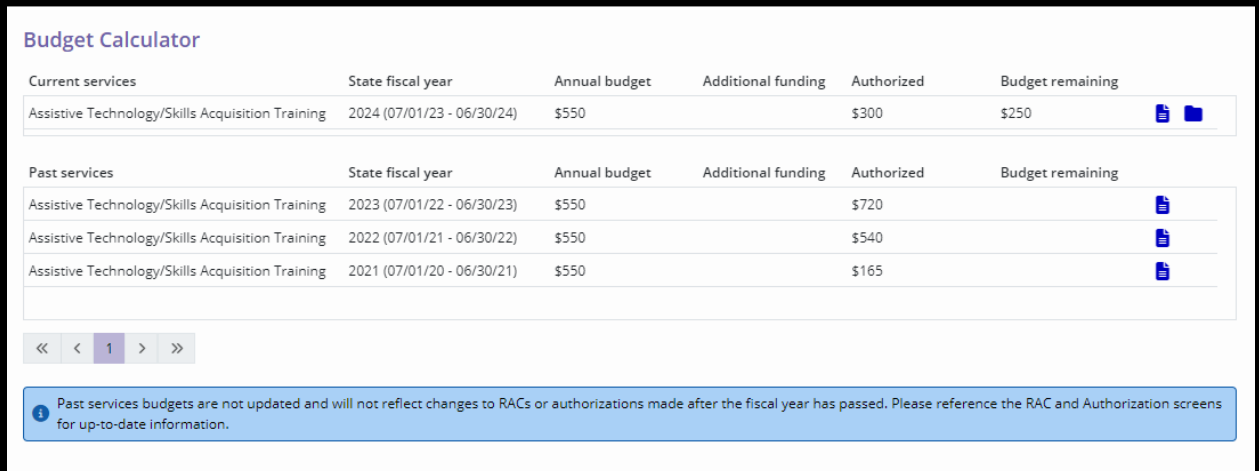
If the CFC client's need for an AT Good, AT Service, or SAT purchased hours, as documented on their individualized CARE plan, exceeds the CFC SFY annual limit (or remaining balance), the case manager may use the "Exceed CFC Annual Service Limit" ETR process to request the amount beyond the client's CFC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



Budget Calculator

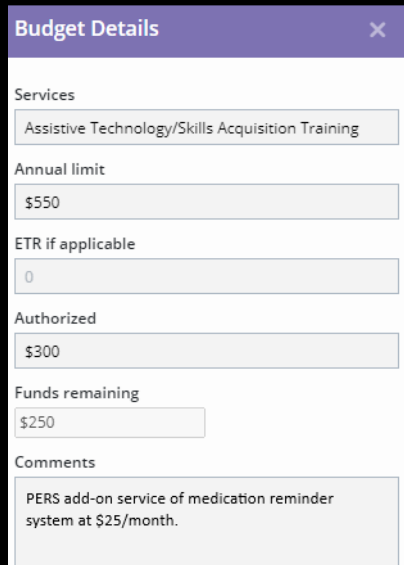
Current services	State fiscal year	Annual budget	Additional funding	Authorized	Budget remaining
Assistive Technology/Skills Acquisition Training	2024 (07/01/23 - 06/30/24)	\$550		\$300	\$250

Past services	State fiscal year	Annual budget	Additional funding	Authorized	Budget remaining
Assistive Technology/Skills Acquisition Training	2023 (07/01/22 - 06/30/23)	\$550		\$720	
Assistive Technology/Skills Acquisition Training	2022 (07/01/21 - 06/30/22)	\$550		\$540	
Assistive Technology/Skills Acquisition Training	2021 (07/01/20 - 06/30/21)	\$550		\$165	

« < 1 > »

1 Past services budgets are not updated and will not reflect changes to RACs or authorizations made after the fiscal year has passed. Please reference the RAC and Authorization screens for up-to-date information.

- 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



Budget Details [X]

Services
 Assistive Technology/Skills Acquisition Training

Annual limit
 \$550

ETR if applicable
 0

Authorized
 \$300

Funds remaining
 \$250

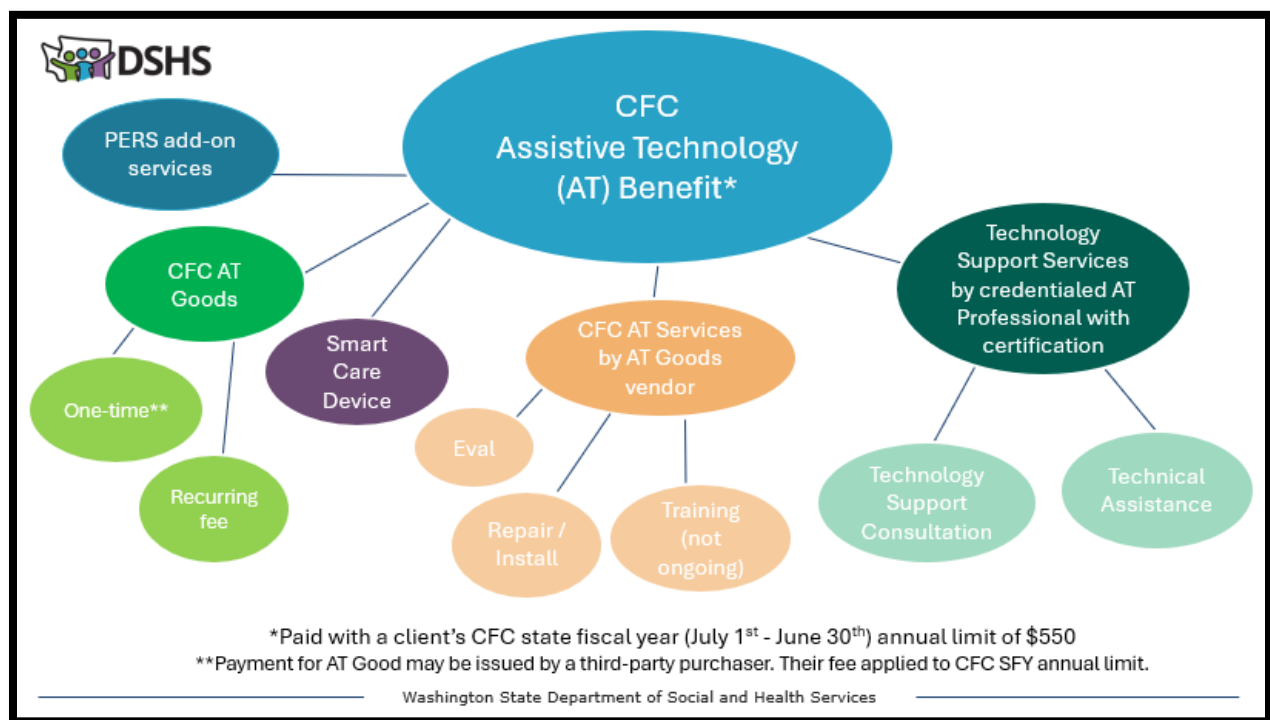
Comments
 PERS add-on service of medication reminder system at \$25/month.

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.

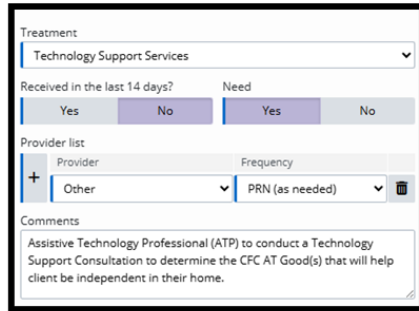
- AT Goods and Smart Care Device
 - For HCS/AAA, add the AT Good in the Equipment box on the most appropriate CARE screen. If necessary, complete an Interim assessment to add the client's need.

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.

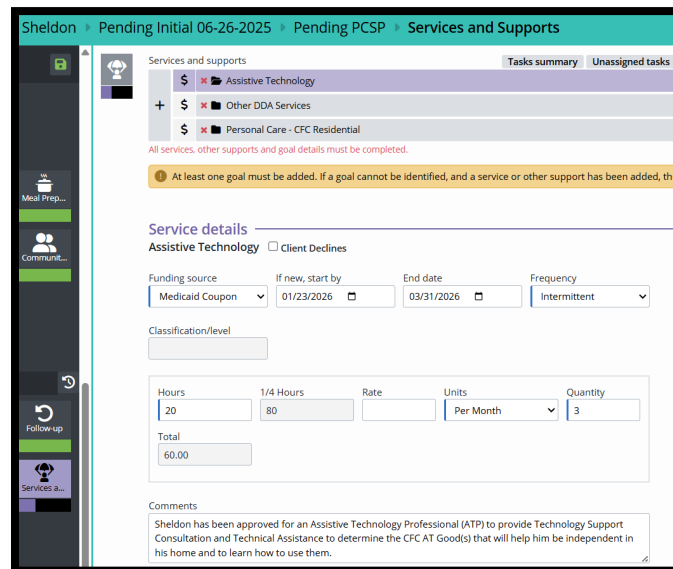
Example for Smart Care Device reflecting need for medication reminders:

Equipment				
	Category	Type	Status	Supplier
+	Med. Mgmt.	Assistive Technology	Needs, wants	Intuition Robotics

- 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 – 246ZRATPOL: 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

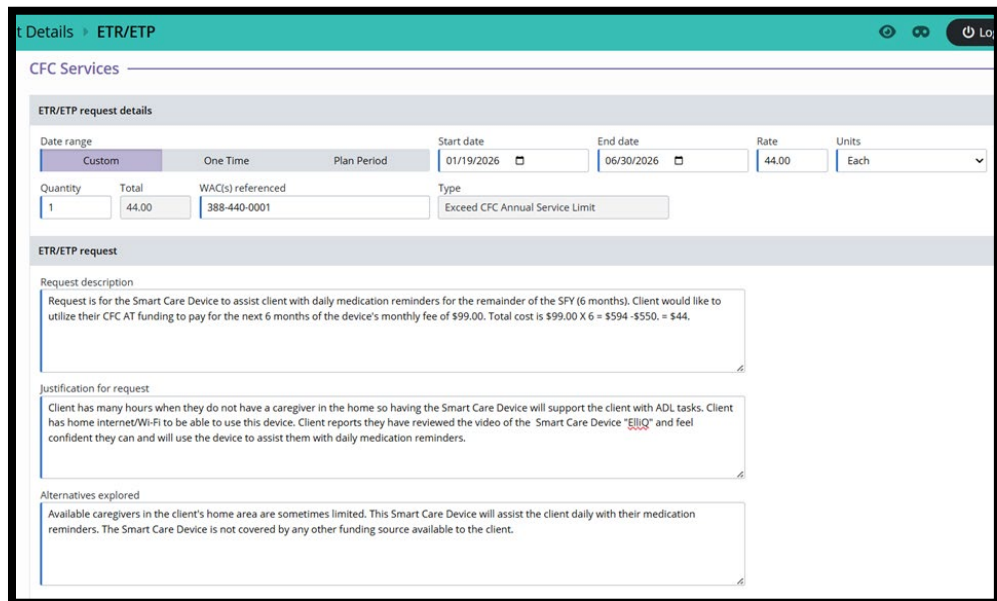
- Connect with a contracted provider.
 - When making the request from an AT contracted provider with the AT Goods subcode, please inform the Contractor that the request is for AT Goods. As many of our AT contractors have multiple contracts, this will help them utilize their correct contract.
- Request 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:
 - 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.
- 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.

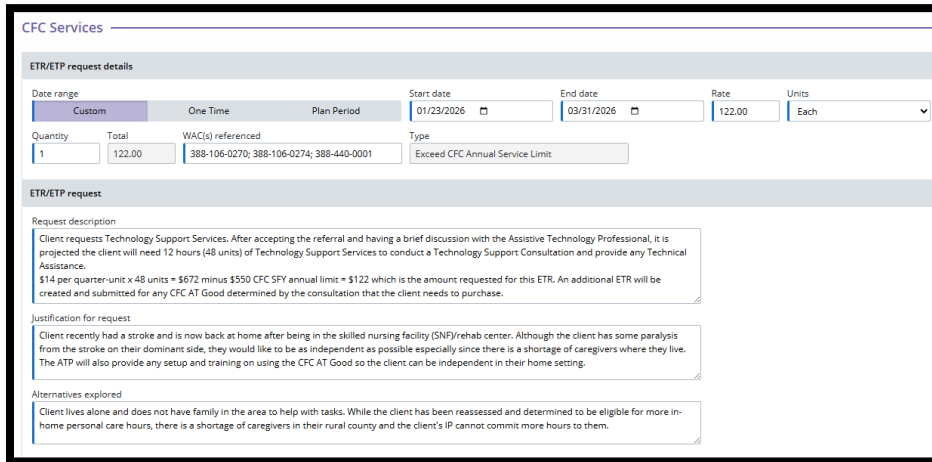
Authorizing Technology Support Consultation and Technical Assistance

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.



CFC Services

ETR/ETP request details

Date range: Custom One Time Plan Period Start date: 01/23/2026 End date: 03/31/2026 Rate: 122.00 Units: Each

Quantity: 1 Total: 122.00 WAC(s) referenced: 388-106-0270; 388-106-0274; 388-440-0001 Type: Exceed CFC Annual Service Limit

ETR/ETP request

Request description

Client requests Technology Support Services. After accepting the referral and having a brief discussion with the Assistive Technology Professional, it is projected the client will need 12 hours (48 units) of Technology Support Services to conduct a Technology Support Consultation and provide any Technical Assistance.

\$14 per quarter-unit x 48 units = \$672 minus \$550 CFC SPY annual limit = \$122, which is the amount requested for this ETR. An additional ETR will be created and submitted for any CFC AT Good determined by the consultation that the client needs to purchase.

Justification for request

Client recently had a stroke and is now back at home after being in the skilled nursing facility (SNF)/rehab center. Although the client has some paralysis from the stroke on their dominant side, they would like to be as independent as possible especially since there is a shortage of caregivers where they live. The ATP will also provide any setup and training on using the CFC AT Good so the client can be independent in their home setting.

Alternatives explored

Client lives alone and does not have family in the area to help with tasks. While the client has been reassessed and determined to be eligible for more in-home personal care hours, there is a shortage of caregivers in their rural county and the client's IP cannot commit more hours to them.

- 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.

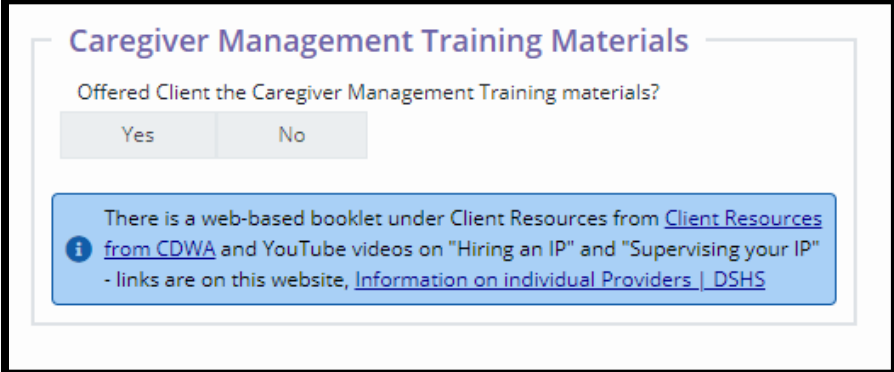
Caregiver Management Training

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.



Caregiver Management Training Materials

Offered Client the Caregiver Management Training materials?

Yes No

There is a web-based booklet under Client Resources from [Client Resources](#) from CDWA and YouTube videos on "Hiring an IP" and "Supervising your IP" - links are on this website, [Information on individual Providers | DSHS](#)

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:

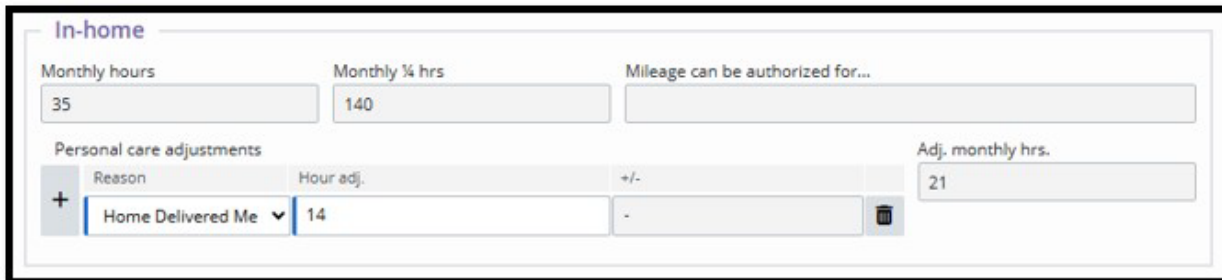
- Is homebound and lives in their own private residence;
 - Homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, intermittent absences for non-medical reasons, such as a trip to the barber or to attend religious services.
- Is 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 screenshot shows the 'In-home' section of the CARE system. It includes fields for 'Monthly hours' (35), 'Monthly ¼ hrs' (140), and 'Mileage can be authorized for...'. Below these is a 'Personal care adjustments' table with columns for 'Reason', 'Hour adj.', and '+/-'. A single row is visible with 'Home Delivered Me' as the reason, '14' as the hour adjustment, and a minus sign in the +/- column. To the right of the table is a field for 'Adj. monthly hrs.' showing the value 21.

In-home		
Monthly hours	Monthly ¼ hrs	Mileage can be authorized for...
35	140	
Personal care adjustments		
Reason	Hour adj.	+/-
+ Home Delivered Me	14	-
		Adj. monthly hrs. 21

The Service Summary will reflect the deduction:

Classification:	A High	Daily Rate:	N/A	Monthly Hours:	35
Hour Adjustments:					
	Home Delivered Meals:			-14.00	
Monthly Hours After Adjustments:				21.00	

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).
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.

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](#).



- 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 <i>every month</i> 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](#)
[WAC 388-106-0271](#)
[WAC 388-106-0272](#)

Services available under CFC
Limits to Skills Acquisition Training
Qualified providers for Skills Acquisition Training

[WAC 388-106-0273](#)

[WAC 388-106-0274](#)

[WAC 388-106-0275](#)

[WAC 388-115-0510](#)

PERS add-on services

Limits to Assistive Technology

Limits to Community Transition Services

Qualifications of an individual provider (IP)

Forms

[DSHS 02-615](#)

[DSHS 10-424](#)

[DSHS 13-712](#)

[DSHS 14-225](#)

[DSHS 14-416](#)

[DSHS 14-443](#)

[HCA 18-005](#)

Social Services Invoice/Receipt Packet Cover Sheet

Voluntary Participation (DDA)

Behavioral Health Wraparound Support (BHWS) Request for MCO Funding

Acknowledgement of Services

Eligibility Review for Long Term Services and Supports

Financial/Social Services Communication (use form in Barcode)

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 DDOS divisions versus Aging & Long-Term Support Administration (ALISA) 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	Jacqueline Cobbs	Changes based on the CFC State Plan Amendment	H17-078
03/2017	Jacqueline 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

Medicaid Personal Care

Chapter 7c describes the Medicaid Personal Care (MPC) program which provides assistance with personal care services that enable individuals to remain in, or return to, their own communities through the provision of coordinated, comprehensive and economical home- & community-based services (HCBS). Rules governing MPC can be found in Washington Administrative Code (WAC) [388-106-0200](#) through [0235](#) – see [Resources](#) for full list of WACs.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

For Home and Community Services (HCS) and Area Agency on Aging (AAA) clients:

Victoria Nuesca, Community First Choice (CFC) Program Manager, HCS

360.725.2393

victoria.nuesca@dshs.wa.gov

For Developmental Disabilities Community Services (DDCS) clients:

Sue Halle, Community First Choice (CFC) Program Manager, DDCS

360.764.3561

suzan.halle@dshs.wa.gov

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BACKGROUND

Medicaid Personal Care (MPC) is a Medicaid program that is allowed under Washington State's Medicaid State Plan. It is available to those clients who do not meet institutional level of care, otherwise known as Nursing Facility Level of Care (NFLOC) for Home and Community Services (HCS) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) for Developmental Disabilities Community Services (DDCS). MPC provides an opportunity for individuals to receive assistance with personal care tasks so they can remain in their own home or move into a community-based setting.

Just like Community First Choice (CFC), MPC pays for 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). 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 (<i>when sole source of heat</i>) • Travel to medical services • Telephone use

ELIGIBILITY

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

Age

If services are authorized by Home and Community Services (HCS)/Area Agency on Aging (AAA), clients must be 18 years of age or older.

If services are authorized by Developmental Disabilities Community Services (DDCS):

- Clients who meet DDCS' determination of a developmental disability may be any age
- Children with functional disabilities who do not meet DDCS' determination of a developmental disability may be served by DDCS until age 18. DDCS will refer adults age 18 and over who are not DDCS eligible to HCS.

Functional eligibility

Individual must meet functional eligibility as determined by Comprehensive Assessment Reporting Evaluation (CARE).

- The individual has an unmet or partially met need as defined in [WAC 388-106-0210](#); and
- Does not meet institutional level of care as outlined in [WAC 388-106-0355\(1\)](#).

Financial eligibility

To be financially eligible for MPC, an individual must be eligible for non-institutional categorically needy (CN) or alternative benefit plan (ABP) medical. See [Chapter 7a](#) of the Long-Term Care (LTC) manual for more information regarding financial eligibility for LTC programs.

SETTINGS & PROVIDER QUALIFICATIONS

Clients enrolled in MPC have the right to choose to receive personal care services using a qualified provider in one of the following settings:

Client's Home

Where the client resides (own home, relative's home, etc.). Client's "own home" is defined in [WAC 388-106-0010](#).

Individual Provider (IP)

Clients may choose an Individual Provider (IP) as their provider. If the client chooses an IP,

- The IP is an employee of the [Consumer Directed Employer \(CDE\) contracted vendor for Washington state, Consumer Direct Washington \(CDWA\)](#),
- 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.

Qualifications:

- Meet the qualifications listed in [WAC 388-115-0510](#);
- Are hired and employed by the CDE (see [LTC Manual, Chapter 11 – Consumer Directed Employer](#) for more information on 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 [Chapter 388-71 WAC](#) (specifically 388-71-0500 through 388-71-1006), and [RCW 74.39A.250](#).

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

For Case Managers *only*:

- 1-866-932-6468

For Clients and IPs:

- 1-866-214-9899

- infocdwa@consumerdirectcare.com

Home Care Agency:

Qualifications:

- 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.

To authorize MPC in-home personal care services, use service code: [T1019-U6](#)

Adult Family Home (AFH)

Qualifications:

- 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.

To authorize MPC personal care services at an AFH, use service code: [T1020-U1](#)

Adult Residential Care (ARC) contracted/licensed assisted living facility

Qualifications:

- Contract with DSHS under Chapter [388-110](#) WAC;
- Current DSHS contract for Adult Residential Care (ARC) services; **and**
- Assisted Living Facility (ALF) license under Chapter [18.20](#) RCW and Chapter [388-78A](#) WAC.

To authorize MPC personal care services at an ARC, use service code: [T1020-U2](#)

Payment for services cannot occur while the client is in an institutional setting (such as hospital, nursing facility, residential habilitation center, or jail). Authorizations for services must be adjusted or terminated during this time.



MPC SERVICES

The services available through MPC are limited to personal care services, nurse delegation (only for clients living in AFH and ARC settings and DDCCS in-home clients only), nursing services, and caregiver management training.

Personal Care Services

The definition of personal care services can be found in [WAC 388-106-0010](#) and is as follows:

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 include assistance:

- Provided to enable clients to accomplish tasks that they would normally do for themselves if they did not have a disability;
 - This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the client to perform a task.
 - Personal care services may be provided on an episodic or on a continuing basis.
- To complete ADLs;
- To complete IADLs if not comprising the entirety of the service for an individual and the client also has an unmet need and accepts assistance with ADLs;
- For tasks completed outside of the client's home as specified in the CARE plan.
 - Personal care may be furnished to support clients in community activities or to access other services in the community.
 - Personal care may be furnished in order to assist a person to function in the workplace or as an adjunct to the provision of employment services.

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

Please see [Chapter 22a – Apple Health Managed Care \(MCO\) and Apple Health Medicare Connect \(DSNP\)](#) for Behavioral Health Wraparound Support (BHWS) or Community Behavioral Health Support (CBHS) service information and eligibility criteria.



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 Consumer Directed Employer (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;
 - Other services, such as nurse delegation, 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 advise 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](#);
6. The client must provide in writing to the case manager with 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 hard copy file for DDCS);
7. Advise the Public Benefits Specialist (PBS) via Barcode (HCS/AAA use [DSHS form 14-443](#) and DDCS use form 15-345) of the following:
 - The dates the client will be out-of-state,
 - The client's intention of returning to Washington and that a written document of such was received and placed in their file, and
 - That the client will continue receiving personal care through MPC.

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



8. Prior to the client leaving the state, an Exception to Rule (ETR) must be reviewed and approved at the local, regional/AAA level.
 - ETR Category and ETR Type will be “Other”
 - Date Range: “Custom”
 - Start date and End date boxes: will be the dates the client will be out of the state.
 - Hours/Rate, Units, and Quantity boxes: leave blank as the client will not be eligible for or able to use hours beyond their current CARE plan.
 - WAC(s) referenced: add [388-106-0035](#) and [182-503-0520](#)
 - 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 out-of-state.
 - 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.
 - ETR must go through your local office process for final review and approval.
9. 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*
10. The client and/or their representative must contact the case manager:
 - *every* 30 days while 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.

Nurse Delegation

Under the MPC program, nurse delegation was legislatively appropriated only for residential MPC clients. Legacy DDCS had a different budget and have allowed nurse delegation for their in-home MPC clients in addition to the residential MPC clients.

Therefore, for MPC clients, nurse delegation is only available in Adult Family Homes (AFH) and some Adult Residential Care (ARC) facilities, and for in-home MPC clients served by DDCS only.

Nurse Delegation means nursing tasks, such as administration of medication, blood glucose monitoring, insulin injections, ostomy care, simple wound care, or straight catheterization, which may be delegated under the direction of a licensed, registered nurse if the provider meets the requirements of a nursing assistant certified and/or registered in the State of Washington.

The following tasks CANNOT be delegated:

- Injections other than insulin,
- Central lines,
- Sterile procedures, and
- Tasks that require nursing judgments.



To authorize nurse delegation for an MPC residential client (at an AFH or ARC) or a DDCS MPC in-home client, use service code: [H2014-U5](#)

For more information related to nurse delegation see LTC Manual [Chapter 13 - Nurse Delegation](#).

Nursing Services

Nursing Services offer clients, providers, and case managers with health-related assessment and consultation in order to enhance the development and implementation of the client's plan of care.

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;
- 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.

A Nursing Services provider is not a direct care provider of intermittent or emergency nursing care, skills, or services requiring physician orders and supervision. Skilled treatment is provided by Nursing Services 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](#).

Nursing Service provider qualifications:

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

Caregiver Management Training

Caregiver Management Training is designed as a self-study training to help clients understand how to select, manage, and dismiss their personal care provider. There is a web-based booklet and also two videos on YouTube. Training should be provided to any client that requests this information.

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.

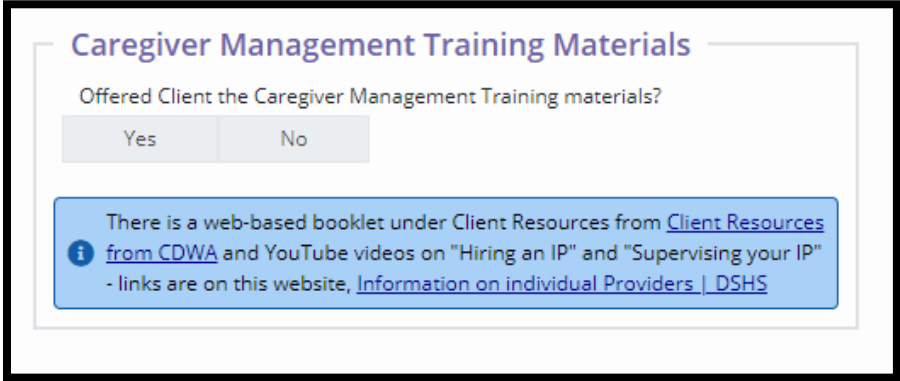
There are also two online videos available on YouTube:

- [How to Hire the Right Individual Provider - YouTube](#)
- [Supervising Your Individual Provider - YouTube](#)

Training 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 services when the regular caregiver is not available or requires relief.

Clients may be offered the training by the Case Manager during service planning such as their assessment or when they are changing to an Individual Provider (IP). Indicate on the Profile screen under the Client Details section in CARE if the client and/or their legal representative was offered and/or if they requested the Caregiver Management Training materials.



Caregiver Management Training Materials

Offered Client the Caregiver Management Training materials?

There is a web-based booklet under Client Resources from [Client Resources](#) from CDWA and YouTube videos on "Hiring an IP" and "Supervising your IP" - links are on this website, [Information on individual Providers | DSHS](#)

SERVICE NEEDS BEYOND MPC

Home Delivered Meals (HDM) is a service paid under the COPES waiver program to a contracted HDM provider. Please see [LTC Chapter 7d – COPES](#) for more information about HDM. To receive HDM, a client must meet all the criteria below:

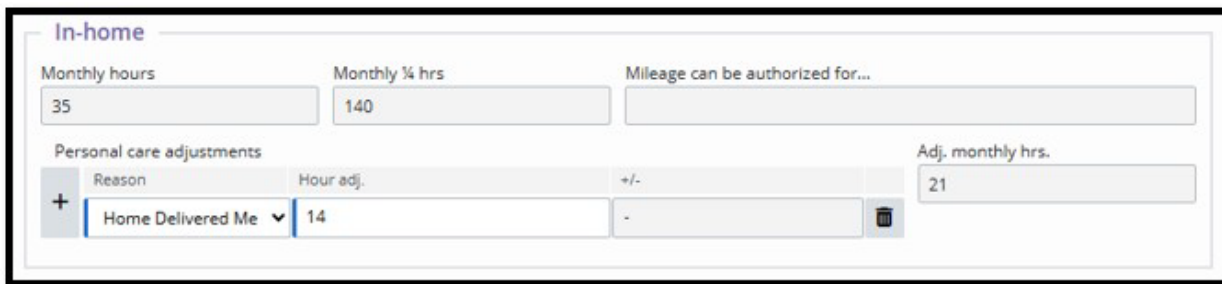
- Is homebound and lives in their own private residence;
 - Homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, intermittent absences for non-medical reasons, such as a trip to the barber or to attend religious services.
- Is 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.

See the [“Moving from MPC to CFC or CFC+COPES”](#) section below to determine if the MPC client would be eligible for CFC+COPES and choose to have HDM through COPES if they meet the criteria.

If, however, an MPC client is not determined eligible for CFC+COPES and they need/want 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 screenshot shows the 'In-home' section of a CARE assessment. It includes fields for 'Monthly hours' (35), 'Monthly ¼ hrs' (140), and 'Mileage can be authorized for...'. Below these is the 'Personal care adjustments' table, which has columns for 'Reason', 'Hour adj.', and '+/-'. A row is added with 'Reason' as 'Home Delivered Me', 'Hour adj.' as '14', and '+/-' as '-'. To the right of the table is a field for 'Adj. monthly hrs.' showing the value '21'.

Reason	Hour adj.	+/-
+ Home Delivered Me	14	-

The Service Summary will reflect the deduction:

Classification: A High	Daily Rate: N/A	Monthly Hours: 35
Hour Adjustments:		
Home Delivered Meals:		-14.00
Monthly Hours After Adjustments:		21.00

Moving from MPC to CFC or CFC+COPES

If an MPC client's needs exceed what MPC can provide, and the MPC client wishes 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.
- If they are re-assessed in CARE and are 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.
- The institutional level of care criteria applies to both CFC and to COPES.

See LTC manual chapter [7b – CFC](#) and chapter [7d – COPES](#) for additional information.

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 Health Care Authority (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.

RESOURCES

Related Washington Administrative Codes (WACs)

WAC 388-106-0200	MPC Services
WAC 388-106-0210	MPC Eligibility
WAC 388-106-0215	MPC Eligibility Date
WAC 388-106-0220	MPC Remaining Eligible
WAC 388-106-0225	MPC Paying for Services
WAC 388-106-0230	MPC Employment
WAC 388-106-0235	MPC Waiting Lists
WAC 388-71	Home and Community Services and Programs
WAC 388-76	Adult Family Home Minimum Licensing Requirements
WAC 388-106	Long-Term Care Services
WAC 388-110	Contracted Residential Care Services
WAC 246-335	In-Home Services Agencies
WAC 246-840	Practical and Registered Nursing

Related Revised Codes of Washington (RCWs)

RCW 18.20	Assisted Living Facilities
RCW 70.127	In-Home Services Agencies
RCW 70.128	Adult Family Homes

Acronyms

AAA	Area Agency on Aging
ABP	Alternative Benefit Plan
ADL	Activities of Daily Living
AFH	Adult Family Home
ALF	Assisted Living Facility
ARC	Adult Residential Care
BHWS	Behavioral Health Wraparound Support
CARE	Comprehensive Assessment and Reporting Evaluation
CBHS	Community Behavioral Health Support services
CDE	Consumer Directed Employer
CDWA	Consumer Direct Care Network of Washington
CFC	Community First Choice
CM	Case Manager
CN	Categorically Needy
COPES	Community Options Program Entry System
CRM	Case Resource Manager with DDCS
DDCS	Developmental Disability Community Services
DOH	Department of Health

DSHS	Department of Social and Health Services
ECR	Electronic Case Record
ETR	Exception to the Rule
HCA	Health Care Authority
HCBS	Home- and Community-Based Services
HCLA	Home and Community Living Administration
HCS	Home and Community Services
IADL	Instrumental Activities of Daily Living
ICF/IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
IP	Individual Provider
LTC	Long-Term Care
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
RAC	Recipient Aid Category
RCW	Revised Code of Washington
RND	Registered Nurse Delegator
SCDS	Service Code Data Sheet
SER	Service Episode Records
SSAM	Social Service Authorization Manual
WAC	Washington Administrative Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
11/2025	Victoria Nuesca	• Updated phone number for DDCCS contact • Updated language to reflect HCS and DDCCS versus Aging & Long-Term Support Administration (ALISA) and Developmental Disabilities Administration (DDA) • Moved service codes to align with the appropriate service provider • Reorganized and clarified “Nurse Delegation” section • Reorganized “Service Needs Beyond MPC” section to clarify receiving home-delivered meals/nutrition services for MPC clients. Added snapshots of how	



		to reflect deduction from CARE-generated monthly personal care hours.	
4/2025	Annie Moua	• Update template • Update MPC contact	H25-010
08/2024	Annie Moua	• Removal of BHPC • Added BHWS and CBHS reference in Chapter 22a	H24-044
04/2024	Annie Moua	• Aligned Out-of-State Personal Care and Caregiver Management Training sections with updated information • Added information about home delivered meals reduction in in-home hours • Fixed formatting, links, and Acronyms	H24-018
10/2023	Annie Moua	• Corrected eligibility for services authorized by DDOS	H23-071
06/2023	Annie Moua	• Updated contacts	H23-039
03/2022	Grace Brower	• Updated contacts and links, updated info to reflect that Individual Providers are now employees of the Consumer Directed Employer (CDE) and made the appropriate changes, clarified information regarding In-Home Personal Care Services Outside Washington, added acronyms	H22-020
10/2020	Beth Adams	• Moved to new template, re-arranged content	

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

If you have questions or need clarification about the content in this chapter, please contact:

Becca Howard	HCBS Waiver Program Manager 564.263.0839	rebecca.howard@dshs.wa.gov
Julie Cope	RCL/NFCM Unit Manager 360.725.2529	julie.cope@dshs.wa.gov
Susan Worthington	Nursing Services Program Manager 360.485.2291	susan.worthington@dshs.wa.gov

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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.

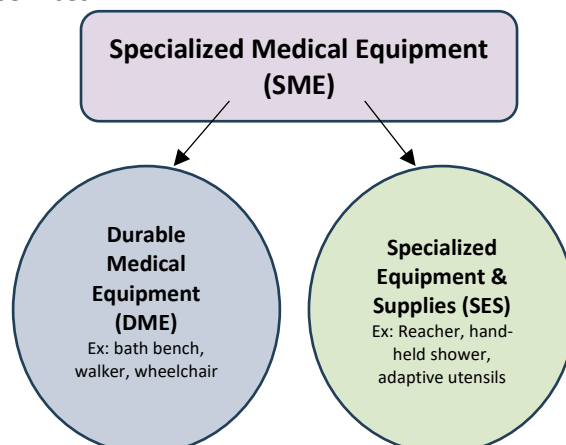
Note: COPES client support training cannot be used to authorize training a nurse to complete skilled nursing tasks.

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](#)



New Freedom Budget-Based Participant Directed Services (Limited availability based upon county of residence)

The purpose of this chapter is to educate staff about the New Freedom waiver and the benefits it offers to participants as well as to provide instruction on how the program works.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Darrellyn Nuesca New Freedom Program Manager
360.725.2446 darrellyn.nuesca1@dshs.wa.gov

If you have questions or need clarification about ACES\$, please contact:

ACES\$ Financial Management Services
goodservice@mycil.org

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BACKGROUND

What is Participant Directed Services?

Participant Directed Services is a philosophy and orientation to home and community-based services that gives participants the authority to make choices about services and supports that work best for them, regardless of the nature or extent of their disability.

Participant direction empowers participants and their families by expanding their degree of choice and control over the long-term services and supports they need to live at home. This is done in Collaboration with the Area Agency on Aging (AAA) Care Consultant. Participants can share authority with or delegate authority to family members or others close to them. Designation of a representative enables adults with cognitive impairments or those who would rather not be fully responsible to be involved in participant direction.

Participant direction represents a major paradigm shift in the delivery of publicly funded home and community-based services. In the traditional service delivery model, decision-making and managerial authority is vested in professionals who may either be state employees/contractors or service providers. Participant direction transfers much (though not all) of this authority and responsibility to participants and their families (when chosen or required to represent them).

What is New Freedom (NF)?

New Freedom is a voluntary budget-based program that provides participants who are eligible for Home and Community Based Services (HCBS) through the 1915c Medicaid Waiver Program. It offers participants a choice in how they receive services in their home. NF offers Participants the opportunity for increased responsibility, choice and control over their services and supports.

The goal of NF is to provide the opportunity for qualified participants to choose from a wide array of approved services to meet their needs within a set monthly budget. NF Participants can choose the amount and type of services **(within the definitions in this chapter and the state and federal regulations)** that meet their needs as long as they have sufficient funds within their individual monthly service budget. NF provides flexibility to adjust services and allows participants to exercise more decision-making authority and to take primary responsibility for obtaining services.

Participants who choose NF receive an individual monthly service budget that they can use to purchase items and services that meet their care needs that enable them to live as independently as possible in the community. The program provides participants the ability to save for and purchase services, equipment or supplies that decrease their need for Medicaid services and/or increase safety in their home environment.

Participants in New Freedom have the choice to decide:

- What qualified services, goods and supports they need within their approved service budget.
- When and how those services and supports are to be delivered.
- Who will provide those services and supports.
- Who will provide personal care assistance (individual provider/homecare agency).



New Freedom Roles

New Freedom participants work with a Care Consultant and a Financial Management Service vendor (ACES\$) to design and implement their individual participant spending plan. Each play an important role in working with participants to develop an individualized monthly service budget that details approved authorizations and guides the participant's purchasing of services/supports to meet their needs.

Role	Summary of Responsibilities
Participant or Authorized Representative	Participant or Authorized Representative will work with their Care Consultant to make choices about approved services and supports that work best for them within their approved New Freedom budget. They will work with ACES\$ Financial Management Services to obtain those approved services and supports. This may entail monitoring their own services including the budget and informing the Care Consultant of any changes.
Care Consultant	Assists the participant in development and management of their New Freedom budget. The Care Consultant is available to advise participants in how to gain access to needed services, assisting in the development of the New Freedom Spending Plan, coaching the participant on how to monitor their services included in the budget, and updating the service plan as necessary. The Care Consultant reviews and approves all purchases and adds them to the New Freedom Spending Plan. In addition, the Care Consultant provides ongoing functional eligibility determinations for participants enrolled in the program.
ACES\$ Financial Management Services (FMS) provider	Handles all financial transactions for New Freedom participants outside of monthly personal care. All New Freedom expenses incurred, except personal care, by participants are billed through ACES\$ Financial Management Services (FMS). The only supports/services that will be allowed under New Freedom have been approved by the Care Consultant under the guidance of this chapter and the appropriate state and federal regulations. .
New Freedom Program Manager	Manages the New Freedom program including all policy. • Responsible for updating program related documents. • Continuing education and training. Darrelyn Nuesca: darrelyn.nuesca1@dshs.wa.gov

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR NEW FREEDOM?

To determine functional eligibility, a personal care assessment, also known as your Comprehensive Assessment Reporting & Evaluation (CARE) assessment, must be completed. The financial and functional eligibility requirements for New Freedom are the same as the other Medicaid waiver programs, such as



the COPES waiver. **New Freedom is also available if a Community First Choice (CFC) participant meets the waiver eligibility criteria, has a need that cannot be met by CFC and wants to enroll in New Freedom.** New Freedom is currently an option available only to participants who live in participating counties and choose to receive in-home services.

Participants who receive services through the New Freedom Waiver meet each of the following criteria ([WAC 388-106-1410](#)):

Participants are eligible for New Freedom Consumer Directed Services (NFCDS)-funded services if they reside in their own home and meet **all** the following criteria. The participants' needs will be assessed using CARE and determine that:

- (1) They are in NFCDS HCBS waiver specified target groups of:
 - (a) Eighteen or older and blind or have a disability; or
 - (b) Sixty-five or older; and
 - (C) They reside in a county where New Freedom is offered (King, Pierce, Ferry, Pend Oreille, Spokane, Stevens, or Whitman County).
- (2) They meet financial eligibility requirements described in WAC 182-513-1315. This means the participant's finances will be assessed if their income and resources fall within the limits, and determine the amount they may be required to contribute, if any, toward the cost of their care as described in WAC 182-515-1505; and
- (3) They:
 - (a) Are not eligible for Medicaid Personal Care services (MPC); or
 - (b) Are eligible for MPC services, but it is determined that the amount, duration, or scope of their needs is beyond what MPC can provide; and
- (4) Their CARE assessment shows they need the level of care provided in a nursing facility as defined in WAC 388-106-0355; and
- (5) They live in their own home or will be living in their own home by the time NFCDS start.

A participant must also be willing and able to self-direct their services or select an Authorized Representative.

WHAT SERVICES ARE COVERED UNDER NEW FREEDOM?

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

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



All purchases under New Freedom must be pre-approved by the Care Consultant and meet the following criteria:

1. Be allowable under [WAC 388 106 1400](#): What services may I receive under New Freedom consumer directed services (NFCDS)?
 - a. Be for the sole benefit of the participant.
 - b. Be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment.
 - c. Meet the participants identified needs and outcomes from the CARE assessment and address the health, safety, and welfare of the participant related to their medical diagnosis, Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks (for example, nurse delegation and PERS units).
 - d. Be documented on the participant's New Freedom Spending Plan;
2. The Care Consultant and/or Financial Management Service may require a physician or other licensed professional, such as an Occupational or Physical Therapist to recommend a specific purchase in writing. This recommendation is required to ensure the service, support, or item will increase, maintain, or delay decline of functional abilities, and to ensure the purchase supports the participants' health and welfare.
3. Medicare or Medicaid state plan benefits or other insurance must be used prior to using NF funds if the goods or services are covered under these programs.
4. A participant may use their individual budget to purchase services, supports, or items that fall into the following service categories (as defined in the WAC 388-106-1400):
 - a. Personal Assistance Services
 - b. Treatment and Health Maintenance
 - c. Individual Directed Goods, Services and Supports
 - d. Environmental or Vehicle Modifications
 - e. Training and Educational Supports
5. A participant may receive comprehensive adult dental services.
 - a. New Freedom funds may be used for dental services that are medically necessary and not covered by the Medicaid State Plan, Medicare, or other programs or services.
6. Trained Service Animals (for specific coverage see Trained Service Animals section).
7. Non-medical transportation: Taxi scripts or ride-share such as "Uber" rides may be authorized for grocery shopping and other essential shopping.
 - a. The FMS cannot prepay for a taxi or ride-share. The participant must have prior authorization, prepay, and be reimbursed.
 - i. Receipts must have time, date, name of transportation company, cost, and name of location (such as "Safeway") on the receipts.
 - ii. The participant cannot be reimbursed for the tip.
 - b. A bundled amount of either a specific number of trips per month or a maximum dollar amount per month may be authorized, not to exceed the care plan year.
 - c. Non-emergency medical and mental health appointments are offered by the state plan and are not covered under New Freedom.



WHAT SERVICES ARE NOT COVERED UNDER NEW FREEDOM?

All purchases under New Freedom must be pre-approved by the Care Consultant and must not be excluded under WAC 388-106-1405 and 1915c waiver. Services and supports that cannot be purchased with New Freedom budgets include:

- Those items identified in [WAC 388 106 1405](#): “What services are not covered under New Freedom Consumer Directed Services (NFCDS)?”
- Any goods, services, or supports that are considered of general utility.
 - **General utility** is defined as an item that is not of direct medical or remedial benefit to the participant. An item that would be a purchase made by any person whether they have a disability or not. Examples include lamps, step stools, air conditioners, rugs, beds, non-specialized clothing etc.
 - The service/good/support is not specific to the individuals' needs based on their disabilities or health conditions as identified in the CARE assessment.
- Services/supports covered by the Medicaid State Plan, Medicare, or other programs or services.
- Any fees related to health or long-term care incurred by you, including co-pays, waiver cost of care (participation), or insurance. This includes costs that other insurances will not pay.
 - If Medicaid funds (Apple Health) are used, then the participant cannot also use New Freedom funds (which are also Medicaid funds) to pay any remaining balance as it would be double dipping into the Medicaid pool of funds.
 - Example: Costs that exceed the participant’s medical/dental benefit allowance for using Medicaid funds.
- Concierge or subscription-based services are not allowed as they may supplant or duplicate items or services that are covered by the medical benefit and are not allowable.
- Home modifications or improvements that only add any square footage to the home.
- Home modifications or improvements that are of general utility and are not of direct medical or remedial benefit to the participant.
- 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.
- Vacation or travel expenses other than the direct cost of provision of personal care services.
 - A participant may not use New Freedom funds to pay travel expenses for their provider.
- Rent/room and board.
- Tobacco or alcohol products.
- Lottery tickets.
- Entertainment items (TV, cable or DVD players), and other electronics, that are nonadaptive in nature.
- Vehicle purchases/maintenance/upgrades that do not include modification related to disability.
- Tickets and related costs to attend sporting or other recreational events.
- Standard household supplies, furnishings, equipment and maintenance, and major household appliances.
- Pets, comfort, or therapy animals and their related costs (including purchase of the pet, comfort or therapy animal, their food or veterinary services).



- Non-routine veterinary services for a Trained Service Animal (Veterinary care over the cost of \$500 per occurrence.)
- Postage outside of shipping costs related to prior approved service plan items.
- Experimental or investigational services, procedures, treatments, devices, medications, or application of associated services, except when the individual factors of an individual participant's condition justify a determination of medical necessity under [WAC 182-500-0070](#).
 - This also applies to Trained Service Animals. Experimental or investigational services, procedures, treatments, devices, medications, or application of associated services are not covered.
- Exercise equipment greater than \$500 per item.
- Monthly service fees for utilities including ongoing utilities.
- Warranties (for equipment, furnishings, or installations).
- Computers and electronics that do not meet therapeutic need or are not adaptive in nature.
- Cosmetic services and treatments.
- Basic groceries, clothing, and footwear.
- Any item previously purchased through Medicaid funding that is within the Health Care Authority replacement period.

TRAINED SERVICE ANIMALS

What is a Trained Service Animal:

The 1915(c) waiver allows New Freedom funds to be used to pay for Trained Service Animals. [WAC 388-106-1405](#) and [WAC 388-473-0040](#) follow the [Americans with Disabilities Act](#) (ADA) definition of a Trained Service Animal and [RCW 49.60.040](#):

ADA:

- Dogs that are trained to perform a task directly related to a person's disability.

RCW 49.60.040 (25):

- Any dog or miniature horse that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. The work or tasks performed by the service animal must be directly related to the individual's disability.

Example: If the dog's mere presence provides comfort, it is **not** a Trained Service Animal under the ADA.

If the dog is trained to perform a task related to a person's disability, it is a service animal under the ADA. The tasks that the service animal provides cannot be duplicative. They cannot be tasks that are already covered by another person, device, or service being provided to the participant. To pay for a trained service animal it must also be the most cost-effective option to meet the client's identified need.

Example: If the dog has been trained to sense that an anxiety attack is about to happen and takes a specific action to help avoid the attack or lessen its impact, the dog **is** a Trained Service Animal. This



action must be related to the participant's medical diagnosis, Activities of Daily Living (ADL), and/or IADL (Instrumental Activities of Daily Living) and documented in the participant's Care Plan.

What is Covered:

The New Freedom waiver and WACs allow for the payment of upkeep expenses related to trained service animals such as food, licensing, and routine veterinary services.

- Food:
 - Benefits may be authorized for a Trained Service Animal – up to a 45-day supply at a time.
- Veterinary care:
 - Routine veterinary services for a Trained Service Animal may be authorized when there is a routine medical necessity that would require treatment so that the Trained Service Animal can continue to do the task they have been trained to perform.
 - Routine services such as vaccines, office visits, nail trimming or routine blood tests.
 - Flea medicine may be approved for up to 90 days.
 - Any routine veterinary costs over \$500 per occurrence requires an approved Headquarters ETR.
 - All non-routine veterinary services for a Trained Service Animal requires an approved Headquarters ETR.
- Additional Training:
 - Enrollment in a course addressing additional training (new tasks only) specifically related to a participant's Trained Service Animal.
 - All service animal training requires a Headquarters ETR approval.
 - Trainings must be completed by a qualified trainer.
 - This should be limited in scope and for a specific task that relates to a participant's ADL/IADL or medical diagnosis within their care plan.
- Boarding:
 - Benefits may be authorized for boarding for a maximum amount of \$300.00 a year if it is determined that the participant needs medical or mental health care and is in a facility in which your Trained Service Animal cannot reside and there is no one who can provide care for your Trained Service Animal.

What is Not Covered:

- All veterinary care beyond the cost of \$500 per occurrence without a Headquarters ETR.
 - Veterinary care must be approved in advance and cannot be approved for emergency services.
- Experimental or investigational services, procedures, treatments, devices, medications, or application of associated services are not covered.
- Concierge or subscription based veterinary services.
- Training to become a Trained Service Animal.
- Obedience or other general utility training.
- Purchase of a pet, comfort or therapy animal.
- Pets, therapy animals and their related costs (including food and veterinary services).



- Emotional support or comfort dogs, because providing emotional support or comfort is not a task related to a person's disability.
- Boarding of a Trained Service Animal for purposes of a vacation or other non-medical participant needs.
- Dog walking and grooming services are considered general utility and not covered.
- Travel time for vendors.

What is Not Required:

- There is no requirement of the Care Consultant to request certification for the Trained Service Animal.
- There is no requirement for a Trained Service Animal to wear a vest or other ID that indicates they are a service dog.

AUTHORIZED REPRESENTATIVE

The New Freedom waiver supports participants to use an Authorized Representative to assist them (or manage on the participant's behalf) in managing and directing their budgets. Both the participant and the representative must sign the [New Freedom Authorized Representative Form](#) giving the responsibility to the person of their choice. An Authorized Representative is authorized to complete and sign all forms. An Authorized Representative will work with the Care Consultant to use the New Freedom Spending Plan (NFSP) monthly budget to purchase goods, services, and other items to meet the participant's personal care needs as identified in their CARE assessment.

Authorized Representatives can ensure that participants' preferences are known and respected and can manage tasks that they would carry out if they were able. These individuals are surrogate decision makers for those who choose or may need some or total assistance to direct their services and supports. In New Freedom (per [WAC 388-106-1435](#)) an Authorized Representative cannot also be a paid provider under the participant's NFSP.

An Authorized Representative Must:

- Act in the participant's best interest
- Respect the participant's preferences
- Maintain regular contact with the participant
- Be willing and able to meet and uphold all program requirements on behalf of the participant
 - Including working and collaborating with the participant's Care Consultant
- Be at least 18 years old

An Authorized Representative CANNOT:

- Be paid for this service
- Be a paid provider for the participant

The participant or Authorized Representative may end this agreement at any time.



HOW DO PARTICIPANTS ENROLL IN NEW FREEDOM?

HCS Case Workers (including Nursing Facility Case Managers):

Prior to transferring the case to an Area Agency on Aging, the HCS case worker must complete the following:

Outside of CARE:

- The participant must sign the [New Freedom Participant Responsibility Agreement](#) form (DSHS 16-244) prior to completing enrollment.
 - The participant cannot be on the program unless this document is signed.
- Provide the participant with a copy of the [New Freedom Participant Handbook](#).
 - This does not require a signature and can be emailed to the participant.
- Provide the participant with the link to the [ACES\\$ Washington Participant Enrollment Packet](#).
 - To be completed online by the participant. Completion is not required prior to transfer to the Area Agency on Aging (AAA).
 - Inform the participant that enrollment in ACES\$ is a requirement of the program.
- If applicable, provide the participant with a copy of the [New Freedom Authorized Representative](#) form.

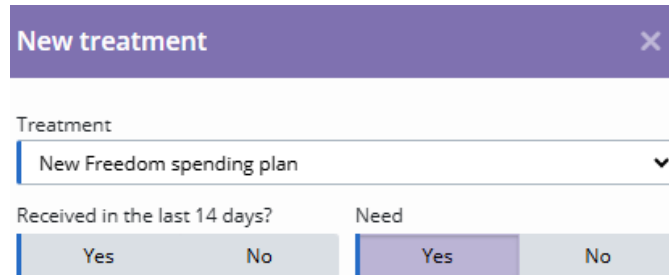
In CARE (For step-by-step instructions see the Choosing New Freedom in CARE section):

- Add the treatment “New Freedom spending plan” to the Medical screen.
- Select New Freedom on the ‘Client chosen program’ on the Care Plan screen.
- Enter in the number of hours the participant has chosen to use for personal care on the Care Plan screen.
- Add “ACES\$ Financial Management Services – New Freedom” agency (ACES\$ 208768001 to the Care Plan Supports screen and assign the task “New Freedom Spending Plan”.

Choosing New Freedom in CARE:

1. Complete the CARE assessment to determine functional eligibility.
2. Obtain a financial eligibility determination;
3. Offer New Freedom as an option when the participant is determined financially and functionally eligible.
 - a. The financial and functional eligibility requirements for New Freedom are the same as the other Medicaid waiver programs, such as the COPES waiver. New Freedom is also available if a Community First Choice (CFC) participant meets the waiver eligibility criteria, has a need that cannot be met by CFC and wants to enroll in New Freedom.
 - b. New Freedom is currently an option available only to participants who live in participating counties and choose to receive in-home services.
 - i. As of 01/01/2025, participants must reside in a county where New Freedom is offered (King, Pierce, Ferry, Pend Oreille, Spokane, Stevens, or Whitman County).
4. If the participant chooses New Freedom, start by adding New Freedom as a Treatment
 - a. On the “Medical” screen, add a New Treatment.

- b. Select the treatment “New Freedom spending plan”.



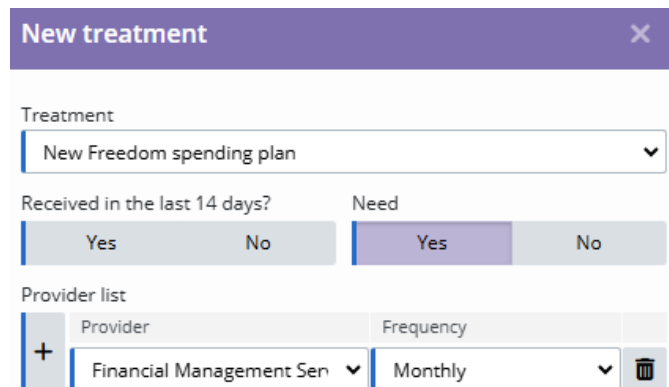
New treatment ✕

Treatment
New Freedom spending plan ▼

Received in the last 14 days? Need

Yes No Yes No

- c. Select No for “Received in the last 14 days?” and Yes for “Need”.
- d. In the Provider List drop down, add “Financial Management Service” with a frequency of Monthly.



New treatment ✕

Treatment
New Freedom spending plan ▼

Received in the last 14 days? Need

Yes No Yes No

Provider list

+	Provider	Frequency	
	Financial Management Sen ▼	Monthly ▼	🗑️

- e. Select “Add Treatment”
5. Once the Treatment screen is completed, add New Freedom to the “Care Plan” screen:
- a. On the “Care Plan” screen in CARE, select New Freedom on the ‘Client chosen program’ screen.



 **Programs**

Client chosen program
New Freedom

Living situation

Recommended living situation
In Home ▼

Client chosen/planned living situation
In Home ▼



- b. Once the CARE classification has been determined, the 'Monthly Budget' will populate in the New Freedom In-Home section of the Care Plan.

New Freedom In-home

Monthly Budget \$3,182.35	Max Hrs/Month 138	Chosen Hrs/Month 58
Remain Budget \$1,850.09	Mileage can be authorized for... Individual Provider	
Personal care adjustments + Click + to add items.		Total Adjustment 0

- c. Enter in the number of hours the participant has chosen to use for personal care and the "Remaining Budget" amount for goods and services will self-populate.
 - i. Per WAC 388-106-1458, participants must choose the number of hours they wish to use for the month before the beginning of that month. After the month starts, the only way to change hours in the current month is through a significant change assessment or an Exception to Rule.
 - ii. If a participant elects to use a certain number of hours, and does not use all those hours, they will not be able to convert those hours back to their budget funds.
 - d. The amount in the 'Remaining Budget' will be transferred to the Financial Management Services (FMS) provider once the Care Plan is brought to current.
6. "Care Planning – Supports" screen in CARE:
- a. Once you have entered New Freedom as the 'Client chosen program', add the PAID caregiver and any UNPAID informal supports to the "Supports" screen and assign tasks as appropriate.
 - b. Add "ACES\$ Financial Management Services – New Freedom" agency (ACES\$ 208768001. DO NOT USE THE 02 LOCATION CODE FOR NEW FREEDOM) on the Supports screen. CMS requires that ALL paid providers be listed as a paid provider and assigned a task.

Provider task assignment

Providers		Manage providers
Provider	Dept. paid/unpaid	
ACCESS Financial Management Services - New Freedom	Paid	

- i. If you add PERS, Environmental Modifications, or Specialized Medical Equipment, assign them to "ACES\$ Financial Management Services - New Freedom".
- c. Next assign the task to ACES\$ in the Task Summary. CMS requires all paid providers to be in the care plan.

Assigned tasks

Task	Task code	Assigned provider	Provider type
New Freedom spending plan		ACCESS Financial Management Services - New Freedom	Paid

CREATING THE NEW FREEDOM SPENDING PLAN (NFSP) IN CARE

- After you have entered New Freedom as the 'Client chosen program', the New Freedom Spending Plan section will be created.
 - This must be completed for every Initial/Annual/Significant Change assessment.
- "Care Planning - New Freedom Spending Plan" screen in CARE:

Pending Significant Change 06-06-2024 ▶ New Freedom Spending Plan

New Freedom Spending Plan

New freedom spending plan last reviewed date
06/10/2024

Does the client have any goods/services not otherwise identified in the Care Plan?

Yes No

Planned purchases

#	Date of Request	Worker name	Frequency	Goods/services	Status	
+	1	June 10, 2024	Mitchell, Anna	One time	Supplements	Active

Purchased

No items in list

- Add at least one Pending or Active, goods or service that the participant has requested (outside of personal care) to the NFSP.
 - At least one item must be present unless the box under "Does the clients have any goods/services not otherwise identified in the Care Plan?" is marked "No".
 - If it is marked "No", have a person-centered conversation with the participant about other program options like CFC + COPES.
 - For a list of approvable items, please see [WAC 388-106-1400](#).
 - "Pending" is for items that are not yet active and require an ETR or additional support documents, such as an insurance denial or a letter from the doctor.
 - "Active" is for items that are ready for purchase and can be added to the ACCESS Service Authorization screen in the ACCESS portal.
- Select the plus button
 - The **Date of Request** will auto generate the current date
 - The **Worker Name** will auto generate with the name of the Care Consultant that is logged into CARE.
 - Select a **Frequency** of "One-Time" if the purchase is for an item occurring only once (such as an adaptive tablet). If the frequency is recurring (such as home delivered meals or PERS) select a frequency of "Monthly".



- iv. List the **Goods/Services** (up to 128 characters). Only one Goods/Services should be listed in each box.
 - v. Select the **Status** as "Active".
 - 4. Approval of the participant regarding the information documented in the CARE assessment that determined their New Freedom budget amount is documented in the Service Summary. The participant needs to approve the plan of care by signing the most recent Initial/Annual/or Significant Change Service Summary, as in all other programs.
 - a. Complete and have the participant sign the most recent versions of the standard DSHS enrollment forms and the following forms:
 - i. Acknowledgement of Services Form (DSHS Form 14-225).
 - ii. The Rights and Responsibilities Form (DSHS Form 16-172).
 - iii. The New Freedom Participant Responsibility Agreement (DSHS Form 16-244).;
 - iv. The Authorized Representative Form (if required).
 - b. Complete the Planned Action Notice (PAN) for New Freedom. Assign the total budget amount under the service heading "Individual Directed Goods, Services and Supports".
 - c. Create New Freedom RAC 3040.
 - 5. Authorizing personal care and goods and services, where applicable.
 - a. If the Participant chooses personal care **only**, HCS workers will authorize personal care services using the T1019, U6 service code in CARE.
 - b. If the Participant chooses personal care only, HCS workers will still complete the New Freedom Spending Plan (NFSP) section 'Does the client have any goods/services not otherwise identified in the Care Plan?' with the answer of **No**.

A screenshot of the "New Freedom Spending Plan" form. The title "New Freedom Spending Plan" is at the top. Below it, there is a field "New freedom spending plan last reviewed date" with the value "09/10/2024". Below that is a question "Does the client have any goods/services not otherwise identified in the Care Plan?". There are two radio button options: "Yes" and "No". The "No" option is selected, and a red arrow points to it.

- c. If the Participant **does not** choose personal care (goods and services only) or chooses **both** personal care **and** good and services, the HCS worker will complete the New Freedom Spending Plan section 'Does the client have any goods/services not otherwise identified in the Care Plan?' with the answer of **Yes**.

A screenshot of the "New Freedom Spending Plan" form. The title "New Freedom Spending Plan" is at the top. Below it, there is a field "New freedom spending plan last reviewed date" with the value "08/16/2024". Below that is a question "Does the client have any goods/services not otherwise identified in the Care Plan?". There are two radio button options: "Yes" and "No". The "Yes" option is selected.

- d. Notify the Public Benefit Specialist of the begin date of New Freedom services using the DSHS Form 14-143;
 - e. Transfer CARE and the case file to the appropriate AAA for on-going Care Consultation Services.



ADDING THE AUTHORIZATIONS FOR NEW FREEDOM IN CARE

- a. When adding the auth be sure to include only ACES\$ Financial Management Services – New Freedom and personal care (either IP or agency).

Authorization

LTC	DDA	Cancelled Authorization
Auth #	Provider name	Provider #
1020374781	ACES\$ Financial Management Services - New Freedom	208768001
1020635796	FIRST CHOICE IN-HOME CARE - 01	111982801

- b. All other authorizations for goods and services such as PERS, home delivered meals etc. will be paid through ACES\$.
- c. When creating service lines for SA334 U1 or SA334 U2 these lines must span the plan period and cannot exceed 12 months.
- d. **Initial Review:** When creating a new plan period authorization (Initial Review only) you will create an SA334 U1 line.
- e. **Annual Review or Significant Change:** When creating a new plan period authorization (Annual Review or Significant Change reviews) you will create both an SA334 U1 and SA334 U2 line.
 - a. There should only be one line of each service code, as applicable, per plan period.
- f. Once ACES\$ has been authorized, create Service code **SA334, U1** from the Remaining Budget amount from the Care Planning Screen.
 - i. If a participant is saving less than \$1,250 per month then you will authorize 900,000 units (\$9,000.00).
 1. HCLA-Rate limit for SA334, U1 can be increased at the local level by the supervisor up to \$15,000.
 - ii. New Freedom Care Consultants should authorize an annual amount of 1,500,000 units (\$15,000.00) if a participant is saving \$1,250 or more per month.
- g. The service code **SA334, U2** represents funds available to the Financial Management System (FMS) vendor to claim against, during a participant's new plan period, that carry over from a participant's previous care plan to the new one. This is based on the FMS' accounting of accrued funds and spending for approved purchases.
 - iii. New Freedom budget is determined by participant's functional assessment.
 - iv. Any increase in limits due to ETR should be added to the SA334, U2 line.

Service lines

Recent service lines	Unresolved errors	All service lines				
#	Status	Service code	Service name	Start date	End date	# Units
18.1	Approved	SA334,U2	NF or VDC Savings/ Adjustment	04/01/2024	03/31/2025	514804
17.1	Approved	SA334,U1	NF or VDC Budget	04/01/2024	03/31/2025	1500000



- h. For information related to social service authorizations and payments refer to the Social Services Authorization Manual (SSAM).

<http://intra.dda.dshs.wa.gov/ddd/p1servicecodes/>

Indexing New Freedom Documents and the Document Management System (DMS)

All New Freedom documents will be indexed as a NF type document. HCS/AAA staff must write “New Freedom” and the “ACES Client ID #” at the top of these documents so the Hub Imaging Unit (HIU) can identify them and index them as a NF document.

HCS Public Benefit Specialist (PBS) will:

1. Determine financial eligibility for long-term care services;
2. Advise New Freedom Care Consultant as the authorized representative of any Medicaid eligibility or cost of care changes as they occur. (They will receive the notices of termination, participation changes, eligibility reviews due, etc.)
 - (i) If a client has participation, inform them that they will still be responsible for their participation while on the New Freedom program.

Once the case has been accepted by the Area Agency on Aging (AAA):

1. AAA supervisor will assign the case to a New Freedom Care Consultant.
2. The New Freedom Care Consultant will complete a 30-day visit.
3. The New Freedom Care Consultant must ensure that the ACES\$ enrollment packet is completed by the client before they can start making purchases.
4. The New Freedom Care Consultant will complete quarterly monitoring calls.

NEW FREEDOM CARE CONSULTANT ROLES AND RESPONSIBILITIES

New Freedom Care Consultation

Care consultation is provided at the direction of the New Freedom participant and includes providing training and support to assist participants to develop and implement their spending plans to obtain approved services within a fixed monthly budget called the New Freedom Spending Plan (NFSP).

The Care Consultant is responsible to assess and assist the participant to determine the services and supports that will address unmet needs identified in the CARE assessment and maintain or increase their ability to maximize independence based on this chapter and state and federal regulations. They help facilitate the participant’s control and selection of services to the greatest extent possible to access preferred services and supports available under the New Freedom waiver. This may include providing assistance to identify costs, manage services within budget, assess risks and assist with problem solving related to the implementation of the NFSP. The Care Consultants reviews and approves all New Freedom program purchases of goods and services. Care Consultants are also responsible for authorizing personal care. AAAs are responsible for monitoring Agency personal care providers to ensure they are in compliance with training and contracting requirements. ALTSA is responsible for monitoring CDE agency personal care providers to ensure they are in compliance with training and contracting requirements.



Roles and Responsibilities:

The Care Consultant ensures that participant's choices of goods/services align with what's allowed and disallowed by the regulations. A Care Consultant has the authority to approve or deny a participant's requests/choices.

The Care Consultant is responsible for sending appropriate Planned Action Notices as described in the LTC Manual, chapter 3.

- When a service is removed, or the participant changes programs, it is the responsibility of the Care Consultant to notify the vendor and the FMS that the service has been terminated.

Orientation to Budget-Based, Participant-Directed Services

The Care Consultant will meet with the participant, and others whom the participant may wish to be present, to explain what participant-direction involves. It is important that the participant understands the responsibilities involved in a participant directed budget-based program. During the first visit the Care Consultant will go over the New Freedom Program and offer to send the participant a copy of the New Freedom Participant Handbook, have the participant sign DSHS form 16-244 (New Freedom Participant Responsibility Agreement) and provide the Financial Management Services New Freedom Participant Handbook and document the conversation in SER.

An individual Participant's Budget Allocation is calculated using the average individual provider hourly wage (including mileage), multiplied by the number of units generated by the CARE assessment, multiplied by 0.93, plus the average participant expenditures for non-personal care supports. This will generate a dollar amount automatically in CARE.

Creating the Participant's New Freedom Spending Plan (NFSP)

The participant spending plan documents how the participant will spend their approved service budget dollars to address the needs that were identified in the Care Plan.

Within the authorized budget, participants may choose services and supports not already covered by Medicaid State Plan or Medicare under the following categories (as outlined in [WAC 388-106-1400](#)):

Personal Assistance Services (PAS)

Supports involving the labor of another person to help participants carry out everyday activities they are unable to perform independently. Services may be provided in the person's home or in the community. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. The following are included in PAS:

- Direct 'Personal care services' defined as physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to your functional limitations. Assistance is evaluated with the use of assistive devices. as defined in [WAC 388-106-0010](#); These must be provided by a qualified individual provider or AAA-contracted homecare agency.



- Delegated health-related tasks per [WAC 246-841-405](#). (Providers of direct personal care services may be asked to do nurse delegation under the supervision of a nurse);
- Additional personal care may be purchased using the participants' savings, for the remainder of the current month without an ETR. The client must then maximize their chosen hours prior to using their savings for additional months. See ETR process for additional information.

Treatment and Health Maintenance Supports

Supports and services defined as treatments or activities that are beyond the scope of the Medicaid State Plan that are necessary to promote the participant's health and ability to live independently in the community and preventing further deterioration of the Participants level of functioning or improving or maintaining your current level of functioning.

This category includes those supports that are typically performed or provided by people with specialized skill, certification or licenses. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. Some examples of these services are:

- Specialized health care, extended therapeutic treatment;
- Dental, vision, audiology;
 - For specific items that are covered by the participant's Medicaid State Plan, Medicare, or other insurance, please consult the Health Care Authority Billing Guide before submitting an ETR.
- Culturally appropriate health services (culturally and linguistically sensitive health care in the areas of primary care, prevention & wellness, e.g. acupuncture, naturopathic medicine);
- Physical therapy;
- Therapeutic massage complementary to physical therapy or provided as a less intrusive alternative.

Individual Directed Goods, Services and Supports

Services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address and support the participant to function more independently, increase safety and welfare, or help the participant to perceive, control or communicate with their environment. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. Some examples of services are:

- Environmental supports (e.g., snow removal, heavy cleaning); Assistive technology, supplies and equipment;
- Adaptive, specialized clothing (not of general utility);
- Specialized diets;
- Home delivered meals (a maximum of one per day);
- Repairs and maintenance of care-related equipment;
- Equipment and services that reduce the need for on-site supervision in an emergency;
- Transportation not provided by a personal assistant.



- Trained Service Animal: Upkeep expenses related to trained service animals such as food, licensing and routine veterinary services.
 - Routine veterinary care over the cost of \$500 per occurrence would require an ETR.
- Assist you to transition from a hospital or nursing facility to your home.

Environmental and Vehicle Modifications

Modifications to a participant's residence or vehicle necessary to accommodate their disability and promote functional independence, health, safety and welfare. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. The alterations cannot be adaptations or improvements that are of general utility or merely add to the total square footage of the home.

Some examples of services are:

- Installation of ramps and grab-bars;
- Widening of doorways;
- Minor household repairs;
- Modification of bathroom facilities;
- Specialized equipment;
- Vehicle modifications include adaptive vehicle controls related to steering, braking, shifting, signaling and acceleration, lift devices, seat adaptations, handrails, and door widening.
 - Vehicles subject to modification must be owned by the Participant or a member of the family that resides with the Participant.
 - Vehicles subject to modification must be in good working condition, licensed, and insured according to Washington state law; and be cost effective when compared to available alternative transportation.

Training and Educational Supports

This service category includes training or education on a participant's health issues or personal skill development (in person within Washington state or online). It can also include training to paid or unpaid caregivers related to the needs of the participant. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. Some examples of supports are:

- Enrollment in a course addressing self-management of diabetes; Drug and alcohol treatment;
- Mental health services;
- Enrollment in a course addressing self-management or training specifically related to a Participant's Diagnosis.
- Enrollment in a course addressing additional training (new tasks only) specifically related to a Participant's Trained Service Animal.

The Participant, with the approval of the Care Consultant, will authorize all purchases from the budget. The development of the NFSP is meant to be a careful process that requires the participant, with the help of their Care Consultant, and representative (if the participant has chosen someone to act in this



role) to make a very intentional plan that balances immediate needs for services like personal care or other goods and services referenced above that are not covered by some other funding source with goals to save funds for a one-time purchase, like a vehicle modification, related to needs identified in the spending plan.

- A 'planned purchase' is any one approved item (e.g. a service, an assistive device, or piece of equipment) that is described in the NFSP for which the participant is saving.
- A participant is allowed to accumulate up to \$3,500 in their account to pay for such a purchase without getting additional approval.
- A participant, with the support of their Care Consultant, may request approval to exceed the \$3,500 cap for exceptional, planned purchases with preapproval from the New Freedom Program Manager.
- If a single purchase exceeds \$3,500, the Care Consultant must notify the New Freedom Program Manager via email. If the purchase is allowable under WAC, no further action is necessary. If the purchase requires an Exception to Rule because it is excluded by WAC or the participant needs additional funds, follow the process outlined below to complete the Exception to Rule. Create an Exception to Rule in CARE and submit to New Freedom Program Manager as discussed in Exceptions to Rule section.
 - Please Note: Personal Care Exception to Rule's must still be submitted to the Long-Term Care Committee. (See [Chapter 3](#) of the Long-Term Care Manual (LTC) for more information on Personal Care Exception to Rules)

The approved purchase NFSP allows participants to identify specific approved planned purchases and the costs associated with the potential purchases. The list is for reference only and is not functionally associated with the budget. Once there is enough funding saved for a specific planned purchase the participant will ask the Care Consultant to create an approved allocation line in the portal so the item can be purchased once the participant submits a completed Participant Purchase/Reimbursement Request Form (PRF) authorizing the Financial Management Services provider to make the purchase.

Once the participant has determined what their spending plan will be the Care Consultant will enter it into the Financial Management Services portal.

The participant's approval of the spending plan verifies his/her involvement in the development of the plan and gives consent to the services and supports outlined in the plan. Obtaining approval of the spending plan is the same process as in other waiver services.

Managing the NFSP

The NFSP must be reviewed quarterly.

All items that the client has requested and are eligible for must be listed in detail on the NFSP under the "Goods/Services" column.

- The information listed must include individual items.
 - As an example, each supplement must be listed.
- All items must be listed clearly and specifically.



- For example, it is not acceptable to list only a general topic such as “supplements”. The specific supplement, like “vitamin B” must be listed.
- All items must list their connection to a diagnosis or identified need within the care plan.
 - For example, it is not acceptable to list only “Epsom salts”. You must connect it to the participant’s diagnosis or identified need that it is meeting, such as “Epsom salts for Edema”.

Status: There are four possible options in the Planned Purchases of the NFSP.

- **“Pending”**: Items that are not yet active and require an ETR or additional supporting documents, such as an insurance denial or a letter from the doctor.
 - This item should NOT be listed in ACES\$.
- **“Active”**: Items that are ready for purchase and can be added to the ACES\$ Service Authorization screen in the ACES\$ portal.
- **“Purchased”**: Items that have been completely or partially purchased during the Care Plan period.
 - This will move the item from Planned Purchases to History and will drop off when the next Annual or Significant Change assessment is created.
- **“Removed”**: Items that the client has declined, changed their mind or are no longer eligible for purchase.
 - This will move the item from Planned Purchases to History and will drop off when the next Annual or Significant Change assessment is created.
- **“Delete”**: The delete or trash can symbol, should only be used when the Care Consultant added an item in error. This permanently deletes the record of the request and cannot be used when the participant has changed their mind or an item is deemed not allowable.

Procuring Providers and Vendors

The Care Consultant and the FMS will be available to assist the participant in selecting providers and vendors. CDWA will facilitate the contracting of the individual provider. For non-personal care services, the Care Consultant will follow the process outlined in the Contracting Non-Personal Care Providers and Vendors section.

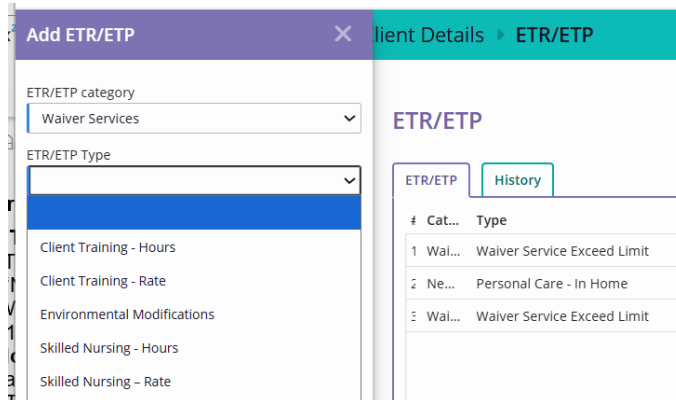
Individual Provider (IP) or Home Care Agency Personal Care (HCA)

The New Freedom budget is calculated based on the assumption that a participant will be hiring an IP for personal care services. If the participant wants to be served by an HCA, there will be no additional charge to their budget, nor will there be additional funds provided to the budget. Depending on the participant’s choice of personal care provider the Care Consultant will authorize services as described in the enrollment section of this chapter.

Exceptions to Rule (ETR)

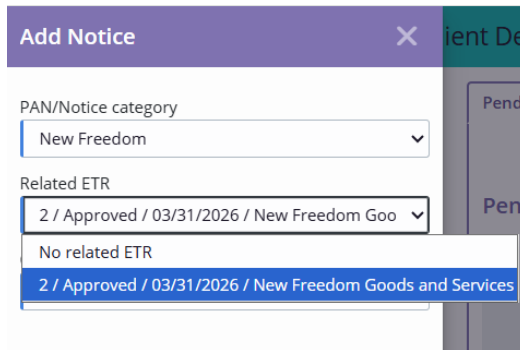
- An Exception to Rule, referenced in [Chapter 3](#), ([WAC 388-440-0001](#)) is required to authorize a higher budget amount than indicated in CARE. The standard ETR process will be followed by creating a request in CARE and submitting the request to the New Freedom Program Manager via the “NFETRTEAM”.
- New Freedom does not allow local ETRs. All ETRs are processed through Headquarters.

- A one-time Exception to Rule budget amount may be approved if the participant needs a specific support and they do not have savings funds accumulated to purchase the item needed for health or safety concerns. The standard ETR process will be followed by creating a request in CARE and submitted to the New Freedom Program Manager via the “NFETRTEAM”.
 - This would be a Waiver Exceeds Limit ETR.
 - This should be set for the plan period and will require annual renewal as needed.



#	Cat...	Type
1	Wal...	Waiver Service Exceed Limit
2	Ne...	Personal Care - In Home
3	Wal...	Waiver Service Exceed Limit

- A one-time ETR may be approved to use participant’s existing funds for a service/item which is not usually covered by New Freedom but is needed to address their unique health or safety concerns. The standard Exception to Rule process will be followed by creating a request in CARE and submitted to the New Freedom Program Manager.
 - Participants receiving in-home, personal care services may ask for more hours following the standard Personal Care Exception to Rule process and submitting to the Long-Term Care Exception to Rule Committee.
 - A participant must spend down their savings prior to requesting an ETR for increased personal care.
 - When submitting an ETR request for personal care, please send it to the personal care committee and notify the New Freedom Program Manager.
- ETR requests must relate to a participant’s ADL, IADL, and/or their medical diagnosis in their care plan.
- ETRs will be reviewed by the New Freedom ETR Committee within 7 business days of receipt.
- Upon approval or denial of the ETR, the Care Consultant will send out DSHS Form 15-601 “New Freedom (NF) Notice of Exception to Rule (ETR) Decision (Goods and Services)”.



- An ETR cannot be approved to supersede a rule from the 1915c waiver.

Note: If an ETR is approved, the additional funds can only be authorized for the service/support that it was requested for.

Quarterly Contacts

Participants in New Freedom may have little or no experience in assuming responsibility for their own service plan and budget. The Care Consultant might need to spend considerable time helping a participant understand, learn and embrace their role in determining what services will best address their individual care needs in addition to hiring and supervising a personal care provider.

The Care Consultant must make quarterly contacts with the participant to:

- Review budget authorizations;
- Review elections for personal care hours;
- Review NFSP and remove those items/services that are no longer needed/wanted and add additional items if appropriate. Check the priority of the items/services on the NFSP to ensure payments can be made timely once funds have been accumulated.
- Confirm that purchases in the past quarter were received; and

Contacts must be made quarterly from the date of assessment. For example, an assessment is conducted on January 9th and moved to current on January 15th. The next contact must be completed by the end of April with the subsequent contacts required by July and October and face-to-face assessments (annual or significant change) may be substituted for one of the quarterly contacts as long as the spending plan information was discussed as above.

- To help the Care Consultant track if they may be overdue for a quarterly contact, document all contacts considered as quarterly contacts in **SER** using **Purpose Code "Monitor Plan"**. This will enable an automated Tickler to notify the Care Consultant if more than 4 months have passed since the last Monitor Plan SER entry.

Institutional Stays

A participant who has been institutionalized for 30 days or less (per [WAC 388-106-1422](#)) with the intent to return to New Freedom upon discharge may stay enrolled in the program with their budget being temporarily suspended. The service budget dollars cannot be used while the participant is institutionalized. Participant funds will not accrue while institutionalized. Upon return home the budget will be reinstated to the amount that was in place when initially institutionalized.

The Care Consultant will notify the New Freedom Program Manager and ACES\$ that the participant's budget must be suspended. The New Freedom Program Manager will notify ACES\$ not to allow any spending against the budget.

If a participant requires funds to be used during a short institutional stay to prevent additional costs (payment for PERS monthly service vs. payment for reinstallation of PERS unit) or to pay for services already received at the time of institutionalization (Home Delivered Meals), the Care Consultant will need to contact the New Freedom Program Manager to have these expenditures approved.

Challenging Cases Protocol

The Care Consultant should follow the Challenging Cases Protocol for any situation when the spending plan cannot assure the health and welfare of the participant due to participant, environmental, or resource issues ([Chapter 5](#)).

A participant's enrollment in the New Freedom program may be ended involuntarily if the participant:

- Moves out of the designated service area or are out of the service area for more than 30 consecutive days; or
- Does not meet the terms for consumer direction of services outlined in the New Freedom Participant Responsibility Agreement when:
 - Even with coaching and collaboration, the participant is unable to develop a NFSP or self-direct services or manage their individual budget or NFSP;
- Any other criteria listed in [WAC 388-106-1475](#).

Skin Observation Protocol

If a participant chooses New Freedom at the time of their CARE assessment (intake/annual/significant change) and the assessment triggers a skin issue, the worker's agency (HCS/AAA) must proceed with the standard skin observation protocol ([Chapter 24](#)).

REASSESSING PARTICIPANTS FOR NEW FREEDOM

The Care Consultant will:

1. Complete the annual and significant change assessment when applicable in CARE to determine ongoing functional eligibility;
2. Obtain a financial eligibility determination;



3. Offer New Freedom as well as other waiver/state plan options, settings, and providers when the participant is determined financially and functionally eligible;
4. If the participant chooses to remain in New Freedom, the Care Consultant will follow the applicable steps under the enrollment section. *(Note: 14-225 does not need to be re-signed at annual/significant change assessments unless; there was a break in services or an updated version of the 14-225 form and an MB states the new version would need to be signed at participants next annual/significant change assessment)*
5. The Care Consultant will review the assessment with the participant and make any applicable updates to his/her spending plan taking into consideration the information in CARE including triggered referrals.
6. If the participant chooses **not** to remain in New Freedom:
 - a. Coordinate the transfer to another ALTA program of choice that the participant is eligible to receive.
7. When a participant is no longer functionally or financially eligible for NF, the Care Consultant will provide timely Planned Action Notice for termination of services.

WHAT ARE FINANCIAL MANAGEMENT SERVICES?

The Financial Management Services provider, ACES\$, is the agency that handles payment and contracting matters on behalf of the participants enrolled in New Freedom. Their responsibilities include accessing the monthly goods and services budget from the Department of Social and Health Services (DSHS); setting up individual accounts for each participant; setting up procedures for verifying qualifications and credentials of providers/vendors of service; implementing efficient and timely participant directed purchasing systems; facilitating payment for labor services and other items needed by participants as identified in the spending plan; and developing contracts with non-personal care providers and vendors.

Contracting Non-Personal Care Providers & Vendors

If the participant needs assistance in identifying appropriate services and supports the Care Consultant will be available to help. This could include assisting the participant to find the service/support at the best possible cost to meet the needs of the participant in terms of quality, quantity, and location.

Once the participant identifies a provider, the participant or the Care Consultant will contact Financial Management Services (FMS) customer service to initiate the 'new vendor' process. The FMS provider will ensure the chosen vendor is qualified to provide the service to the participant, including verifying provider credentials and contracting with vendors (if necessary). If a vendor chooses not to contract with the FMS provider or is not eligible to contract with the FMS provider, the participant will need to choose another vendor.

When the contracting and credentialing is complete, the FMS provider will notify the Care Consultant, the participant and the vendor. The participant will then be responsible to send in the Participant Purchase/Reimbursement Request Form and any other required documentation (receipt, invoice, etc.) to the Financial Management Services provider to allow purchase and/or payment.



Payments for Goods & Services

There are three ways in which a New Freedom participant's services and supports can be paid through the FMS provider.

1. Check payable directly to the approved vendor.
2. Online purchases made on the participant's behalf by the FMS provider.
3. Participant reimbursement for approved services that the participant paid for.
 - a. The participant must have the funds available for the purchase.
 - b. Receipts must be less than one year old from the date of purchase.
 - c. The participant is responsible for providing a clear and legible receipt that has the following information:
 - i. Name of vendor.
 - ii. Date of purchase.
 - iii. Cost of purchase.
 - iv. Clearly identified item that was pre-approved for purchase by the Care Consultant.

Participants themselves authorize all services and supports, other than personal care. This is done by completing a Payment Request Form and submitting the form to the FMS provider. Payment requests can be completed without the Payment Request Form (PRF) by using the FMS online portal and uploading any necessary documentation. If a participant is unable to complete the PRF on their own, an authorized representative may be used.

Managing & Reporting of Accounts

The FMS provider will document and track all participant payments, excluding monthly personal care, related to individual spending plans. On a quarterly basis the FMS provider will send participants a budget report that contains expenditures and the budget balance. The Web portal is available to all participants who want to view their account on-line. Participants can register for the portal by visiting the ACES\$ website: www.mycil.org.

MANDATORY REPORTING

New Freedom Care Consultants and the Financial Management Services provider are mandatory reporters and must follow all the mandatory reporting laws. *For additional APS information, refer [to APS Policy & Procedure in the Long-Term Care Manual chapter 5](#).

ADMINISTRATIVE HEARINGS

When a participant disagrees or files for an administrative hearing based on a decision made by a Care Consultant or the Financial Management Services provider, the following processes will be used based on the situations outlined below:



If the participant is not satisfied with the outcome of their New Freedom functional eligibility determination (CARE assessment):

- The Care Consultant will follow the Administrative Hearing Process outlined in the ALTSA Long-term Care Manual [Chapter 26](#).

If the participant is not satisfied with the denial of a provider and they contact the Care Consultant or the FMS provider regarding the issue:

- The Financial Management Services provider will:
 - Offer to mail the participant an administrative hearing request form.
 - If the participant files for an administrative hearing:
 - The Financial Management Services provider will contact the participant to see if they would like to schedule a pre-hearing meeting regarding the denial; and
 - If the pre-hearing meeting does not resolve the issue, the FMS provider will prepare a summary statement of the pre-hearing meeting and send the summary statement, notes and any other applicable information to the New Freedom Program Manager as soon as possible and no later than two weeks prior to the hearing unless the pre-hearing is scheduled within a week of the hearing.
- The Care Consultant will:
 - If the provider is not an IP:
 - Refer the participant to the Financial Management Services Representative regarding the provider denial who will follow the steps above.
 - Document the conversation in SER and notify the FMS representative of the issue.
 - If the provider is an IP:
 - Refer to the ALTSA Long-term Care Manual [Chapter 11](#).

If the participant is not satisfied with the denial of a spending plan service or support:

- The Care Consultant will follow the Administrative Hearing Process outlined in the ALTSA Long-term Care Manual [Chapter 26](#).

HOW DO PARTICIPANTS DISENROLL FROM NEW FREEDOM?

Voluntary Disenrollment

New Freedom is a voluntary program, and a participant may choose to disenroll and move to another Long-Term Care program. If a participant wants to disenroll the Care Consultant will work with them to switch to another program as seamlessly as possible. As a general rule if the participant asks to disenroll before the 15th of the month the disenrollment will be effective the first of the following month; if they ask to disenroll the 15th of the month or later, the disenrollment will be effective the first of the second following month (e.g., the participant calls on September 18th; the disenrollment will occur November 1st). On a case-by-case basis the transition can be expedited in order to support the participant's needs.



When a New Freedom participant disenrolls the Care Consultant will contact the Financial Management Services provider to notify them of the disenrollment date.

Involuntary Disenrollment

Participant enrollment in New Freedom may end involuntarily if:

1. The participant moves out of the designated service area or is out of the service area for more than 30 consecutive days, unless the purpose of the longer absence is documented in the SER;
OR
2. The participant does not meet the terms for participant direction services outlined in the New Freedom Participant Responsibility Agreement (DSHS form 16-244). The terms are as follows:
 - a. Even with help from a representative, the participant is unable to develop a spending plan, direct services or manage his/her individual budget or spending plan.
 - b. Any one factor or several factors of such a magnitude jeopardize the health, welfare, and safety of the New Freedom participant or others, requiring termination of services under [WAC 388-106-0047](#).
 - c. Misuse of program funds and services.

Process for Involuntary Disenrollment

1. The Care Consultant must compose a written notice to the participant that fully documents that one or more of the conditions exist to justify involuntary disenrollment and forward the notice to the ALTSA New Freedom Program Manager.
2. The ALTSA New Freedom Program Manager will notify the Care Consultant of the approval/denial of the request for disenrollment within 15 days of receipt.
3. The Care Consultant will follow the Challenging Cases Protocol as applicable.
4. If the involuntary disenrollment is approved by the ALTSA New Freedom Program Manager, the Care Consultant will follow the disenrollment process noted above for voluntary disenrollment.

The participant may be eligible for other programs.

Loss of Eligibility

1. Participants must meet the functional and financial eligibility to remain in New Freedom. If a participant is determined to no longer meet program eligibility, the Care Consultant will work with the participant on a termination plan.
2. New Freedom is available only to participants who live in their own homes. If a participant wants/needs to move to a residential or long-term placement in a nursing facility, they are no longer eligible for the New Freedom waiver.
3. New Freedom participants who are institutionalized for more than 45 days lose eligibility for the program and must be disenrolled.

RESOURCES

Related WACs and RCWs



Regulation	Description
Chapter 388-106 WAC	Long-Term Care Services
WACs 388-106-1400 through 388-106-1480	New Freedom Budget-Based, Participant-Directed Services
WAC 388-106-1400	What services may I receive under New Freedom consumer directed services (NFCDS)?
WAC 388-106-1405	What services are not covered under New Freedom consumer directed services (NFCDS)?
WAC 182-513-1315	General eligibility for Long-Term Care
WAC 388-106-1435	AREP
WAC 388-106-1458	NFSP
WAC 388-106-0010	ADL/IADL definitions
WAC 388-440-0001	ETR
WAC 388-106-1422	Institutional Stays
WAC 388-106-0047	When can the department terminate or deny long-term care services to me?

Acronyms

- AAA Area Agency on Aging
- ADA Americans with Disabilities Act
- ADL Activity of Daily Living
- CARE Comprehensive Assessment Reporting Evaluation
- CC Care Consultant
- CCG Community Choice Guide
- CFC Community First Choice
- CIL Centers for Independent Living
- CM Case Manager
- COPES Community Options Program Entry System
- DME Durable Medical Equipment
- DMS Document Management Services
- DSHS Department of Social and Health Services
- ETR Exception to Rule
- HCA Health Care Authority
- HCLA Home and Community Living Administration
- HDM Home Delivered Meals
- HQ Headquarters
- IADL Instrumental Activity of Daily Living
- LPN Licensed Registered Nurse
- LTC Long Term Care
- MAGI Modified adjusted gross income
- MCO Managed Care Organization
- MPC Medicaid Personal Care



- NFCDS New Freedom Consumer Directed Services
- OAA Older Americans Act
- OT Occupational Therapist
- PA Prior authorization
- 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

Glossary of terms specific to New Freedom

WORD	DEFINITION
<i>Care Consultant (CC)</i>	The person responsible to assist and work with Participants to determine the services and supports that will maintain or increase independence, advises Participants on how to access services and supports, assists in developing the NFSP, assists to procure/monitor services and supports on the NFSP, coordinates with the Financial Management Service responsible for managing Participant's service budget allocation based on the NFSP and updates the NFSP as necessary. The CC also authorizes payments for personal assistance services and determines ongoing functional eligibility using the CARE assessment.
<i>Authorized Representative</i>	A person of the Participant's choice who is authorized to complete and sign all necessary paperwork and work with the CC to create the New Freedom Spending Plan on behalf of the Participant. This person cannot be paid to provide care to the Participant.
<i>Financial Management Services (FMS)</i>	The agency that handles payments for approved items and services purchases on behalf of Participants enrolled in NF. The FMS also ensures vendors are qualified to provide the services per Medicaid rules. FMS are currently being provided by ACES\$ Financial Management Services. Email contact: goodservicewa@mycil.org
<i>New Freedom Program</i>	A voluntary budget-based program that provides Participants who are eligible for home and community- based services through the Medicaid Waiver Program a choice in how they receive services in their home.
<i>New Freedom Spending Plan (NFSP)</i>	The individual plan created by Participants and their CC at least annually and updated as necessary, which documents Participants' intention to purchase approved services and supports to meet their assessed needs and to help maintain or increase their independence.
<i>Participant Directed Services</i>	A philosophy and orientation to home and community-based services in which Participants are given the authority to make choices about services and



	supports that work best for them, regardless of the nature or extent of their disability.
<i>Payment Request Form (PRF)</i>	An ACES\$ form used by Participants to request payment for an authorized service or item from a qualified vendor/company.
<i>Service Budget (SB)</i>	The amount of service dollars the Participant has available monthly to spend on services and supports to address their care needs.
<i>Services & Supports</i>	Work performed or items that meet an identified therapeutic level of need in a Participants CARE assessment and are documented on his/her spending plan.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
February 2026	Darrellyn Nuesca	Update to bring chapter in alignment with current guidance. Clarify Trained Service Animal section	TBD
5/19/2025	Darrellyn Nuesca	Update to changes to bring chapter in alignment with current guidance	H25-003



Residential Support Waiver (RSW)

Chapter 7f describes the Residential Support Waiver (RSW), a home and community-based services (HCBS) program approved by the Centers for Medicare and Medicaid in 2014 under the 1915c waiver authority. RSW is designed to support eligible individuals with personal care and behavior support services in residential settings.

Ask the Experts

If you have questions or need clarification about the content in this chapter, please contact:

JD Selby Residential Support Waiver Program Manager - ECS, SBS, & BSP Services
360.890.2640
james.selby@dshs.wa.gov

Pam Young ESF & CSS Program Manager
360.789.4976
pamela.young@dshs.wa.gov

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BACKGROUND

WHAT IS THE RESIDENTIAL SUPPORT WAIVER (RSW)?

The RSW 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 RSW, would otherwise require the level of care furnished in a nursing facility or other institutional setting.

RSW services are designed for eligible Clients who require support from caregiving staff who have completed specialized training in providing personal care, crisis response techniques, and are able to implement proactive behavioral supportive interventions developed by a community behavior support services provider.

Many Clients receiving RSW services have, historically, not had the support they needed to safely remain in other community residential settings. In order to provide a stable residential home environment, RSW Clients often have primary or co-occurring neurocognitive, substance use, or traumatic brain disorder which require an array of behavioral health support both through the RSW and as coordinated with the state plan and other community services.

The RSW serves Clients who are either returning to the community from state or community psychiatric hospitals, have had a single or multiple unsuccessful community residential settings, or are at risk of losing their current community residential setting due to behavioral challenges.

Non-RSW Behavior Support Services

Expanded Behavior Support

- Please see LTC Manual [Chapter 10 Nursing Facility Case Management and Relocation](#) for more information on EBS or EBS-Plus in a skilled nursing facility.

COPES Client Training-Behavior Support

- [Please see LTC Manual Chapter 7d: COPES](#)
- [H2019](#) Behavior Support – Individual

WHO IS ELIGIBLE FOR RSW?

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

Functional Eligibility:

- Age 18 or older & blind or has a disability as outlined in [WAC 182-512-0050](#); or is
- Age 65 or older



- CARE algorithm determines that the individual meets nursing facility level of care as outlined in [WAC 388-106-0355\(1\)](#), [WAC 182-515-1506](#);
- CARE algorithm determines that the individual meets RSW eligibility as outlined in [388-106-0388](#) when the following 5 questions are answered “yes” or “no”:
 1. Is the Client currently admitted to a state mental or psychiatric unit of a hospital and is deemed ready for discharge?
 2. Does the Client have a history of frequent and repeated episodes of destabilization resulting in loss of services, homelessness, hospitalization or incarceration?
 3. Does Client have a history of an inability to remain medically or behaviorally stable for a period of longer than six months?
 4. Has the Client exhibited behaviors or uncontrolled symptoms and has an unmet need for supportive interventions?
 5. Has the Client demonstrated difficulty managing medications, which has affected their ability to live in the community?

Note: you will notice that the [WAC 388-106-0338](#) and the RSW CARE Eligibility Questions don’t match word for word. That’s okay. Answer the question in CARE as they are written in CARE. The Help Screen has been updated to help you answer the questions. If you are unsure, please reach out to your direct supervisor.

Financial Eligibility:

Case Managers should confirm financial eligibility requirements listed below:

- Meet the Supplemental Security Income (SSI) disability criteria; and
- Be eligible for institutional categorically needy (CN) medical coverage group.

Note: Per [LTC Manual Chapter 7a Financial Eligibility for Core Programs](#), MAGI-based medical coverage groups are not eligible for HCBS waiver services (including the RSW) , though they may apply, and be related to SSI via a non-grant medical assistance (NGMA) determination (a disability / blindness determination).

See [Chapter 7a](#) of the LTC manual for more information regarding financial eligibility for LTC programs.

Acknowledgement of Services—Documenting Client Consent

Clients who are functionally and financially eligible for the waiver services can choose to receive their care in an institution or in the community. If the individual is choosing RSW, they will be choosing to receive their care in the community. CMs must complete the Acknowledgment of Services form ([DSHS 14-225](#)) to document that the program choices have been explained to the Client and the Client has acknowledged their choice of waiver services over nursing facility care. This form is a federal



requirement, and **waiver services cannot be authorized without the Client's signature on the Acknowledgment of Services form (DSHS 14-225)**. The Case Manager must 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 their eligibility re-established if he/she re-enters 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.

Federal rules require 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 insurance 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.
- Waiver services may not supplement the reimbursement rate from other resources.
- ETRs are not allowed for the above circumstances.

For more information about acknowledgement of services including form DSHS 14-225, see [LTC Manual Chapter 3: Assessment and Care Planning](#).

WHERE CAN INDIVIDUALS RECEIVE RESIDENTIAL SERVICES UNDER THE RSW?

RSW services are available in contracted Adult Family Homes (AFH), Assisted Living Facilities (ALF), Enhanced Adult Residential Care (EARC) facility, and Enhanced Services Facilities (ESF).

Residential Settings	Expanded Community Services (ECS)	Specialized Behavior Support (SBS)	Community Stability Supports (CSS)	Enhanced Services Facility (ESF)
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Adult Family Home (AFH)	Yes, with ECS Contract	Yes, with SBS Contract	No	No
Assisted Living Facility (ALF)	Yes, with ECS Contract	No	Yes, with CSS Contract	No
Enhanced Services Facility (ESF)	No	No	No	Yes, with ESF Contract

SERVICES AVAILABLE THROUGH THE RSW

Clients who meet functional and financial requirements for the Residential Support Waiver may receive the following RSW services:

Expanded Community Services (ECS)

Offered in:

- Adult Family Homes with an ECS contract
- Assisted Living Facilities and Enhanced Adult Residential Care (EARC) facilities with an ECS contract.

In collaboration with:

- An ECS-contracted Community Behavior Support Provider

What services are available under ECS?

- Personal care;
- 24-hour on-site support and response staff;
- Medication management; and
- Behavior Support Services
- An RSW Client and the residential provider work in coordination and collaboration with a contracted behavior support provider to develop and implement an individualized Behavior Support and Crisis Plan (BSCP).

ECS Provider Qualifications and Responsibilities

AFH/ALF/EARC Residential Provider Qualifications

- Be an official AFH/ALF/EARC licensee with the State of Washington for twelve (12) months or more.
- Have had no significant enforcement actions, as determined by a review of the enforcement history, during the twelve (12) months preceding

AFH/ALF/EARC Residential Provider Responsibilities



- Coordinate the delivery of Behavior Support Services with an appropriate Behavior Support Provider who has a contract with DSHS to provide ECS;
- Prepare for and facilitate Behavior Support Services that will be provided in the AFH and will include training provided to or on behalf of specific ECS Clients in order to support each ECS Client's ability to remain in the community.
- Identify an ECS team for each ECS Client. The ECS team will include, but not be limited to the ECS Behavior Support Provider, facility staff and other professional staff involved with the ongoing care of the Client.
- Coordinate facility team meetings at least once a month for each ECS Client.
 - The Residential provider shall ensure facility staff attend the meetings and participate in the development of the Behavior Support Plan for each ECS Client. The Behavior Support Plan shall be incorporated into the ECS Client's Service Plan and NCP or NSA.
- Coordinate opportunities for staff and ECS Clients to receive training that supports each ECS Client. Training provided shall range from broad behavioral care topics to specific consultation and training related to the needs of the ECS Client. The training may be provided in cooperation with the Behavior Support Provider
- Collaborate with the Behavior Support Provider to develop a written Behavior Support and Crisis Plan (BSCP) to respond to identified ECS Client indicators of potential crisis.
 - The goal of the BSCP is to develop interventions to prevent and respond to crises. The program strategy shall include specific courses of action to respond to the needs of the ECS Client.
 - It will also describe the mechanisms that will be used to document facility staff training for each Behavior Plan.
 - The BSCP strategy shall be developed cooperatively with appropriate parties. If the Client's physical or behavioral status changes significantly, the Provider shall immediately notify the HCS Social Worker and the Behavior Support Provider.
 - The BSCP will be incorporated into the Client's NCP or NSA.

Contracted Behavior Support Provider Qualifications

- **Have a current ECS contract**
- **Have the required professional staff to fulfil the ECS Contract**

The contracted behavior support provider will provide a team of professionals experienced in behavioral health interventions (herein referred to as Behavior Support Team) to provide specialized formal and informal training and consultation on behavior management to or on behalf of HCLA Clients who have been authorized to receive ECS.

Behavior Support Team must consist of:



- A **prescriber** licensed by the state of Washington as either a Psychiatrist, Psychiatric ARNP, a Physician's Assistant (PA) with at least two (2) years' experience in working with adults who have exceptional long-term care needs due to a combination of medical and behavioral issues, or a Registered Pharmacist or Pharmacist D (Pharm D) who works under the oversight of a Psychiatrist or ARNP.
- **Behavior Support Clinician:** Is a licensed or certified psychiatric nurse, mental health professional, or board-certified behavior analyst with two years' experience working with adults who have exceptional long-term care needs due to a combination of medical and behavioral issues. Staff with at least a bachelor's degree in a related field, who are working toward becoming a mental health professional, may provide services as a clinician under the direction of a licensed behavior analyst.
- **Certified Peer Counselors (CPC)** In addition to the certified professionals, a Provider may also choose to include a Washington State Certified Peer Counselor (licensed per WAC 182-115-0100 through December 31, 2026) to provide community integration, activity support/development, encouragement and resources to the Clients served in this Contract. On January 1, 2027, the profession of certified peer support specialist, as defined in RCW 18.420.010, will supersede certified peer counselors. On and after that date, only certified peer support specialists and peer support specialist trainees may provide Medicaid-reimbursable peer services.
 - a. The number of billed Service Episodes provided by a CPC through this Contract are limited to no more than four (4) per month.
 - b. The ECS Behavior Support Services provider must ensure that CPC is not the only professional providing services to the Client in any given month.

Consultation to the residential care provider billed through this Contract must be provided by the professionals described in the roles above.

Members of the Behavior Support Team shall be proficient in the following:

- Behavioral management strategies and planning for individuals whose abilities to remain in community settings are compromised by behavior and personal care needs;
- Development and implementation of formal and informal training on relevant topics for identified Clients and their residential care provider and/or staff; and
- Collaborative care planning, implementation, and documentation on behalf of identified Clients and their residential care provider and/or staff.

Contracted Behavior Support Provider Responsibilities

Behavior Support Team Responsibilities:

1. Respond to referrals from the HCS Regional Field Services Administrator or designated regional staff to provide Waiver ECS Behavior Support/Client Support Training services as authorized.
2. Upon receipt of a referral for an identified Client, arrange to have an initial visit with the Client using the following parameters:



- a. If the Client has been referred while still in an institutional setting, meet with the Client and/or the Client's guardian and communicate with collateral contacts, at that setting within a timeframe established by HCS, for this referral to help support transition planning.
 - Services provided while the Client is in the institutional setting will be considered a part of the development of the required Behavior Support Plan and included in the episode(s) of billing associated with the delivery of the Behavior Support Plan or the initial outline of the plan as described in section 4.c., below.
 - In addition to the initial visit with the Client and/or the Client's guardian and collateral contacts, meet with the Client and/or the Client's guardian and the residential care provider in the residential setting, on the day the individual moves into his/her residence in the community, unless the HCS Field Services Administrator or designee has given explicit approval of an alternate schedule.
 - If there are extenuating circumstances, such as inclement weather or geographical barriers, that prohibit the Provider from meeting with the Client in an institutional setting face-to-face, the HCS Field Services Administrator or designee may authorize in writing that the initial visit may be conducted by phone or via telehealth. The Provider must document this authorization and the service(s) provided as well as the Client's consent to telehealth.
- b. If the Client is referred while in a community setting, the initial visit with the Client must take place within three business days of the initial authorization, unless the HCS Field Services Administrator or designee has given explicit approval of an alternate schedule.
 - a. If there are extenuating circumstances (such as inclement weather or geographical barriers) that prohibit the Provider from meeting with the Client in an institutional setting face-to-face, the HCS Field Services Administrator or designee may authorize in writing that the initial visit may be conducted by phone or via telemedicine. The Provider must document this authorization and the service(s) provided as well as the Client's consent to telehealth.
3. Provide a professional evaluation to assess individual's training and support needs related to behavior management and complete a Behavior Support Plan, using the following parameters:
 - a. Develop the Behavior Support Plan based on information gathered from the Client and/or the Client's guardian, family members, residential care provider, HCS Regional Field Services Administrator or designee, and source of referral and/or any other sources identified as important by the Behavior Support Team. If the Client is in a hospital or other institutional setting, the Provider may provide no more than two (2) Service Episodes while the Client is in the hospital or other institutional setting. Services provided in a hospital or other institutional setting are considered complete and billable on or after the date the Client is enrolled in the waiver.



- b. Identify a specific and measurable goal or set of goals that the Client will be working toward in terms of the Client's goals and safe interventions to address "identified behavioral problem(s)."
 - c. Inform HCLA/HCS of any barriers to implementing the Behavior Support Plan as soon as they are identified and provide details about the circumstances.
 - d. Design the Behavior Support Plan to prevent behavioral escalations or crises that lead to hospitalization and loss of community placement.
 - e. Outline strategies that the Client and the residential care provider can use to meet the goals and mitigate crises related to behaviors or other circumstances that put the Client at risk for loss of community placement.
 - f. Include the behavioral goals and timelines that address the behavioral and functional challenges identified in the individual's CARE assessment as well as problems or challenges identified by the Client and/or the Client's guardian and/or collateral contacts.
 4. The Behavior Support and Crisis Plan (BCSP) must include the following elements:
 - a. A crisis prevention and response protocol that outlines specific indicators which may signal a potential crisis for the Client;
 - b. Identifies specific actions that staff or caregivers are to take prior to/during a crisis to assist the Client in maintaining community placement;
 - c. Specific interventions and pre-crisis prevention strategies for each of the Client's indicators of a potential crisis;
 - d. A crisis prevention and response protocol that outlines steps to be taken if the prevention or intervention strategies are unsuccessful in diverting the crisis, including the community crisis responder's coordination plan; and
 - e. A description of how to respond to a Client's refusal of care or treatment, including when the Client's physician or practitioner should be notified of the refusal.
 - f. In the event of any known hospitalization or need to assist during a crisis, provide the Designated Crisis Responder (DCR), Designated Mental Health Professional (DMHP) or other relevant crisis responders with pertinent information about the Client. Document the sharing of Client information for hospitalizations or crisis services and document the details of any known events leading to hospitalization or crisis services.
 - g. If a Client is diverted from psychiatric hospitalization, prioritize the Client for a face-to-face visit the following business day.
 - h. If a Client is treated at a hospital for any reason, upon re-admission to the residential facility, prioritize, based on Client need, a review of the medication list and the Behavior Support Plan to ensure any changes to either are addressed.
 5. Clients who have an LRA issued by a court, the Provider should include this in the Behavior Support and Crisis Plan, including contact information for the Client's mental health team that has oversight of the LRA, and discuss the LRA with the residential care provider. It is expected that the ECS Provider and the LRA provider will communicate and coordinate to ensure consistent and clear expectations, responsibilities and roles.



6. Complete and revise the Behavior Support Plan and provide a copy of the completed Behavior Support Plan to the residential care provider, the Client and/or the Client's guardian, and the HCS field office within fourteen (14) business days of the initial visit with the Client.
7. Review and provide training on the details, goals and interventions of the Behavior Support Plan with the Client and/or the Client's guardian and the residential care provider and staff upon completion of the Behavior Support Plan with the Client in a residential setting.
8. If the Client was referred to this Contract while in a residential setting or was referred while in an institution and moves before the Behavior Support Plan is completed, supply the residential care provider an initial written outline of the Behavior Support Plan on the first visit with the Client at the residential setting.
 - a. The purpose of the outline is to ensure that the provider and Client have strategies to support the stability of the placement and a clear protocol for communicating with Provider about behavioral challenges while the Behavior Support Plan is under development. The initial written outline must include:
 - b. Behavior-specific support strategies the Client and provider can use to address the behaviors that initiated the referral for services, and
 - c. Appropriate contact numbers the residential care provider should use if the Client's behaviors escalate.
9. Share, as needed, the crisis plan section of the Behavior Support Plan, with permission of the Client and/or the Client's guardian, with community partners including LRA, IRT or other providers who will support the Client.
10. Provide consultation and training to the residential care provider(s) that supports their ability to incorporate each Client's Behavior Support Plan into the Client's NSA or NCP.
11. Provide consultation and/or formal or informal training to caregiving staff in support of the implementation of the plan. All consultations and trainings to caregiving staff must be documented in the Client's clinical records. Documentation of the consultation and training must include dates and details, including topics discussed and any interventions identified.
12. Monitor the Behavior Support Plan monthly and update as needed to address emerging issues; and provide a formal review of the plan every six (6) months to ensure it reflects the Client's needs. The formal review will be conducted in collaboration with the residential care provider and HCLA/HCS, and copies will be forwarded to both. Provide any updates of Behavior Support Plan to the residential care provider.
13. Collaborate with primary health care team, the Client's current provider (residential or institutional), and/or other sources e.g., nurses, mental health technicians, substance abuse professionals, psychiatrists, dentists, crisis responders, hospital personnel, family, hospice providers or other community-based professionals, as appropriate, to help ensure progress toward Client care and Client goals identified in the Behavior Support Plan, who was involved in the development or modification of the Behavior Support Plan.
14. Make appropriate referrals to the BHO, BHSO, or MCO for ongoing assessment and treatment services, and collaborate with the BHO, BHSO, or MCO to coordinate services.
15. Provide a documented response capability that offers consultation and formal/informal training for the residential care provider and staff on a broad array of behavioral support topics that enable facility staff to circumvent crises for individual Clients.



- a. The ECS program shall include the capacity to provide unscheduled onsite visits for management of behavioral challenges that compromise a Client's placement as outlined in the Behavior Support Plan.
- 16. Service Episodes can be provided at the rate specified in this Contract at any hour of the day or night, as necessary, to support an individual's ability to maintain community placement.
 - a. The number of episodes provided to any particular Client per month will be discussed and coordinated with HCS staff who will provide final direction on the number of expected Service Episodes provided per week.
 - b. The number of Service Episodes should reflect the Client's needs, with the expectation that more Service Episodes will be needed during the first several weeks or months of transition.
 - c. Ensuing frequency of Service Episodes should reflect the Client's needs and be adjusted accordingly over time, as directed by HCS Field Services Administrator or designee. The Provider must provide and document at least one Service Episode per month.
 - d. If, in order to achieve or maintain stability in a community placement, a Client requires Service Episodes during a specified period of time that would exceed the number of Service Episodes authorized by the region, the Provider must seek approval by the Regional Field Services Administrator or designee prior to providing additional Service Episodes.
 - e. Unless the Client has access to psychopharmacological services through the behavioral health system, provide psychopharmacological evaluation for each Client within fourteen (14) days of the initial authorization of services and monthly reviews thereafter to ensure the individual medication regimen supports the Client's training goals.
 - i. If the Client chooses to have psychopharmacological evaluation or reviews provided by another prescriber or is able to receive psychopharmacological evaluations through the behavioral health system, the Provider must document the name, address, and phone number of the prescriber in the Behavior Support Plan or Client record.
 - ii. If the monthly medication review by the Provider's prescriber is a face-to-face or telehealth Service Episode, the Provider may bill for the Service Episode. Consent to telehealth must be documented in the Client record.
 - iii. If the monthly medication review by the Provider's prescriber is a record review without the Client being present, the Provider may not bill for the Service Episode.
 - iv. All psychopharmacological evaluations and monthly medication reviews must be documented in the Client record.
- 17. The Provider's prescriber must see the Client face-to-face or via telemedicine at least once every ninety (90) days, unless the Client has access to this service through the behavioral health system.
- 18. Under guidance and approval of HCS, establish processes for supporting Clients who may no longer benefit from the level of training and consultation provided by the services designated in this Contract.
 - a. The intent of transition planning should be to evaluate, on a regular basis, each Client's progress toward reaching and maintaining the goals outlined in the Behavior Support Plan.



- b. If a Client continues to need monthly clinical and prescriber services that are not otherwise accessed through the state's behavioral health system, maintain the Client on ECS or SBS services with written approval from the HCS Field Services Administrator or designee.
- 19. Inform DSHS/HCS of any changes that affect the Client's personal care plan or Behavior Support Plan on the next business day after the event; changes include, but are not limited to:
 - a. Death
 - b. significant change in medical or psychiatric condition
 - c. calls to emergency or crisis responders, hospitalization, and
 - d. encounters with law enforcement or other community agencies.

Case Manager's Responsibilities

In addition to the roles and responsibilities outlined in [Chapter 3 of the LTC Manual: Assessment and Care Planning](#) and as described in [Chapter 5 of the LTC Manual: Case Management](#), the following are the responsibilities of the Case Manager:

1. Provide final approval for all Clients who are eligible to receive the services.
2. For each Client:
 - a. Authorize Waiver Client Support Training/ECS Behavior Support through ProviderOne using the codes specified for each Client population;
 - b. Track authorizations for each Client as necessary;
 - c. Respond to Providers' requests for exception to rules related to limits on the number of Service Episodes within one week of request; and
 - d. Provide a written explanation for denial of additional Service Episode requests.
3. Collaborate with the Providers to establish a plan of transition for each Client and work with Provider to review each Client's progress toward meeting the goals that would allow the Client to discharge safely from the program, if and when, those goals are met.
4. Meet with the Provider every six months or as needed to review Client progress or changes in condition.
5. Participate in monthly ECS provider update meetings (Either in-person or virtually) to review and update the Behavior Support Plan and NSA to support the Client's ability to maintain the community placement and minimize the use of emergency departments, hospitalizations, and crisis responders.
6. Coordinate monthly check-in meeting (Either virtually, telephonic, or in-person) with residential provider to ensure ECS services are supportive.
7. Conduct regular in-person records reviews to ensure Providers meets performance expectations.

Client Participation with behavior support services

If an ECS-eligible Client is unable or unwilling to participate in the development and implementation of their behavior support services, with the Client's consent, the Behavior Support Provider may continue providing training, support and consultation to the residential provider. Additionally, the Behavior Support Provider will continue to collaborate with the assigned prescriber to verify that medication management is being utilized by the Client.



The reason for the Client's lack of participation must be documented in CARE in a SER and addressed within the Comments section in the Behavior Screen as a future concern for a upcoming annual or significant change assessment.

Willingness and ability to participate should be revisited every 6 months along with the effectiveness and suitability of the service authorization.

Specialized Behavior Supports (SBS)

SBS is offered in:

- Adult Family Homes with an SBS contract

In collaboration with:

- An ECS-contracted Community Behavior Support Provider

SBS is offered in an AFH setting, when an RSW-eligible Client does not qualify for 1:1 enhanced staffing through CBHS state plan services.

Clients receiving SBS are provided the same Behavior Support Services as ECS along with 6-8 hours of daily 1:1, enhanced staffing provided by the residential staff to provide proactive supports identified in the Behavior Support Plan to engage in daily scheduled activities relevant to the interests, choices, abilities and goals of the individual.

What services are available under SBS?

- Personal care
- 24-hour on-site support and response staff
- The development and implementation of an individualized behavior support plan to prevent and respond to crises
- Medication management, and
- Specialized behavior support that provides six to eight hours a day of individualized staff time and planned activities.
 - a. Planned activities must be relevant to the residents' interests, choices, and abilities are planned and available daily. The activities program should include individual and some facilitated group activities. Opportunities for independent, self-directed and individualized activities should be available at any time; and.
 - b. Planned activities must be documented by the SBS contracted AFH in a calendar fashion to reflect caregiver engagement and activities provided.

SBS Providers' Qualifications and Responsibilities

AFH Residential Provider Qualifications

- Be an official AFH licensee with the State of Washington for twelve (12) months or more.
- Have had no significant enforcement actions, as determined by a review of the enforcement history, during the twelve (12) months preceding



AFH Residential Provider Responsibilities

- Coordinate the delivery of Behavior Support Services with an appropriate Behavior Support Provider who has a contract with DSHS to provide ECS;
- Prepare for and facilitate Behavior Support Services that will be provided in the AFH and will include training provided to or on behalf of specific SBS Clients in order to support each SBS Client's ability to remain in the community.
- Identify a Behavior Support Team for each SBS Client. The SBS team will include, but not be limited to the ECS Behavior Support Provider, facility staff and other professional staff involved with the ongoing care of the Client.
- Coordinate SBS Team meetings at least once a month for each SBS Client.
 - The Residential provider shall ensure facility staff attend the meetings and participate in the development of the Behavior Support Plan for each SBS Client. The Behavior Support Plan shall be incorporated into the SBS Client's Service Plan and NCP or NSA.
- Coordinate opportunities for staff and SBS Clients to receive training that supports each ECS Client. Training provided shall range from broad behavioral care topics to specific consultation and training related to the needs of the ECS Client. The training may be provided in cooperation with the Behavior Support Provider
- Collaborate with the Behavior Support Provider to develop a written Behavior Support Plan to respond to identified ECS Client indicators of potential crisis.
 - The goal of the Behavior Support Plan shall be to develop the ability to prevent and respond to crises. The program strategy shall include specific courses of action to respond to the needs of the SBS Client.
 - It will also describe the mechanisms that will be used to document facility staff training for each Behavior Plan.
 - The Behavior Support Plan strategy shall be developed cooperatively with appropriate parties. If the Client's physical or behavioral status changes significantly, the Provider shall immediately notify the HCS Social Worker and the Behavior Support Provider.
 - The Behavior Support Plan will be incorporated into the Client's NCP or NSA.
- Collaborate with the Behavior Support Provider to monitor for 1:1 enhanced staffing and activities calendar effectiveness or recommendations for modifications.

SBS 1:1 Residential Staffing and Activities Calendar

The AFH must, with the Client, develop a 1:1 staffing and activities calendar and provide it promptly to the case manager and Behavior Support Provider, if/when identified. The staffing and activities calendar must be included in the Client's Negotiated Care Plan. The Case Manager will upload documents to DMS.

1:1 Staffing

For every SBS resident served in the SBS contracted AFH, provide a minimum of 6 (six) hours per day of staffing in addition to the current staffing model in the AFH.

The current staffing model must include 24-hour staff presence for residents who are not SBS Clients.

The staffing schedule must contain all the following elements. An example has been provide for the AFH provider's convenience:

SBS Staffing Schedule Example

Name of Facility: _____

Date: _____

Name of Client: _____

Please identify the additional caregiver(s) that will be scheduled to meet the staffing requirement of 6-8 hours per day to provide 1:1 services and supports.
(For example: 1pm-3pm and 5pm-9pm or 6am-2pm)

Day of Week	1:1 Caregiver Name	1:1 Time(s)	Name of Back-up 1:1 Caregiver <i>(if 1:1 Caregiver is unavailable)</i>	Routine Caregiver on Shift <i>During 1:1 Shift(s)</i>
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

SBS Activity Plan Requirement Reminder

The SBS Contract requires the AFH Provider to have a written activity plan for each SBS resident. The activity plan must reflect activities that:

- support the SBS resident's strengths and needs and provide recreational opportunities specifically designed to meet behavioral challenges of the resident;
- can be integrated into the daily routine of the resident and staff; and
- address specific issues identified by the resident and the SBS Team.

The written activity plan must be incorporated into the SBS Client's Negotiated Care Plan.



The need for 1:1 enhanced staffing and individualized activities must be included in the Client's CARE assessment. The assigned Case Manager will provide the Client and AFH provider and the Behavior Support Provider with a copy of the Client's CARE Assessment.

Activities Calendar

With the Client and in coordination with the contracted behavior support provider, the Residential Provider will develop a written activity calendar to support each SBS resident's strengths and needs and provide recreational opportunities specifically designed to meet behavioral challenges of the resident.

Activities in this plan must be integrated into the daily routine of the resident and staff and must address specific issues identified by the resident and the SBS team.

The Case Manager will review the staffing and activities calendar and will write a Service Episode Record (SER) documenting the receipt and review of the calendar.

Note: it is expected that the 1:1 staffing schedule and activities change over time as the AFH, Behavior Support Provider and Client build rapport, trust and discover how to effectively design supports and interventions relevant to the individual's goals, preferences, needs.

Client Participation with Behavior Support Services

If a SBS-eligible Client is unable or unwilling to participate in the development and implementation of their behavior support services, with the Client's consent, the Behavior Support Provider may continue providing training, support and consultation to the residential provider. Additionally, the Behavior Support Provider will continue to collaborate with the assigned prescriber to verify that medication management is being utilized by the Client.

The reason for the Client's lack of participation must be documented in CARE in a SER and addressed within the Comments section in the Behavior Screen as a future concern for a upcoming annual or significant change assessment.

Willingness and ability to participate should be revisited every 6 months along with the effectiveness and suitability of the service authorization.

Community Stability Supports (CSS)

CSS is an RSW service that may be accessed and is only available in a licensed Assisted Living Facility or EARC with a CSS contract. This service is appropriate for Clients who, due to their behavioral and personal care needs, require a higher level of support than is available through ECS or SBS. Unlike ECS and SBS where behavior support services are provided by contracted ECS providers, CSS, behavior support services are provided onsite and are the responsibility of the CSS-contracted residential provider (ALF/EARC).

What services are available under CSS?

- Personal care
- 24-hour on-site support and response staff
- Medication management
- Onsite intermittent nursing services including nutritional services
- The development and implementation of an individualized behavior support plan to prevent and respond to crises
- Activity Program
- On-site staffing ratios and professional staffing as described in the CSS contract:

Staffing and CSS Provider Responsibilities

All CSS Clients receive enhanced services through an interdisciplinary team including but not limited to nursing, a Behavior Support Clinician, an Activities Coordinator, and caregiving staff.

There must be at least three (3) interdisciplinary staff on duty for each shift, and the minimum staffing requirements shall be provided with the following exception during the overnight shift:

- Nursing:
 - a. RN/LPN staff on-site forty (40) hours per week and on-call providing twenty-four (24) hour coverage, seven (7) days per week. Nursing staff credentials must meet the medical complexity of the Client per WAC 246-840-700.
 - b. Ensures access to Nutritional Services monthly to monitor weight and develop dietary plans (failure to thrive, eating disorder, morbid obesity, etc.).
 - c. Ensures access to a Physician, Advanced Registered Nurse Practitioner, or Physician's Assistant for monthly medication review for all CSS Clients.
- Behavior Support Clinician:
 - a. Available on-site forty (40) hours per week, to provide staff consultation, training, and professional level behavior support services to CSS Clients.
- Activity Coordinator:
 - a. Available onsite forty (40) hours per week. Activity Program includes the following activities:
 - b. Develop and maintain a structured meaningful activities program under the guidance and oversight of an Activities
 - c. Will provide person-centered appropriate activities:
 - d. Structured activities provided seven days per week and documented on a monthly activity calendar;
 - e. CSS Clients must have an individualized, person-centered activity plan developed monthly, placed in their record and incorporated into their BSP.
 - f. Scheduled and unscheduled facility and community-based activities for CSS Clients offering group and individual options.
- CNA/HC Caregiving Staff
 - a. Staff designated to CSS Client care 24/7, with a minimum staffing ratio of 1:6 during the day and evening shifts.
 - b. CNA/HCA staff are required to meet all Client needs to maintain the health and safety of all Clients.



Onsite Behavior Support Services

The Behavior Support Clinician will coordinate behavior support services for each CSS Client and will:

1. Conduct an initial evaluation of the Client's behaviors and behavior support needs to begin the process of developing the Behavior Support Plan (BSP), including identifying approaches and strategies for staff to manage the Client's behaviors during the transition to a new setting.
 - a. Incorporate relevant behavioral and medical information from collateral contacts and admissions documents.
 - b. Document and describe the behaviors and strategies in the Client's record within the first seven (7) days of admission.
2. Develop Behavior Support Plans (BSP), including an activity section, and Crisis Plans.
 - a. The BSP must be written for each CSS Client within the first fourteen (14) days of admission and updated every six (6) months or more often as needed.
 - b. The Behavior Support Clinician shall review the BSP with the Client and staff, as a person-centered guide to provide behavior support interventions and strategies, as well as for consultation and training needs.
 - c. Within thirty (30) days, the BSP must be sent to the HCS case manager, reviewed with the facility staff, and incorporated into the Client's Negotiated Service Agreement (NSA).
 - d. The Crisis Plan must identify a 24/7 response strategy that identifies someone from the interdisciplinary behavior support team to manage crisis response.
 - e. Facilitate and document monthly, or more often as needed, interdisciplinary team meetings to review each Client's BSP, including medications and strategies, to ensure Clients' behavioral and medical needs are being addressed across the various disciplines; (i.e. may include Nurse, Prescriber, Social Worker, Activities Coordinator, Dietician, and HCS Case Manager).
3. Formally review and update the Client's BSP every six (6) months, or more often as needed, and provide copies to the HCS Case Manager.

Client Participation with Services

If a CSS-eligible Client is unable or unwilling to participate in the development and implementation of their behavior support services, with the Client's consent, the Behavior Support Provider may continue providing training, support and consultation to the residential provider. Additionally, the Behavior Support Provider will continue to collaborate with the assigned prescriber to verify that medication management is being utilized by the Client.

The reason for the Client's lack of participation must be documented in CARE in a SER and addressed within the Comments section in the Behavior Screen as a future concern for an upcoming annual or significant change assessment.

Willingness and ability to participated should be revisited every 6 months along with the effectiveness and suitability of the service authorization.

Enhanced Services Facility (ESF)

ESF provides the most intensive RSW services available and is only provided in an ESF-contracted setting. Unlike other services in the RSW, Enhanced Services Facilities have specific and required admission criteria required by [WAC 388-107-0030](#). Also unlike other RSW services, an Enhanced Services Facility serves only RSW Clients as it is an exclusively-RSW setting serving individual who meet RSW criteria AND need staffing and services available only in an ESF.

Note: how teams and services are described is different than for other RSW services.

What services are available under ESF?

- Personal care;
- 24-hour on-site support and response staff per [WAC 388-107-0240](#);
- The development and implementation of an individualized behavior support plan to prevent and respond to crises;
- Medication management; and
- On-site staffing ratios and professional staffing required in the ESF contract and [WAC 388-107](#).

Staffing and ESF Provider Responsibilities

Staffing

When Clients are in the Facility, the ESF Provider shall ensure that at least two (2) staff are on duty and shall provide a staffing ratio of one (1) staff to four (4) Clients at all times.

If a Facility consists of more than one building under the same license, there must be at least two (2) staff on duty in each building and a staffing ratio of one (1) staff to four (4) Clients in each building at all times.

If, in order to meet the Clients' needs or medical complexity, a higher staff to Client ratio is necessary, then the ESF Provider shall provide additional staffing for all shifts.

The ESF must ensure the staffing ratios are met with the following credentialed staff, who are in good professional standing:

- Registered nurse;
- Licensed practical nurse;
- Nursing assistant certified or certified home care aide; and
- Mental health professional

The Enhanced Services Facility must ensure that:

- Sufficient numbers of appropriately qualified and trained staff are available to safely provide necessary care and services consistent with residents' person-centered service plans under routine conditions, as well as during fire, emergency, and disaster situations; and



- At least two staff are awake and on duty in the facility at all times if there are any residents in the facility.
- 1. A registered nurse must be available to meet the needs of the residents as follows:
 - a. On duty in the facility at least twenty hours per week; and
 - b. When not present, available on-call and able to respond within thirty minutes by phone or in person.
- 2. A licensed nurse must be on duty in the facility whenever a registered nurse is not on site.
- 3. A mental health professional must be available to meet the needs of the residents as follows:
 - a. On duty in the facility at least eight hours per day; and
 - b. When not present, available on-call and able to respond within thirty minutes by phone or in person.

ESF Provider Responsibilities

The ESF Provider shall provide as identified in the Client's Person Center Support Plan (PCSP) per [WAC 388-107-0160](#):

- a. Address complex behavioral needs, supervision, and coordination of services related to behavioral concerns, and supports for participants with traumatic brain injuries, substance use, or cognitive impairments;
- b. Personal care services as specified on the Client's authorized PCSP based on the Client's CARE assessment; and
- c. Health-related services including skilled or nursing care and medication administration to the extent permitted by State law.
- d. Meet with potential Clients, referent staff, DSHS staff, and other involved parties as needed prior to admitting a DSHS Client to the Provider's facility.
- e. Lead the pre-transition and coordination planning process.
 - i. The ESF Provider must meet, either in-person or virtually with the prospective Client, the referent, and any relevant staff while the Client is hospitalized. The Contractor must complete a preadmission assessment, to include all of the elements per [WAC 388-107-0040](#). The enhanced services facility will integrate information from the state's last comprehensive assessment reporting evaluation (CARE) into the facility's preadmission assessment.
- f. Provide a homelike environment.
- g. Develop a Person Centered Service Plan with each DSHS Client that lists all services to be provided and any other known service that is available to, or may impact, the Client. The PCSP must:
 - i. Be based on the Provider Assessment or Reassessment completed by the Provider and the Client's CARE Assessment.



- ii. Be developed in accordance with the format provided by DSHS and must include the following:
 1. An Activity Section written to support each ESF Client's interests, strengths, and needs and provide for recreational opportunities specifically designed to meet the behavioral challenges of the Client. Activities must be integrated into the daily routine of the Client and staff and must address specific issues identified by the Client and the PCSP Team.
 2. A Behavior Support Plan developed by the Facility's MHP that is designed to prevent crises and to maintain the Client's residency at the ESF. The Behavior Support Plan shall include the following elements:
 - a. A Crisis Prevention and Response Protocol that outlines specific indicators, which may signal a potential crisis for the Client or that, when left unaddressed in the past, has led to a behavioral crisis.
 - b. These signals would include, but not be limited to, typical behaviors the Client displays when escalating, actions the Client may typically take prior to a behavioral outburst, or words or phrases the Client has been known to express during a time of escalation.
 - c. The Crisis Prevention and Response Protocol shall include a plan to ensure coordination with community crisis responders in regard to each Client's PCSP as part of a regular, routine protocol for crisis prevention and intervention. The Crisis Prevention and Response Protocol must include:
 - i. Specific interventions and pre-crisis prevention strategies for each of the indicators described above;
 - ii. A description of the types of holding techniques (if used by the Provider) that are safe for the Client; and
 - iii. A Crisis Prevention and Response Protocol that outline steps to be taken by facility staff and by each of the PCSP Team members if the prevention or intervention strategies are unsuccessful in diverting the Client from a behavior or action that leads to crisis.
 3. The Behavior Support Plan must include measurable goals, outcomes, and appropriate information needed to support the Client if he or she is ready to move from the ESF in order to live more independently in the community.
 4. Maximize the opportunities for independence, employment, community participation and integration, the Client's participation in service planning, collaboration with peer-supported services, and the provision of care and services in the least restrictive manner appropriate to the individual Client, and, where relevant, to comply with any current court orders.



5. Be made available for review by the DSHS Case Manager and provided to the Case Manager on a yearly basis and as significant changes and updates are made.
6. Stipulations about Transitions to Other Community Settings.
 - a. During the annual reassessment and/or significant change assessment the DSHS Case Manager and in collaboration with the PCSP Team shall discuss all available setting options and develop a plan of transition for ESF Clients who would like to move to another community setting, as required in [WAC 388-107-0110](#) and [388-107-0120](#).
7. Document the specific procedure for de-escalating, preventing, and redirecting challenging behavior, to include: data collection, review and evaluation of interventions, behaviors and progress towards goals/outcomes.
8. The specific assessed need is identified in the PCSP, which is signed by the Client;
9. Participation by the Client in the development of the PCSP;
10. Other positive interventions and less restrictive interventions that have **not** been successful;
11. Any impacts to other Clients and how those will be addressed;
12. Staff training on prevention of escalation of behavior, consistent with the requirements below.
13. Techniques for staff to use in response to challenging behaviors; and
14. If the facility uses holding techniques as a last resort to physically restrain residents in emergency situations and as part of behavioral intervention protocols, provide an Incident Report on the reason, the interventions used, the duration, and the Client's condition when the hold is released.
15. Plan and make available the activities relevant to the Clients' interests, choices, and abilities. The activities program must include:
 - a. Daily facilitated group activities, that provide opportunities for Clients to choose whether or not to participate;
 - b. Opportunities for independent, self-directed and individualized activities that are available at any time; and
 - c. Activities in the local community.
 - i. Advance notice must be given to Clients for activities that require the Client to pay for participation (such as entrance fees to parks/events, bowling, movies, dining out)



16. Provide behavior support services as identified in each Client's PCSP;
17. Coordinate with the entity that administers Medicaid-funded behavioral health services in the local community; and.
18. Ensure that Quality Improvement measures are in place as outlined in the contract.

PCSP Team Roles

The ESF Provider must:

1. Develop and maintain a PCSP Team for each Client. The Team must include:
 - a. The Client and, the Client's representative (if applicable);
 - b. Individuals chosen by the Client;
 - c. A mental health professional;
 - d. Nursing staff;
 - e. The Client's DSHS Case Manager; and
 - f. Other persons as needed.
- g. Additional Team members may be added to the PCSP Team:
- h. If requested by the Client or the Client's representative; or
 - i. To address specific needs identified by the Client or any other member of the Team on either a one-time or ongoing basis.
- i. Provide the necessary information and support to ensure that the Client has an opportunity to identify Team members, make informed choices and decisions regarding care and services, and direct the PCSP process to the maximum extent possible.
- j. Ensure a coordinated approach to the development, implementation and evaluation of the comprehensive PCSP for the Client.
- k. Ensure the PCSP Team meets at least monthly and more often as needed, at times and locations convenient to the Client, to review and modify the comprehensive PCSP when necessary.
- l. Convene additional PCSP Team meetings as needed if the Client is experiencing signs or symptoms of crisis that:
 - i. Put a Client at risk of hospitalization, institutionalization, or loss of residence; and/or
 - ii. Exceeds a Client's individual ability to cope/remain stable; and/or
 - iii. Exceeds the ability of the Client's caregivers to provide the necessary supports.



- m. Ensure the Facility staff attend the meetings and participate in the development and review of the PCSP for each ESF Client. All work performed under this Contract and any PCSP shall be performed under [WAC 388-107-0190 Rights of Resident](#).
- n. Confirm the PCSP Team develops one PCSP for each ESF Client.
- o. Verify the development of the PCSP included collaboration with the Client and the Client's self-identified support team.
- p. Confirm the PCSP Team reviewed and updated the PCSP monthly and after each Contractor Assessment and Reassessment, as needed.
- q. Document in writing all PCSP Team meetings to reflect who was present, the topics discussed, any decisions made, and activities the Client participated in since the last PCSP Team meeting.

Client Participation with Services

If an ESF-eligible Client is unable or unwilling to participate in the development and implementation of their behavior support services, with the Client's consent, the Behavior Support Provider may continue providing training, support and consultation to the residential provider.

The reason for the Client's lack of participation must be documented in CARE in a SER and addressed within the Comments section in the Behavior Screen as a future concern for an upcoming annual or significant change assessment.

Willingness and ability to participated should be revisited every 6 months along with the effectiveness and suitability of the service authorization.

Enhanced Services Facility Utilization and Admission Criteria

In addition to meeting the RSW eligibility criteria as determined in CARE, per [WAC 388-107-0030](#), ESF has additional Client criteria that must be met prior to admission.

A Client MUST:

- Eighteen years old or older
- Require daily care by or under the supervision of a mental health professional, chemical dependency professional, or nurse; **OR**
 - a. Assistance with three or more activities of daily living; **and**
- Have any of the following:
 - a. A mental disorder, chemical dependency disorder, or both;
 - b. An organic or traumatic brain injury; or
 - c. A cognitive impairment that results in symptoms or behaviors requiring supervision and facility services.
- Benefit from the enhanced staffing levels and professional supports provided in this setting;



- If at the state hospital, community hospital, or psychiatric hospital/stabilizing facility, has been deemed stable and ready for discharge. **AND**
- Does not meet the requirement for active treatment at a state hospital, but has not found a community setting sufficient to provide the services and supports to successfully live in the community due to a history of **two or more** of the following:
 - a. Aggressive, threatening, or assaultive behaviors that create a risk to the health or safety of other residents or staff, or a significant risk to property and these behaviors are frequent or difficult to manage; **AND/OR**
 - b. Intrusive behaviors that put residents or staff at risk; **AND/OR**
 - c. Complex medication needs which include psychotropic medications; **AND/OR**
 - d. A history of or likelihood of unsuccessful supports in either a licensed facility or other state facility **or** a history of rejected applications for admission to other licensed facilities based on the resident's behaviors, history, or security needs; **AND/OR**
 - A history of offenses against a person or felony offenses that created substantial damage to property, **and/or**
 - A history of frequent or lengthy mental health hospitalizations

ESF Provider Responsibilities

Immediately upon a Client requesting admission to the ESF, the CM must provide the Client's CARE assessment.

Upon admission of a Client to the Provider's ESF, the Provider shall prepare a Client file,

The Provider must notify the DSHS Case Manager in writing when a Client requires more care than the Provider can provide.

In addition, the Provider must notify the DSHS Case Manager when the Client's care needs change and do not return to the level of care of the current assessment within a two-week period of time.

The enhanced services facility must complete a face-to-face or virtual preadmission assessment at the hospital with each potential resident prior to admission which includes the following minimum information:

1. Resident identification information such as but not limited to the name, address and telephone number of the resident's:
 - i. Representative;
 - ii. Health care providers;
 - iii. Significant family members identified by the resident;
 - iv. Other individuals the resident wants involved or notified; and
2. Presenting issues;
3. Current medical and mental health history;



4. Necessary and contraindicated medications, including psychotropic;
5. A licensed medical or health professional's physical and mental health diagnoses;
6. Significant known behaviors such as but not limited to aggressive, threatening, intrusive, assaultive, self-endangering including attempted suicide and/or homicide or other symptoms that may cause concern or require special care and staffing;
7. Chemical dependency history, including tobacco;
8. Level of personal care needs, assistance with activities of daily living;
9. Activities and service preferences;
10. Preferences regarding other issues important to the prospective resident, such as food and daily routine;
11. Information that a potential resident is or is not court-ordered for treatment or under the supervision of the department of corrections;
12. Individual's anticipated level of need for supervision in the community;
13. Cognitive impairments that result in symptoms of behaviors requiring supervision and facility services;
14. History of unsuccessful placement in the community settings; and
15. Treatment recommendations or recommendations for additional program-specific assessment.
16. A transition plan that:
 - i. Allows the facility to work with the referent staff to understand what the resident responds to in difficult situations; and
 - ii. Allows the facility to request referent staff to visit resident in new environment and teach enhanced services facility staff techniques that have been successful in the hospital.

GUIDANCE FOR 1:1/ENHANCED STAFFING IN RESIDENTIAL SETTINGS

Referrals to CBHS/1915i and RSW should be initiated concurrently for Clients who meet criteria for both programs and are interested in 1:1/enhanced staffing, allowing RSW services to provide additional wraparound supports.

To support this transition, Washington Administrative Code (WAC) sections [388-106-0336](#) and [388-106-0338](#) were amended, effective July 1, 2025. These amendments clarify CBHS/1915i State Plan is the first program of consideration and authorization for 1:1/enhanced staffing in a residential setting. If a Client meets eligibility for CBHS, this service must be referred to, prior to RSW services.

- **CBHS State Plan:** Administered by HCA under the 1915(i) authority, this program offers 1:1/enhanced staffing referred to as supportive supervision.

- **RSW program:** Managed by HCLA, this waiver provides enhanced staffing services through various levels of services.

For **CBHS specific information** and documentation please reference *Community Behavioral Health Support (CBHS) Services Residential* section in the Long-Term Care Manual for information regarding Behavioral Health Wraparound Supports (BHWS) [Chapter 22a: Apple Health Managed Care and Apple Health Medicare Connect \(D-SNP\)](#).

For RSW and CBHS staff resource please reference [LTC Manual Chapter 22d: Community Behavioral Health Supports](#)

RSW Services Offering 1:1/Enhanced Staffing

Specialized Behavior Support (SBS)

- Can only be authorized for Clients who do not meet CBHS eligibility.

Community Stability Supports (CSS)

- Prior to authorizing ESF services, a CBHS referral must be considered and sent if Client meets CBHS/1915i eligibility including having a qualifying diagnosis and meets other criteria as outlined in [LTC Manual Chapter 22d: Community Behavioral Health Supports](#) and consents to services.
- [CSS rate](#) is only available to Clients not eligible for CBHS.

Enhanced Services Facility (ESF)

- Prior to authorizing ESF services, a CBHS referral must be considered and sent if Client meets CBHS/1915i eligibility including has a qualifying diagnosis and meets other criteria as outlined in [LTC Manual Chapter 22d: Community Behavioral Health Supports](#) and consents to services.
- Full [ESF rate](#) is only available to Clients not eligible for CBHS.

Process for accessing Community Behavioral Health (CBHS) state plan for 1:1 enhanced staffing and RSW Services within the CARE assessment.

Is the Client interested in 1:1/enhanced staffing in a residential setting?

- **Yes** → Document a SER in CARE Client's agreement with CBHS referral.
- **No** → Document a SER in CARE Client declining need for 1:1 enhanced staffing

Does the Client meet CBHS/1915i referral criteria? ([Community Behavioral Health Support Services](#))

- **Yes** → Answer "Yes" for CBHS referral question "[Was a referral made for CBHS/1915i eligibility?](#)" within the Behavior screen of the CARE assessment.

Was a referral made for CBHS/1915i eligibility?

Yes

No

- → Enter date referral was sent to MCO/HCA.

Date referral was sent to MCO/HCA

08/20/2026



- **No** → Answer “No” for CBHS referral in Behavior screen of CARE assessment.

Was a referral made for CBHS/1915i eligibility?

Yes

No

→ Utilize drop-down answers within the Behavior screen for CBHS referral and reason for declining 1:1 /Enhanced staffing

Why was a referral not made?

Care plan is in-home

Does not want or need individualized staffing support

Does not meet the risk criteria outlined in CBHS referral form

Other

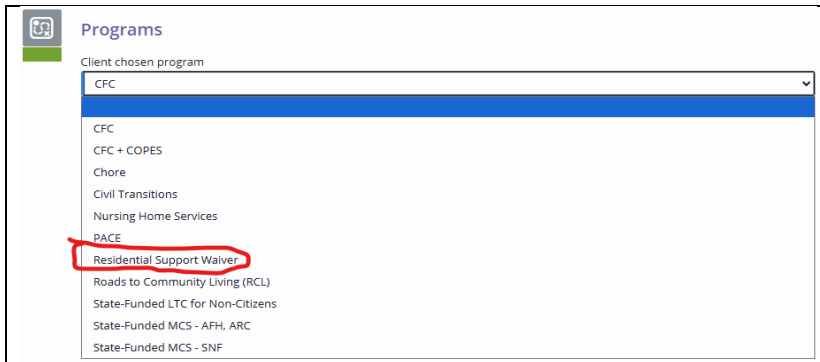
- Select "other" for the reason no referral was made. Document the reason the CBHS referral was not made in the required comment box.

What if my Client declines a CBHS referral?

Declining a referral for 1:1 / enhanced staffing through CBHS means they are also declining a referral for 1:1/enhanced staffing through RSW (SBS, CSS and ESF).

Does the Client meet RSW criteria per CARE?

- **Yes** → RSW will populate in the Care Plan screen for Client Chosen Program



Programs

Client chosen program

CFC

CFC

CFC + COPEs

Chore

Civil Transitions

Nursing Home Services

PACE

Residential Support Waiver

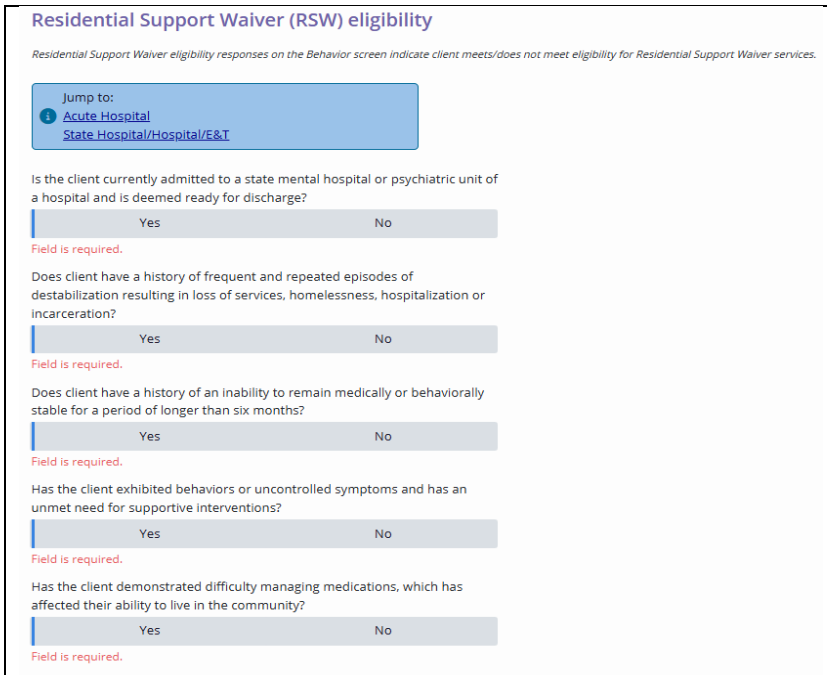
Roads to Community Living (RCL)

State-Funded LTC for Non-Citizens

State-Funded MCS - AFH, ARC

State-Funded MCS - SNF

- Proceed with Referral to RSW Committee (See section below);
- Answer RSW Eligibility questions within the Behavior screen of the CARE assessment



Residential Support Waiver (RSW) eligibility

Residential Support Waiver eligibility responses on the Behavior screen indicate client meets/does not meet eligibility for Residential Support Waiver services.

Jump to:

- Acute Hospital
- State Hospital/Hospital/E&T

Is the client currently admitted to a state mental hospital or psychiatric unit of a hospital and is deemed ready for discharge?

Yes No

Field is required.

Does client have a history of frequent and repeated episodes of destabilization resulting in loss of services, homelessness, hospitalization or incarceration?

Yes No

Field is required.

Does client have a history of an inability to remain medically or behaviorally stable for a period of longer than six months?

Yes No

Field is required.

Has the client exhibited behaviors or uncontrolled symptoms and has an unmet need for supportive interventions?

Yes No

Field is required.

Has the client demonstrated difficulty managing medications, which has affected their ability to live in the community?

Yes No

Field is required.

- **No** → Continue eligibility determination for other programs

See [LTC Manual Chapter 22a – Apple Health Managed Care and Medicare Dual-Eligible Special Needs Plans \(D-SNP\)](#) to review criteria for **Community Behavioral Health Support (CBHS)** services paid by a Managed Care Organization (MCO) or Health Care Authority (HCA). [Chapter 22a](#) includes the process for requesting funding from the MCO/HCA if additional supports are needed. CBHS services is a State Plan service and must be utilized prior to authorizing RSW services if the Client is eligible.

NOTE: Expanded Community Services (ECS) does not offer 1:1/enhanced staffing.
CBHS referral is not required.

CARE Assessment and RSW Referral

- The HCS/AAA Case Manager completes a CARE assessment, in accordance with [Chapter 3](#) and [Chapter 8](#) of the LTC Manual
- RSW Eligibility Questions answered—RSW Eligibility determined in CARE
- The HCS/AAA Case Manager submits the RSW referral to the RSW Committee using the RSW Referral Submission Process for HCS/AAA Case Managers. Note: each region's process is slightly different. Please follow your region's process.

RSW Referral Submission Process for HCS/AAA Case Managers

HCS Case Managers submit RSW referrals to:

Region 1: hcsrsw@dshs.wa.gov

Region 2: <http://region4aasa.dshs.wa.gov/RSW/Main.asp>

Region 3: [R3 RSW Referral request](#)

AAA Case Manager emails RSW referrals ([DSHS form 11-130](#)) to:

Region 1: hcsrsw@dshs.wa.gov

Region 2: r2rsw@dshs.wa.gov

Region 3: aaarswreferrals@dshs.wa.gov

Regional RSW Committees and Case Manager Responsibilities

- The RSW Committee reviews the referral and confirms functional, financial eligibility and that a CBHS referral was made when appropriate.
- If the Client *does not meet eligibility*, the committee documents the outcome on [DSHS form 11-130](#), provides a SER that cites which criteria were not met, and communicates the decision to the Case Manager via email.
- If Client's eligibility and CBHS referral appropriateness is confirmed, the Case Manager coordinates discussion and coordination with the Client to identify how their assessed needs will be best met among the RSW services and settings.
- The Case Manager will complete DSHS form 11-130 to indicate the Client's choice of services.
- The completed [DSHS form 11-130](#) is submitted to DMS by the Case Manager.

HOW TO SUBMIT REFERRALS TO A RESIDENTIAL PROVIDER?

Referrals

Referrals must include Assessment Details (AD) and Service Summary (SS) to allow the provider to review prior to admission. Additionally, for individuals with challenging behaviors (i.e., assaultive, property destruction, self-injurious, challenging sexualized behaviors, history of arson, and/or history or criminal activity), the assigned case manager or assessor must complete [DSHS 10-234a](#) and include in the residential provider referral packet per [Chapter 9a](#) of the [LTC Manual](#).

Note: See Admission Criteria for ESF [WAC 388-107-0030](#)

Behavior Support Services CARE Requirements

Clients authorized for RSW services must have at least one of the following identified in CARE under the Medical Treatment section for all residential settings (AFH, ALF, and ESF):

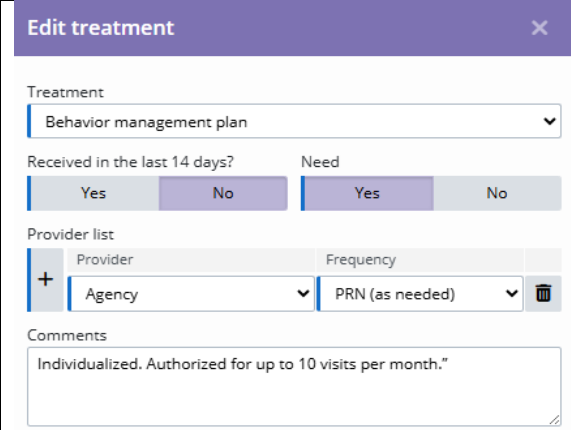
- Behavior Management Plan (BMP)
- Behavior Evaluation Program (BEP)

Implementation Guidelines

Utilization of BMP or BEP is dependent on the Client's specific needs and setting, utilization of state plan and MCO services. CSS and ESF providers are required to complete a BEP prior to admission and have a functional BMP for ongoing supports. AFH providers are required to coordinate with Behavior Support Providers (BSP) for the completion of a BMP for the entirety of a Client's admission.

Examples of the use of BMP & BEP within CARE

BMP for ECS, SBS Client:

	Provider: "Agency" (there is no separate option for "Behavior Support Provider" as BSPs for ECS/SBS Clients are contracted, so "Agency" is the best option). Frequency: "PRN (as needed)" (Entering PRN indicates that the frequency is individualized and could change over time.) Comments: "Individualized. Authorized for up to 10 visits per month."
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BMP for CSS or ESF Client:

Edit treatment × Treatment Behavior management plan ▼ Received in the last 14 days? Need Yes No Yes No Provider list <table><thead><tr><th>+</th><th>Provider</th><th>Frequency</th><th></th></tr></thead><tbody><tr><td></td><td>Facility staff ▼</td><td>PRN (as needed) ▼</td><td>✕</td></tr></tbody></table> Comments Individualized. Behavior support provider on staff to provide services	+	Provider	Frequency			Facility staff ▼	PRN (as needed) ▼	✕	Provider: “Facility staff” (CSS/ESF facilities are required to have a behavior support provider on staff) Frequency: “PRN (as needed)” (Entering PRN indicates that the frequency is individualized and could change over time.) Comments: “Individualized. Behavior support provider on staff to provide services.”
+	Provider	Frequency							
	Facility staff ▼	PRN (as needed) ▼	✕						

BEP for CSS or ESF Client:

Edit treatment × Treatment Behavior evaluation program ▼ Received in the last 14 days? Need Yes No Yes No Provider list <table><thead><tr><th>+</th><th>Provider</th><th>Frequency</th><th></th></tr></thead><tbody><tr><td></td><td>Facility staff ▼</td><td>PRN (as needed) ▼</td><td>✕</td></tr></tbody></table> Comments Individualized. Behavior support team on staff to complete behavior evaluation program (Functional Behavior Assessment) prior to admission to identify the predictors of challenging behaviors and the functions, or purpose of that behavior	+	Provider	Frequency			Facility staff ▼	PRN (as needed) ▼	✕	Provider: “Facility staff” (CSS/ESF facilities are required to complete a Behavior Evaluation Plan prior to admission based on the needs of each Client) Frequency: “PRN (as needed)” (entering PRN indicates that this program is individualized). Comments: “Individualized. Behavior support team on staff to complete behavior evaluation program (Functional Behavior Assessment) prior to admission to identify the predictors of challenging behaviors and the functions, or purpose of that behavior”.
+	Provider	Frequency							
	Facility staff ▼	PRN (as needed) ▼	✕						

CASE MANAGER RESOURCE FOR PROVIDERS

FACILITY LOCATOR

- [AFH Facility Search \(wa.gov\)](#)
- [Assisted Living Facility Locator](#)
- [ESF Locator](#)

AUTHORIZING RSW SERVICES

Authorization for RSW Medicaid coverage (ECS, SBS, CSS, ESF) is a two-step process for initiating Recipient Aid Categories (RACs) and services. Case Managers may open RSW RACs for Clients who have pre-existing HCS services (CFC, CFC+COPEs, etc.) on the day of RSW eligibility approval by the RSW



Committee.* This will allow for any needed pre-transitional Behavior Support services prior to the Client's admission to ECS or SBS contracted AFHs.

In the case where a Client has no pre-existing services, the authorization period for RSW Services begins on the first day the Client arrives at the community residential setting that is contracted to provide the service.

For ECS and SBS services, the Behavioral Support Provider (BSP) must also be confirmed by the Case Manager to authorize services. Authorization of BSP services is dependent on confirmation by the BSP to provide services, if any pre-transitional BSP support planning is needed or requested by the referent or AFH provider, and the start date the BSP provider commits to. In some situations, contracted Behavior Support Services may be authorized for a limited number of episodes to facilitate pre-transition behavior support activities with the aim of supporting a successful transition. Prior to service authorization for SBS services, an approved staffing calendar from the AFH is required.

Clients admitted to an ESF require coordinated transition planning to ensure all preparations have been completed and the Client and the Provider are ready for admission.

In cases where Clients are transitioning from existing services to RSW, start dates for RSW RACs and authorization of services require Case Manager coordination to determine effective end and start dates for RACs and authorization of services.

When communicating with Public Benefits Specialists (PBS) regarding RSW Clients, Case Managers will use the Financial/Social Services Communication Form ([DSHS 14-443](#)). On the form:

- Select the RSW program for all RSW Clients
- Select the CFC program if the RSW Client is also receiving an ongoing CFC Ancillary service. Do not select CFC if the RSW Client is getting a one-time CFC service.

For more information on how financial eligibility is determined, see [Chapter 7a: Financial Eligibility of Core Programs of the LTC Manual](#).

RACs for RSW Services

Program Name	RAC Code
ESF	3030
AFH-SBS	3031
Expanded Community Services	3032
ESF Fast Track*	3033

Program Name	RAC Code
SBS Fast Track*	3034
ECS Fast Track*	3035
CSS Fast Track*	3038
CSS	3039
CFC Ancillary Services	3056
RSW CFC Ancillary Services Fast Track*	3057

*For more information on Fast Track, see [Chapter 7a](#) of the [LTC Manual](#).

FAST TRACK

Fast Track may be considered for RSW if a Client does not have a disability determination and is open on MAGI-based NO5 program. A Non-Grant Medical Application (NGMA) must be completed to begin this process and should be done early in the assessment process. For more information on Fast Track, see LTC Manual [Chapter 7h: Appendices](#).

Utilization of the RSW Fast Track RAC is dependent on Case Manager submission of NGMA application and approval from regional RSW Committee for RSW services and should only be done in rare cases if the NGMA has not yet been approved. By using the Fast Track RACs for these Clients, they will be able to receive RSW services as soon as they move into a community setting. However, best practice is to confirm NGMA approval prior to discharge to ensure waiver eligibility and service continuation.

Case Managers are required to monitor the NGMA determination of a Client. Once approval of NGMA is received and adjust RACs and authorizations to reflect financial approval for waiver services.

In rare cases, a Client may be found ineligible for waiver services because of NGMA denial, requiring adjustment of RACs to State Only Adjustment of Payment (SOAP) RACs. Utilization of RSW RACs will require supervisory oversight to override mismatch authorization errors. Person-centered planning will need to occur, to transition the Client to an eligible program such as Community First Choice (CFC) state plan option.

NOTE:

- RSW Fast Track eligibility is allowed for MAGI/NO5. Please reference [Fast Track Service Agreement \(DSHS form 13-713\)](#) process outlined in [Chapter 7a](#) in the LTC Manual.



- RSW Fast Track eligibility is allowed for NGMA applications. Please reference Instructions for Completing NGMA Referral in Barcode outlined in [Chapter 7h](#) of the LTC Manual.

Authorizing Personal Care and RSW Add-On Rates

In the RSW, personal care services are bundled into the Client's daily rate. When selecting one of the RACs listed above, authorization includes these personal care services.

For ECS, SBS, CSS, and ESF personal care add-ons include both Clients eligible and not eligible for CBHS. Refer to the current [All HCS Rates.xls](#) or consult the Service Code Data Sheets for additional details.

Authorizing ECS

When a Client is approved for ECS and chooses a contracted residential provider, the Case Manager will authorize the following codes:

ECS in AFH	
1. Personal Care Service Code:	T1020 U1 Personal Care Residential AFH
2. ECS Service Code:	T2033 U1 AFH Add-On

Authorizing SBS

When a Client is approved for SBS and chooses a contracted AFH, the Case Manager will confirm that the [SBS staffing Schedule](#) is completed (Reference SBS Staffing Requirements) and will:

SBS in AFH	
1. Personal Care Service Code:	T1020 U1 Personal Care Residential AFH
2. SBS Service Code:	T2033 U5 RSW SBS AFH Add on
NOTE: Case Managers must consult Home & Community Services Rates to enter correct CARE Classification rate for SBS Add-on for RSW SBS AFH Add-on (T2033 U3)	

ECS in ALF	
1. Personal Care Service Code:	T2031 Assisted Living
2. ECS ALF Add-on Service Code:	T2033 UA
3. ECS EARC Add-on Service Code:	T2033 U3 EARC Add On
4. ECS ALF Service Code:	T2033 UA

ECS in EARC																						
1. Personal Care Service Code:	<u>T1020 U3 Personal Care Residential ARC Enhanced</u>																					
2. ECS Service Code:	<u>T2033 U3 EARC Add On</u>																					
NOTE: Case Managers must consult Home & Community Services Rates to enter correct CARE Classification rate for ECS Add-on for EARC (T2033 U3)																						
<table border="1"> <thead> <tr> <th>Rate</th> <th>ECS Add-on for EARC (T2033,U3)</th> <th>T1020</th> </tr> </thead> <tbody> <tr> <td>9</td> <td>\$68.68</td> <td>\$</td> </tr> <tr> <td>8</td> <td>\$61.40</td> <td>\$</td> </tr> <tr> <td>6</td> <td>\$55.37</td> <td>\$</td> </tr> <tr> <td>9</td> <td>\$68.68</td> <td>\$</td> </tr> <tr> <td>3</td> <td>\$54.12</td> <td>\$</td> </tr> <tr> <td>3</td> <td>\$49.76</td> <td>\$</td> </tr> </tbody> </table>		Rate	ECS Add-on for EARC (T2033,U3)	T1020	9	\$68.68	\$	8	\$61.40	\$	6	\$55.37	\$	9	\$68.68	\$	3	\$54.12	\$	3	\$49.76	\$
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3	\$49.76	\$																				

Authorizations for ECS or SBS are approved to accommodate regional absence of Behavior Support Provider. There is no defined limitation on the duration of these authorizations and are dependent on Case Managers coordination for next available Behavior Support Provider.

ECS or SBS add-ons may be temporarily authorized for AFHs when:

- The Client has an assessed behavior support need
- The Client elects to receive ECS or SBS services
- A behavioral support provider is not currently available

In these cases, the HCS Case Manager will coordinate with the local RSW supervisor to review alternative plans to temporarily meet the Client's behavioral health needs until a qualified behavioral health provider is authorized to serve the Client. (Per [Adult Family Home Council Collective Bargaining Agreement 2025-2027](#))

NOTE: A Behavior Support Provider should be in place prior to starting ECS/SBS services. If not, Case Managers should, with the Client, prospective provider and transition partners, document the plan and timeline for when a BSP will be in place. Some transition activities may impact the timing of establishing a BSP prior to start of ECS/SBS services.

Authorizing CSS Add-on Rates

When a Client is found eligible, agrees to CSS services, and chooses a CSS-contracted ALF the Case Manager will authorize the following:

1. Personal Care Service Code : [T1020, U3 Personal Care Residential – EARC*](#)
2. CSS Service Code: [T2033 U4 CSS Add On*](#)
 - If the Client is eligible for Community Behavioral Health Support (CBHS) Services (Reference for detailed CBHS information). Authorize the [CSS Add On](#) rate which does not include the 1:6 enhanced staffing.
 - If the Client does not meet eligibility criteria for CBHS, authorize the [CSS Add On](#) rate, which includes the 1:6 enhanced staffing ratio.

CSS

1. Personal Care Service Code:	<u>T1020 U3 Personal Care Residential ARC Enhanced</u>
2. SBS Service Code:	<u>T2033 U4 CSS Add on</u>

NOTE: Case Managers must consult [Home & Community Services Rates](#) to enter the correct rate and reason code based on the Client’s CBHS eligibility/ineligibility

For CSS Clients eligible for Community Behavioral Health Supports (CBHS):			
CBHS Tier	Service Code/ Modifier	Reason Code	Rate
Tier 1	T2033,U4	MCO Funded Tier 1	\$115.00
Tier 2	T2033,U4	MCO Funded Tier 2	
Tier 3	T2033,U4	MCO Funded Tier 3	
Tier 4	T2033,U4	MCO Funded Tier 4	
Tier 5	T2033,U4	MCO Funded Tier 5	
Tier 6	T2033,U4	MCO Funded Tier 6	

For CSS Clients not eligible for CBHS:			
CBHS Tier	Service Code/ Modifier	Reason Code	Rate
n/a	T2033,U4	No Reason Code Needed	\$245.00

Authorizing ESF Rates

When a Client is eligible, agrees to Enhanced Services Facility (ESF) support, and selects an ESF-contracted residential provider, the Case Manager will authorize the following:

1. Personal Care Service Code: [T1020 U5 Personal Care RSW ESF*](#)
2. The authorized rate depends on the Client's funding source and CBHS tier approval.

- Clients **Not eligible for CBHS**
 - Service Code: [T1020 U5 Personal Care RSW ESF*](#)
 - Reason Code: Not required

For Clients not eligible for CBHS in an ESF:			
Tier	Service Code/ Modifier	Reason Code	Rate
n/a	T1020,U5	No Reason Code Needed	\$596.10

- Clients **Eligible for CBHS**
 - Clients approved for Community Behavioral Health Support (CBHS) services will be assigned one of six tiers. Each tier includes:
 - Service Code: [T1020 U5 Personal Care RSW ESF*](#)
 - Reason Code: CBHS Funded Tier Level Client is approved for
 - ▽ A supplemental payment made directly by CBHS/HCA to the ESF provider (not entered in CARE)

For Clients eligible for Community Behavioral Health Supports (CBHS) in an ESF:			
Tier	Service Code/ Modifier	Reason Code	Rate
Tier 1	T1020,U5	MCO Funded Tier 1	\$559.80
Tier 2	T1020,U5	MCO Funded Tier 2	\$498.09
Tier 3	T1020,U5	MCO Funded Tier 3	\$401.29
Tier 4	T1020,U5	MCO Funded Tier 4	\$390.95
Tier 5	T1020,U5	MCO Funded Tier 5	\$390.95
Tier 6	T1020,U5	MCO Funded Tier 6	\$390.95

NOTE: ETRs will not be accepted for ESFs.

NOTE: Clients who agree to services at Unified Residential Care in Spokane are eligible for provider rate enhancement. The Case Manager will authorize the following:

For Clients at Unified Residential Care in Spokane eligible for CBHS:			
Tier	Service Code/ Modifier	Reason Code	Rate
Tier 1	T1020,U5	MCO Funded Tier 1	\$583.80
Tier 2	T1020,U5	MCO Funded Tier 2	\$522.09
Tier 3	T1020,U5	MCO Funded Tier 3	\$425.29
Tier 4	T1020,U5	MCO Funded Tier 4	\$414.95
Tier 5	T1020,U5	MCO Funded Tier 5	\$414.95
Tier 6	T1020,U5	MCO Funded Tier 6	\$414.95

For Clients at Unified Residential Care in Spokane not eligible for CBHS:			
Tier	Service Code/ Modifier	Reason Code	Rate
n/a	T1020,U5	No Reason Code Needed	\$620.10

Authorizing Contracted Behavior Support Provider (BSP) for ECS or SBS Clients

The maximum number of episodes or units of Behavior Support is 10 per month. Any request by the BSP for episodes in excess of 10 per month will require supervisory approval. Each ECS/SBS Client must receive a minimum of 1 unit per month to remain qualified for ECS/SBS.

The contracted Behavior Support service for AFHs is not available for the CSS service or in an ESF as those settings provide behavior support as part of the service package provided in the facility.



When an ECS or SBS Client is approved for Behavior Support, the Case Manager will authorize the Behavior Support service using Service Code: [T2025, U3 Client Training, Intensive Behavior Support](#).

Behavior Support services include:

- A professional evaluation to assess the Client's behavior support needs and a written Behavior Support Plan;
- A Crisis Plan to address steps for the residential setting staff to take when faced with a crisis situation, including a list of all formal and informal supports, medications, and strategies to use for de-escalation;

NOTE: The Behavior Support Plan and Crisis Plan may be referred to as BS/CP

- Regularly scheduled behavior support visits in the Client's residence, usually one to two times per week, with no more than ten visits per month (the HCS Field Services Administrator or designee may pre-approve additional visits on a case-by-case basis);
- Specialized training and consultation to facility staff on managing the Client's behaviors; and
- Monthly psychopharmacological management to ensure that appropriate levels and types of medications are prescribed.

An episode of service by a Behavior Support Provider must be at least a 15-minute interaction that is usually done in-person (but can be done by phone or virtually on a limited basis). If a staff of the Behavior Support Provider is dually credentialed (such as a Prescriber and a Clinician), the Behavior Support Provider may **not** bill for two separate services delivered by a dually credentialed staff on the same day.

Behavior Support Plans and Crisis Plans (BSCP) must be updated at least every six months. The Behavior Support Provider must provide a copy of all updated Behavior Support and crisis plans to both the residential setting provider and the Case Manager.

Note: The Behavior Support Provider may provide up to two episodes of service to individuals who are not in a residential setting, under the following specific criteria:

Criteria #1: The individual has not yet moved into a residential setting – The Behavior Support Provider could visit potential Client to develop a Behavior Support Plan and prepare the individual to transition into a community setting. These visits would occur in acute care hospitals or institutional settings (such as state hospitals, residential treatment facilities, or evaluation and treatment centers). The Case Manager must confirm the dates of the requested visits with the BSP and enter an authorization under RSW RAC that coincides with the Client's residential admission date. The BSP service is allowed to date and submit a claim for the visits after the authorization/admission date with supportive documentation that reflects visit(s) occurred prior to authorization. Utilization of SOAP RAC for BSP services is allowable for Clients discharges that fail to admit under RSW Services. *The Behavior Support provided must not include any duplicative services that would otherwise be available to the individual in the inpatient setting.*



If the individual has already moved into a residential setting and subsequently leaves the residential setting for a medical hospitalization in an acute care hospital or community hospital for a temporary stay, the Behavior Support Provider may visit the Client to provide services in alignment with the Behavior Support Plan.

Criteria #2: If the individual has already moved into a residential setting and subsequently leaves the residential setting for a mental health or behavioral hospitalization by going into an institutional setting (such as a state hospital, residential treatment facility, or evaluation and treatment center), the Behavior Support Provider may not provide services to the Client, as that would be duplicative of the services already available in an institutional setting.

These visits are an important component of the Client's Behavior Support services; however, the Behavior Support Provider cannot bill for these visits until the ECS/SBS Client moves into (or returns to) the residential setting.

When an ECS or SBS Client is authorized to receive services under the RSW, the assigned Case Manager will follow the Region-to-Region transfer process. Coordination includes identifying contact person(s) for communicating intent to transfer and coordinating with the residential provider and Behavior Support Provider services.

Clients eligible for ECS or SBS may receive both Behavior Support services and outpatient mental health services through the MCO to maintain their community residential setting, if needed.

Document the name and contact information of the Client's Behavior Support Provider and outpatient Mental Health services provider (if applicable) on the Contact Details CARE screen.

Note: Individuals accessing a Behavior Management Plan provided through a local community mental health provider (i.e. – PACT, IRT, SUD, out-patient mental services) are not eligible for ECS or SBS. This provision is created for instances where a Client declines a Behavior Support Provider referral in preference of a Behavior Management Plan from a community mental health provider. In this case, the CARE assessment must reflect the use of "Mental Health Therapy/Program" in the Medical Treatment section.

Case Managers must ensure that Behavior Support Provider services are not authorized when community mental services are providing a Behavior Management Plan to avoid duplication of services.

WHAT OTHER SERVICES ARE OFFERED UNDER THE RSW?

Adult Day Health (ADH)

Nursing, or rehabilitative therapy, services are available for Clients with medical or disabling conditions that require interventions or services from a registered nurse, licensed speech therapist,



occupational therapist, or physical therapist under the supervision of the Client's physician, when required. The need for ADH services must be identified in the Client's PCSP. Example – an ESF Client is eligible for speech therapy from an ADH center because the Client's assessment indicates this is needed.

ADH services may not duplicate any other Medicaid service received by the Client. See [Chapter 12](#) of the [LTC Manual](#) for more information on ADH.

Wellness Education

Wellness Education supports Client health literacy and Client engagement in healthcare. This service is provided by Smart Source. If a Client chooses to receive Wellness Education, it may be authorized for one unit per month using [Service Code SA080](#). Wellness Education provides targeted information based on the individual's CARE details and is mailed to the individual's address.

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.

Wellness Education is available in 28 languages, based on the Client's preferred written language in CARE. Some Clients indicate Braille in CARE but prefer to have Wellness Education read to them. If a Client with visual impairment wants Wellness Education in Braille, please contact the Wellness Education Program Manager to have the Client added to the list for Braille transcription.

Wellness Education Newsletters are offered in the following languages or formats:

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

QR Code read-out (Added 2025)

Specialized Equipment/Supplies and Durable Medical Equipment

Specialized Equipment and Supplies (SES) are non-medical equipment and supplies that are not covered by Health Care Authority, such as waterproof mattress covers, handheld showers (when used by the caregiver), urinals, and portable ramps that don't involve any structural modifications to the Client's home. These items 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.

Maintenance and upkeep of items covered under this service are also available, as well as training for the Client and caregivers for how to operate and maintain the equipment. Items reimbursed under RSW exclude items that are not of direct medical or remedial benefit to the Client; items requested that are not of a direct medical or remedial benefit are limited to \$700 per occurrence without an ETR.

Durable Medical Equipment (DME) as defined under [Chapter 182-543 WAC](#) include items which are:

- Medically necessary under [WAC 182-500](#);
- Necessary to increase the Client's ability to perform ADLs, or to perceive, control, or communicate with the environment in which the Client lives;
- Directly medically or remedially beneficial to the Client; and
- In addition to, and do not replace, any medical equipment and/or supplies otherwise provided under Medicare and/or Medicaid.

Refer to [LTC Manual COPES Chapter 7d](#) for additional directions on durable medical equipment, including how to authorize this service.

Nurse Delegation

This waiver service is authorized under [RCW 18.79.260](#) and [Chapter 246-840 WAC](#), and is available in AFHs with either an SBS or ECS contract. **This service is not available in ESFs or ALFs.** Nurse delegation can be provided in ALFs by the facility nurses. When the ALF provides nurse delegation, it is included in the ALF rate and is not authorized by the Social Services Specialist.

Under Nurse Delegation, a Registered Nurse (RN) delegates specific nursing care tasks, which are normally done by a nurse, to a qualified long-term care worker or caregiver who has completed the required training and is able to demonstrate that they are competent to perform the tasks to the satisfaction of the delegating RN.

For more information on nurse delegation, please see [Chapter 13](#) of the [LTC Manual](#).

Private Duty Nursing Services

This state plan service is available in AFHs, provided it does not duplicate nursing services included in the residential service. **It is not available in ESFs because nursing services are already provided in this setting.** Private Duty Nursing (PDN) is a program that provides in-home or Adult Family Home based skilled nursing care to Medicaid Clients 18 years of age and over who would otherwise be served in a Medicaid Medical Institution (MMI). Home and Community Services (HCS) is responsible for this service. PDN is an alternative to institutional care and is the program of last resort.



For more information about Nursing Services, including referral process and resources, see LTC Manual [Chapter 25 Private Duty Nursing](#).

Nursing Services

This is not a specific waiver service but is available to RSW Clients per [RCW 74.09.520 \(2\) \(b\) and \(c\)](#) and is available in AFHs with either an SBS or ECS contract. **This service is not available in ESFs.** Nursing Services offer Clients, providers, and Case Managers, health-related assessment and consultation to enhance the development and implementation of the Client's plan of care. These services are provided as an administrative function. This service does not require an authorization in ProviderOne since HCS and AAA nursing staff provide this function.

For more information about Nursing Services, including referral process and resources, see LTC Manual [Chapter 24 Nursing Services](#).

WHAT IF A RSW CLIENT WANTS TO MOVE?

If a RSW Client wants to voluntarily move out of the community residential setting or private setting, the Case Manager will work with the Client and provider to address any related issues, and work with the Client to find another community setting option. If case management responsibilities are transferred to another Case Manager, the former and current Case Managers will coordinate to ensure a smooth transition for the Client. CCG services may help an individual transition to a community setting of choice and receive RSW services in that setting, if eligible.

CAN A RSW CLIENT RECEIVE COMMUNITY CHOICE GUIDE (CCG) SERVICES TO SUPPORT MOVES AND TRANSITIONS?

Yes. It is the responsibility of the Client and case manager to determine the appropriate setting and RSW service; setting determination may not be assigned to a CCG, though after the setting is chosen the CCG can support the Client's move to that new community setting.

Community Choice Guide (CCG)

Community Choice Guide (CCG) Community Choice Guide (CCG) services can be authorized to Clients enrolled in RSW 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 RSW to assist the eligible RSW 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, ALF and ESF 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.

Tasks a CCG can be authorized to assist the case manager

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.
 - Note: 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.

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](#).

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. See additional Client Training information in [Chapter 7d: COPES or](#) RSW 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 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 of 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 in [Chapter 7d: COPES](#) site.



NOTE: For more information on how to authorize CCG services please refer to the For more information and guidance related to CCG services and authorization steps, please review [Chapter 7d – COPES](#) and the [CCG Services SharePoint](#).

Community Choice Guide is one of the several stabilization services available to RSW participants. The Washington Roads service package may also be beneficial. See [Chapter 5a](#) for more information.

WHAT IF A RSW CLIENT NEEDS HOSPICE?

An RSW Client may receive hospice services as long as the hospice services are not duplicative of any service available under the RSW.

WHAT ARE THE CASE MANAGEMENT RESPONSIBILITIES REGARDING HOSPITAL DISCHARGES TO AN ESF?

When a Client chooses an ESF setting, the Regional RSW Team will coordinate with the ESF Administrator—who is contractually responsible for oversight of the facility—to ensure all needed services and supports are in place for the Client prior to the Client moving into the ESF. The ESF Administrator is responsible for coordinating with the local MCO to provide mental health services to the Client.

The Case Manager will work with the “transferring facility” (state hospital, psychiatric facility, or residential facility) to coordinate details such as medications, appointments with prescribers, equipment, legal issues, etc., in preparation for the Client’s move into the ESF.

The Case Manager should be involved in all activities and planning for the Client’s transition to the community and has the following specific duties:

- Review and approve the ESF provider’s pre-admission assessment and transition plan prior to admission;
- Ensure the Client has an adequate supply of medications prior to discharge;
- Ensure the Client has an appointment with a medication prescriber in the community prior to discharge; and

When the Client is ready to move to the facility, the Case Manager or hospital assessor will:

- Authorize services;
- Notify the financial worker of the discharge date using [DSHS Form 14-443](#); and
- Authorize the payment to the provider, effective the date the Client is to move into the facility.

As best practice, when a Client is transitioning to an ESF, the Case Manager must:

- Ensure Clients only move into an ESF at the beginning of the week (Monday-Wednesday);
- Visit the Client in the facility frequently (Based on Client’s transitional needs)

- How frequently the Case Manager visits the Client is dependent on Client need and the required core and supportive functions of the Case Manager. For Case Management policy, please see [LTC Manual Chapter 5: Case Management](#).
- Regularly review the Behavior Support Plans;
- Participate in the Client's PCSP Team meetings; and
- Conduct the initial Client visit within three business days of the Client transition into the ESF.

WHAT IF A RSW CLIENT'S LESS-RESTRICTIVE ALTERNATIVE (LRA) IS EXPIRING?

Any RSW Client who wants to transition from an RSW setting to another living situation should receive support and transition services from the Client's PCSP Team. If a Client is on a Less-Restrictive Alternative (LRA), the PCSP Team should begin the transition planning well in advance of the LRA expiration date. The RSW Client must be included in all discussions regarding transition planning.

WHAT ARE THE RESIDENTIAL PROVIDER MEDICAID CONTRACT REQUIREMENTS?

ECS Contract Requirements

To be eligible for the ECS contract:

- ALFs and EARC's must be licensed under [Chapter 18.20 RCW](#) and [Chapter 388-78A WAC](#), meet all qualifications established within this RCW and WAC, and:
 - The license holder must be licensed with the State of Washington for twelve months preceding the application for an AL-ECS or EARC-ECS contract; and
 - The license holder and any affiliates must have no significant enforcement actions during the twelve months preceding the application for the AL-ECS or EARC-ECS contract.
- AFHs must be licensed under [Chapter 70.128 RCW](#) and [Chapter 388-76 WAC](#) and meet all qualifications established within the RCW and WAC. In addition, AFHs must meet the criteria and qualifications of the Expanded Community Services contract, and:
 - The AFH license holder must be licensed with the State of Washington for twelve months preceding the application for an AFH-ECS contract; and
 - The AFH license holder and any affiliates must have no significant enforcement actions during the twelve months preceding the application for the AFH-ECS contract.

An AFH or ALF Provider must complete ECS Contract Training (provided by the Regional Resource Specialist) prior to receiving the contract.

SBS Contract Requirements

To be eligible for the SBS contract, AFHs must be licensed under [Chapter 70.128 RCW](#) and [Chapter 388-76 WAC](#), meet all qualifications established within this RCW and WAC, and:

- The AFH license holder must have a Washington State AFH license for at least 12 months prior to applying for this contract;
- The AFH license holder and any affiliations must have had no significant enforcement actions during 12 months prior to applying for this contract; and
- The AFH license holder must have a demonstrated history of successfully working with people with behavioral challenges.

Note: A demonstrated history can be either positive or negative. The HCS Regional Administrator may deny an SBS contract if the provider has a **negative** history of working with individuals with challenging behavior that includes any of the following:

- Not accepting Clients back when they go to the hospital;
- Frequently issuing 30-day discharge notices to Clients;
- A pattern of disregarding Client rights;
- A pattern of not complying with general AFH contract requirements;
- A pattern of not working with the contracted Behavior Support Provider; or
- Declining referrals for ALTSa assistance (RCS Behavioral Health Support Team and/or HCS Behavioral Support Training).

An AFH provider must complete SBS Contract Training (provided by the Regional Resource Specialist) prior to receiving the contract.

Note: An AFH with an SBS contract may only serve up to three SBS residents at any given time. One additional SBS resident may be authorized at the discretion of the HCS Regional Administrator, who must review the performance history of the AFH. If the AFH has a positive history and has had no RCS citations or RCS enforcement actions within the prior 12 months, the HCS Regional Administrator may authorize up to one additional SBS resident for the AFH. **An AFH may not have more than four SBS residents.** If the fourth SBS Client leaves or is discharged, any new SBS referral for the fourth SBS bed must be staffed with the HCS Regional Administrator. The HCS Regional Administrator will coordinate with the assigned Case Manager to submit documentation of the approval or denial of the specific fourth SBS resident. Documentation may be represented as either email confirmation of approval/denial or formalized regional letter.

CSS Contract Requirements

To be eligible for the CSS contract, ALFs must be licensed under [Chapter 18.20 RCW](#) and [Chapter 388-78A WAC](#), meet all qualifications established within this RCW and WAC, and:

- The license holder and any affiliates must have no significant enforcement actions during the twelve months preceding the application for the CSS contract.
- The ALF must have the EARC **and** ECS contracts.
- The ALF license holder must have a demonstrated history of successfully working with people with behavioral challenges.



Note: A demonstrated history can be either positive or negative. HQ may deny a CSS contract if the provider has a **negative** history of working with individuals with challenging behavior that includes any of the following:

- Not accepting Clients back when they go to the hospital.
- Frequently issuing 30-day discharge notices to Clients.
- A pattern of disregarding Client rights.
- A pattern of not complying with general ALF/ECS contract requirements.
- A pattern of not working with the contracted Behavior Support Provider.
- Declining referrals for ALISA assistance (RCS Behavioral Health Support Team and/or HCS Behavioral Support Training).
- Have demonstrated ability to provide or arrange for all required staff trainings.
- Ensure that qualified professionals are available as required by the CSS contract to provide direct services and supports to the Clients.

NOTE: Providers interested in contracting for CSS should contact the HQ Resource Support and Development team at ResourceDevelopment@dshs.wa.gov.

ESF Contract Requirements

To be eligible for the ESF contract, ESFs must be licensed under [Chapter 70.97 RCW](#) and [Chapter 388-107 WAC](#), meet all criteria and qualifications within this RCW and WAC, and must:

- Have demonstrated experience providing services and supports to adults with challenging behavior;
- Have demonstrated ability to serve individuals whose criminal or behavioral history has kept them from being served in the community;
- Have demonstrated ability to provide or arrange for all required staff trainings; and
- Ensure that qualified professionals are available as required to provide the direct services and supports to the Clients.

NOTE: An ESF may accept private-pay residents. In doing so, the ESF:

- Nurse will need to assess the individual;
- Must determine, in advance, the payment/rate for private-pay status;
- Must have a clear, documented list of all charges for private-pay status that is provided to the resident;
- Must have a clear, documented list of all charges for private-pay status that is provided to the resident;
- Must have a clear, documented process for private-pay billing; and
- Must utilize an Admission Agreement to ensure the resident understands – and agrees to – why and how the resident’s funds are being spent.



HOW ARE CONTRACTS MONITORED?

Contracts with residential settings Adult Family Homes (AFH), Assisted Living Facilities (ALF), and Enhanced Services Facilities (ESF) that provide Residential Support Waiver (RSW) services are actively monitored. This includes oversight of Behavior Support Provider (BSP) contracts.

The Home and Community Programs Contract Monitoring Team is responsible for monitoring contracts for Enhanced Community Services (ECS), Specialized Behavioral Support (SBS), Community Support Services (CSS), and Behavior Support Providers. Each team member is assigned to a specific region and collaborates closely with HCS Regional Administrators to prioritize which facilities or agencies will be monitored.

The RSW Program Manager oversees monitoring of ESF contracts.

To meet the AFH provider contract requirement for monthly meetings, monthly staffing between BSPs and Case Managers are considered sufficient.

Any concerns regarding contract compliance should be immediately staffed with the local RSW Supervisor to determine whether a referral to the Contract Monitoring Team or the Behavior Training/Support Team is appropriate. Referrals for contract monitoring may be submitted via email: hcpcontractmonitoring@dshs.wa.gov. Referrals for HCS Behavior Support Team for providers may be submitted via email: BSTRef@dshs.wa.gov

RESOURCES

Related WACs and RCWs

WAC 182-500	Medical Definitions
WAC 182-512-0050	SSI-related medical—General information
WAC 182-551-2100	Skilled nursing services
WAC 182-543	Medical Equipment, Supplies, and Appliances
WAC 246-840	Practical and Registered Nursing
WAC 388-106-0336	What services may I receive under the residential support waiver?
WAC 388-106-0337	When are you not eligible for adult day health services?
WAC 388-106-0338	Am I eligible for services funded by the residential support waiver?
WAC 388-106-0340	When do services from the residential support waiver start?
WAC 388-106-0342	How do I remain eligible for residential support waiver services?
WAC 388-106-0344	How do I pay for residential support waiver services?
WAC 388-106-0346	Can I be employed and receive residential support waiver services?
WAC 388-106-0348	Are there waiting lists for the residential support waiver services?
WAC 388-106-0355	Am I eligible for nursing facility care services?
WAC 388-107-0030	Admission Criteria
WAC 388-107	Licensing requirements for enhanced services facilities
WAC 388-76	Adult Family Home Minimum Licensing Requirements
WAC 388-78A	Assisted Living Facility Licensing Rules
RCW 18.20	Assisted Living Facilities
RCW 18.79.260	Registered nurse—Activities allowed—Delegation of tasks
RCW 70.97	Enhanced services facilities
RCW 70.97.030	Admission criteria
RCW 70.128	Adult Family Homes
RCW 70.129	Long-term care resident rights
RCW 74.09.520	Medical assistance—Care and services included—Funding limitations.
CMS [42 CFR 441.301(c)(2)]	Home and Community-Based Services (HCBS)

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
8/21/2026	JD Selby	- Added 5 RSW Care Eligibility Questions - Clarified Functional And Financial Eligibility - Updated ECS Alf Add On Service Code - Updated And Clarified CCG Per Regions' Recommendations - ECS Provider and CM Responsibilities - SBS Provider and CM Responsibilities - CSS Provider and CM Responsibilities - ESF Provider and CM Responsibilities	



		• ESF PCSP TEAM, ROLES AND RESPONSIBILITIES • ESF STAFFING • CSS STAFFING • CSS PROVIDER RESPONSIBILITIES	
4/7/2026	JD Selby	• Clarified Service code authorizations • Functional and financial eligibility • ESFs eligibility • Updated use of BMP, BEP	
7/14/2025	Jamie Tong	• Updated multiple chapter sections for grammar and flow in chapter per regional feedback. • Clarified Fast-Track process.	
07/01/2024	JD Selby	• Updated multiple chapter sections to reflect regional feedback to include: • Revisions for RSW referral process and regional contacts for RSW referral submissions and integration of State Hospital Discharge and Diversion (SHDD) teams for ESF & Community Stability Supports (CSS) service coordination, • Updates for RSW Committee review for eligibility and service determinations, • Revised language for RSW Fast Track utilization, • Updates to ECS and SBS Case Management and frequency of monitoring, • Integration of CSS services into RSW chapter, • Updates for Wellness Education newsletter language and formats, • Updates for provider contract requirements section to reflect current contracting agreements, • Updates for contract monitoring • Inclusion of July 1, 2024 1915i waiver/Community Behavioral Health Support (CBHS) service information to include: • Updates for management of Behavioral Health Personal Care (BHPC) and Managed Care Organization (MCO)	H24-046

		utilization of Behavioral Health Wraparound Supports (BHWS), • References for Chapter 22a for coordinating additional MCO behavioral supports, • Updates to CSS and ESF tier CARE authorizations • Corrected all broken or missing links • Added or updated attachments to the appendix: • Service Level Guidance For RSW-Eligible Individuals • RSW and EBS Eligibility Determination form • Repaired links for DSHS forms 11-130, 15-596 • RSW/EBS Referral Flow Chart • BHPC + RSW to CBHS Crosswalk	
12/14/2023	JD Selby	• Updated CMS approval for RSW renewal	H23-086
7/1/2023	JD Selby	• Updated “Ask the Expert” for current RSW Program Manager contact information • Chapter section updates for RSW Referrals, RSW Eligibility and Service determinations • Inclusion of Community Stability Supports (CSS) information • Based on regional feedback, provided clarifying language and references regarding ○ RSW referral and eligibility and service determination ○ Utilization of ALTSA and MCO-funded codes for ESF • Corrected all broken or missing links • Added attachments to the appendix: ○ Service Level Guidance For RSW-Eligible Individuals ○ RSW Referral Requirements Elements ○ RSW-SBS Staffing Schedule Template	

1/8/2020	Sandy Spiegelberg	Minor content changes and updated to new format	
5/19/2020	Sandy Spiegelberg	Clarify Wellness Education, add the RSW CFC Ancillary Fast Track RAC, and update the ESF Referral Process to replace the Clinical Review with a review by the Mental Health Nurse Program Manager	
11/1/2020	Sandy Spiegelberg	Clarify the one-to-one additional support for SBS Clients, clarify the use of Behavior Management Plan or Behavior Evaluation Program, update how to access MCO funding, update the Resource list to include additional statutes and the licensing regulations, and update the Table of Contents.	
3/1/2021	Sandy Spiegelberg	Change ECS monthly meeting requirement to as needed, but at least every six months; add financial eligibility language; clarify that AFH Providers are responsible for scheduling monthly SBS PCSP Team meetings; clarify the services provided by the Behavior Support Provider; and make formatting and grammatical changes	
8/1/2021	Sandy Spiegelberg	Explain how an AFH can increase the number of SBS Clients from 3 to 4; add a limit of 4 SBS Clients per home; allow HCS regions to provide SBS staffing schedule examples to AFH providers; require AFHs to receive SBS contract training before receiving the contract; clarify the role of the contracted Behavior Support Provider; and make formatting and grammatical changes.	
3/1/2022	Sandy Spiegelberg	Clarify that Case Managers must ensure SBS 1:1 staffing is hired before authorizing the service; clarify that a dually-credentialed staff of a Behavior Support Provider cannot bill for two services provided at the same time; provide guidance to HCS staff on AFH Provider eligibility for the SBS contract and the consideration of negative	



		history; provide ESF daily rate; identify contract monitoring responsibilities; and address hospice services for an RSW Client.	
6/1/2022	Sandy Spiegelberg	• Update Table of Contents; clarify steps to take when an ECS Client refuses services; add new example for SBS Staffing Schedule; add that providers must take ECS Contract Training before receiving the contract; clarify ESF referral process; add requirements for accepting private-pay residents in an ESF; and minor grammatical changes.	



Chapter 7g – State-Funded Programs

This chapter provides an introduction to the state-funded programs currently available to individuals who are not eligible to receive Medicaid funded programs but wish to remain in or return to their own communities through the provision of coordinated, comprehensive and economical home and community-based services.

Ask the Expert

If you have questions or need clarification about the content in these Appendices, please contact the expert(s) listed in each Appendix section.

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CHORE

Ask the Expert

If you have questions or need clarification about the content of Chore, please contact:

Becca Howard

HCBS Waiver Program Manager

564-263-0839

Rebecca.Howard@dshs.wa.gov

What is Chore? [WAC 388-106-0600](#) through 0630

Chore is a program using state-only funds. **Chore was frozen to new applicants as of August 2001. Do not authorize Chore services for any new clients** or clients on other home and community-based services. Current Chore clients have been grandfathered into the program. Chore is the only program that allows a spouse to be a paid caregiver; however, the monthly payment to the spouse CANNOT exceed the monthly income limit for the Medical Care Services (MCS) medical program per [WAC 388-478-0090](#).

A client may remain on the Chore program until he/she:

- Becomes eligible for MPC or CFC;
- No longer meets functional or financial eligibility for Chore;
- No longer has a spouse being paid to provide care and the client is eligible for MPC or CFC;
- Has a break in services; or
- Chooses to terminate services.

Once terminated from CHORE services, clients cannot return to the program.

Who is eligible?

To be eligible for Chore, the client must meet the following eligibility criteria:

- Reside in a private home (not a licensed residential setting);
- Be grandfathered on the Chore program before August 1, 2001, and have continued to receive Chore without a break in service;
- Be 18 years of age or older;
- Meet [Functional Eligibility](#) - the participant continues to be functional eligibility for the program based on his/her CARE assessment. To be eligible, the individual must have an unmet or partially met need outlined in [WAC 388-106-0610](#);
- Meet Financial Eligibility **as determined by the case manager at least annually** or when there is a change in income. The case manager also determines participation for Chore clients. Instructions for both financial eligibility and determination of participation are provided in [Chapter 7a](#) – Core Long-Term Services & Supports Financial Eligibility.



What services are available?

The only service available under the Chore program is personal care services. The monthly benefit is the number of hours generated by CARE up to a **maximum limit of 116 hours**. If it is determined that additional hours are needed, an ETR must be submitted via CARE.

An ETR approved by the HQ ETR committee is required when the number of monthly hours being requested exceed the number of monthly hours generated by CARE.

An ETR approved by the HQ Chore Program Manager is required under the following circumstances:

1. The client is eligible for MPC or CFC but wants to remain on Chore to keep their spouse as the paid caregiver;
2. Authorizing a payment to a spouse provider in excess of MCS standard;
3. Requesting more than the program limit of 116 hours per month, but equal to or less than the base hours generated by CARE.

NOTE: A separate ETR must be submitted for [#1 and/or #2] and #3 of the above three reasons. For example, you cannot submit one ETR to allow payment to a spouse in excess of Medical Care Services (MCS) standard and to request hours above the 116 hour limit. They must be two separate ETRs. You may submit one ETR when the client is requesting to remain on Chore to keep a spouse provider even though they are now eligible for MPC or CFC AND the payment to the spouse provider will exceed the MCS standard.

Who are the qualified providers?

Clients on the Chore program may choose to receive services from the following qualified provider types:

- Individual Provider (IP) who:
 - Has a current contract with DSHS or AAA
 - Passes a BCCU criminal history background check
 - Meets all training and certification requirements outlined in [WAC 388-71-0500 through 1006](#).
- Home Care Agency (HCA) that:
 - Is licensed by Dept. of Health per [Chapter 70.127 RCW](#) and Chapter [246-335 WAC](#)
 - Has a current DSHS contract with an AAA

Where can individuals receive services?

Personal care services provided through the Chore program are delivered in the client's home. Personal care services may also be provided for tasks completed outside of the client's home, as specified in the service plan, in order to support clients to access other services in the community. Personal care may be furnished to assist a person to function in the workplace or as an adjunct to the provision of employment services.

MEDICAL CARE SERVICES

Ask the Expert

If you have questions or need clarification about the content of Medical Care Services, please contact:

Emily Watts Residential Policy Program Manager
360.725.3426 emily.watts1@dshs.wa.gov

What is State-funded Medical Care Services? [WAC 182-508-0005](#) and [0150](#)

Medical Care Services (MCS) is a small program funded 100% by state dollars. LTC services are limited and only available in certain residential settings. A person can be placed in these settings on MCS without a NGMA being completed first. Clients on this program are not eligible for waiver services unless there is a change in the client's citizenship status.

MCS clients must pay for room and board (R&B). However, ACES does not create and send cost of care letters therefore the case worker must calculate R&B. R&B is determined by subtracting the client's personal needs allowance (PNA) from their countable income and/or cash grant. The remaining income is applied to R&B up to the R&B standard. **Case managers must send a copy of [DSHS 18-720 Client Responsibility Notice informing clients of their R&B amount](#).** Please see [Chapter 8](#) for additional information on determining R&B.

Who is eligible?

Individuals may receive services under this program if they are:

1. Immigrants in their 5-year Medicaid bar or lawfully present non-citizens not subject to the 5-year bar (previously known as PRUCOL); and
2. Eligible for aged, blind disabled (ABD) cash program or housing and essential needs (HEN) program; and
3. Determined functionally eligible for MPC or CFC; and
4. Determined to be financially ineligible for CFC or MPC because of their citizenship status.

What services are available?

Available services in this program include:

- Skilled Nursing Facility services
- Personal care services in a residential setting
- Nurse delegation in an AFH or ARC
- Additional services can be found in Column MCS of [WAC 182-501-0060](#). Details on what is included in each service category are available in [WAC 182-501-0065](#).



Who are the qualified providers?

Clients may choose from the following qualified provider types:

- Skilled Nursing Facility that:
 - ✓ Is Medicaid certified
- Adult Family Home (AFH) that has a current:
 - ✓ AFH license under [Chapter 70.128 RCW](#) and [Chapter 388-76 WAC](#); and
 - ✓ Contract with DSHS
- Adult Residential Care (ARC) facility that has a current:
 - ✓ Assisted Living Facility (ALF) license under [Chapter 18.20 RCW](#) and [Chapter 388-110 WAC](#); and
 - ✓ Contract with DSHS

Where can individuals receive services?

Under this program, clients may choose to receive services in a nursing facility, adult family home or adult residential care facility. In-home services are not allowed.

LONG-TERM CARE SERVICES FOR NON-CITIZENS

If you have questions or need clarification about the content of Long-Term Care service for Non-Citizens, please contact:

Emily Watts	Assisted Living Facility Policy Program Manager
360.725.3426	hcsresidentialpolicy@dshs.wa.gov

What is State-funded LTC for Non-Citizens? [WAC 182-507-0125](#)

The State-funded LTC for Non-Citizens program is available to clients who do not qualify for any other Medicaid program or the State-funded MCS program and have heavy care needs. It is used only as a last resort. There are a limited number of slots statewide for this program. There is a long wait list for this program. Enrollment requires approval from HCS HQ program manager.

ACES calculates Room and Board (R&B) for clients in the L24 coverage group and sends a client letter.

Note: Alien Emergency Medical (AEM) is a separate Medicaid program that offers coverage for qualifying medical emergencies. AEM is overseen by the Healthcare Authority. It does not provide LTC services.

For more information on how to apply and what is covered, please visit the [HCA Apple Health Alien Emergency Medical page](#).

Who is eligible?

Individuals may receive services under this program if they are:

- Age 19 or older;



- Not eligible for federally funded **Medicaid** or state-funded **Medical Care Services (MCS)** **because of their citizenship status**
- Assessed in CARE to meet nursing facility level of care, there is no NGMA requirement for this program

What services are available?

Available services in this program include:

- Personal care services in a client's own home or a licensed residential setting
- Specialized Dementia Care Program
- Nurse delegation in an AFH or ARC
- Skilled Nursing Facility services
- Additional services can be found in Column CN 21+ of [WAC 182-501-0060](#). Details on what is included in each service category are available in [WAC 182-501-0065](#).
- Washington Roads Services (available for SNF and acute care clients only)
- Medical Escort and Medical Mileage (available for AFH clients only)

Individuals
Non-Citizen
program are
for:

Prior to receiving Washington Roads services, case managers must receive HQ approval from the MCS Program Manager or a delegate. For more information on Washington Roads, please see [Chapter 5a](#).

on the LTC
Medicaid
not eligible

- Expanded Community Services (ECS)
- Specialized Behavioral Support (SBS)
- Enhanced Service Facilities (ESF)

If you are looking for information on the 100% state funded GOSH service and subsidy, please see [Chapter 5b: Housing Resources for HCS Clients](#).

Who are the qualified providers?

Clients choosing to live in their own home may select from the following qualified provider types:

- Individual Provider (IP) who:
 - Has a current contract with DSHS or AAA
 - Passes a BCCU criminal history background check
 - Meets all training and certification requirements outlined in [WAC 388-71-0500 through 1006](#).
- Home Care Agency (HCA) that:
 - Is licensed by Dept. of Health per [Chapter 70.127 RCW](#) and [Chapter 246-335 WAC](#)
 - Has a current DSHS contract with an AAA

Clients choosing to live in a residential setting may select from the following qualified provider types:

- Skilled Nursing Facility that:

- ✓ Is Medicaid certified
- Adult Family Home (AFH) that has a current:
 - ✓ AFH license under [Chapter 70.128 RCW](#) and [Chapter 388-76 WAC](#); and
 - ✓ Contract with DSHS
- Adult Residential Care (ARC) facility that has a current:
 - ✓ Assisted Living Facility (ALF) license under [Chapter 18.20 RCW](#) and [Chapter 388-110 WAC](#); and
 - ✓ Contract with DSHS
- Enhanced Adult Residential Care (EARC) facility that has a current:
 - ✓ Assisted Living Facility (ALF) license under [Chapter 18.20 RCW](#) and [Chapter 388-110 WAC](#); and
 - ✓ Contract with DSHS
- Assisted Living that has a current:
 - ✓ Assisted Living Facility (ALF) license under [Chapter 18.20 RCW](#) and [Chapter 388-110 WAC](#); and
 - ✓ Contract with DSHS

Where can individuals receive services?

Under this program, clients may choose to receive services in their own home, an adult family home (AFH), adult residential care (ARC), enhanced adult residential care (EARC), assisted living (AL), or a nursing facility.

How can a client get added to the waitlist?

An application for long term care services must be submitted by the client or a representative prior to requesting placement on the waitlist. This is to ensure the client meets financial eligibility and is not eligible for any other services. The case manager only needs to screen the client for nursing facility level of care; a full assessment is not required until client has been awarded a slot.

After the application has been reviewed, the PBS or case manager will send an e-mail to hcsresidentialpolicy@dshs.wa.gov with the following information:

- Client's Name
- Client ID (if available)
- ProviderOne Number (if available)
- Date of Birth
- Current residence or setting, including the address
- Client or representative contact information
- Primary diagnoses or care services required

Once this information is received, the client will be added to the waitlist effective the date of initial request. An e-mail confirmation will be sent once the client's information has been added to the waitlist. The HQ Program Manager will notify the client/representative, Public Benefit Specialist, and Case Manager once a spot becomes available.



GUARDIANSHIP AND CONSERVATORSHIP ASSISTANCE

If you have questions or need clarification about the content of Guardianship and Conservatorship Assistance program, please contact:

Sarah Tremblay Guardianship Program Manager
360.725.3704 office sarah.tremblay@dshs.wa.gov

What is State-funded Guardianship and Conservatorship Assistance Program (GCAP)? **WAC 388-106-2100**

The State-funded Guardianship and Conservatorship Assistance program is available to LTSS eligible clients who are currently hospitalized in an acute care hospital, have been determined to no longer have decision making capacity, and who do not have an identified legal decision maker needed to access LTSS benefits for hospital transitions. It is used only as a last resort who no other available, less restrictive decision maker is available to serve the client. There are a limited number of slots statewide for this program. There can be a wait list for this program, dependent on tier designation required to meet the client's needs. Enrollment requires approval from HCS HQ program manager.

Note: The Office of Public Guardians (OPG) is a separate guardianship and conservatorship program that offers decision maker services for qualifying individuals. OPG is overseen by the Administrative Office of the Courts (AOC).

For more information on how to apply for a public guardian or conservator and to verify what is covered, please visit the OPG website at [Washington State Courts - Guardian Portal](#)

Who is eligible? WAC388-106-2110(2)-(3)

At the time of referral and eligibility determination, individuals may receive services under this program if they:

- Are age 18 or older;
- Meet long-term care services and supports (LTSS) Medicaid functional eligibility requirements in [chapter 388-106 WAC](#) and financial eligibility requirements in [WAC 182-513-1315\(1\)-\(3\)](#) or be determined provisionally approved;
- Do not have financial resources to pay for guardianship services, fees, or costs from their estate;
- Are occupying an acute care hospital bed, and not be in a restricted sub-group including current occupancy in a bed readiness program, skilled nursing facility, inpatient rehabilitation, inpatient mental health, emergency department, long-term acute care hospital bed, facility bed under observation status, or in a facility bed under a single bed certification pursuant to a cause under [Chapter 71.05 RCW](#);
- Determined to be non-decisional for consent to LTSS services purposes and have no identified less restrictive legal representative willing or able to provide consent to LTSS services or to serve as guardian or conservator;



- Who have at least one qualifying neuro-cognitive diagnosis as defined om [WAC 388-106-2105](#);
- No longer requires an inpatient level of care at an acute care hospital;
- Likely require the appointment of a guardian or conservator to be able to access and maintain long-term services and supports.

What services are available?

Available services in this program include:

- Professional guardianship services
- Professional conservatorship services
- Limited filing and case related service fees
- Additional services information can be found in [WAC 388-106-2100](#). Details on tier terms are available in [WAC 388-106-2105](#).

Who are the qualified providers? [WAC388-106-2110\(1\)](#)

All GCAP providers:

- Hold a current DSHS GCAP contract and maintain sufficient insurance coverage per contract terms;
- Hold certification Certified Professional Guardians and Conservators approved by the state of Washington supreme court;
- Must be in good standing with the certified professional guardian and conservator review board (CPGCRB); and
- Pass a BCCU criminal history background check.

While every effort is made to ensure client preference and client choice in the nomination of a proposed guardian and conservator contractor, the Court has ultimate determination as to which contractor is appointed, if any.

Where can individuals receive services?

Under this program, clients may choose to receive services in their own home, an adult family home (AFH), adult residential care (ARC), enhanced adult residential care (EARC), assisted living (AL), specialized dementia care program (SDCP) facility, or a nursing facility.

How can a client get added to the waitlist? [WAC 388-106-2120](#)

A client will be added to the waitlist by the Guardianship Program Manager after the Acute care hospital has completed the referral procedure outlined in [Chapter 388-106-2115 WAC](#) and:

- The individual is determined eligible for GCAP services;
- It is determined that there is not an appropriate GCAP program slot available for the eligible individual based on the client's tier designation;
 - a. If a person is found eligible for a tier 2 slot, but at the time of acceptance only a tier 1 slot is available, DSHS will accept the person into the tier 1 slot while simultaneously placing



the person on the waitlist for a tier 2 slot. Acceptance into the tier 2 waitlist does not guarantee that a person will be accepted into the program under a tier 2 slot designation.

An e-mail confirmation will be sent once the client's information has been added to the waitlist. The Guardianship Program Manager will notify the client/representative, Public Benefit Specialist, and Case Manager once a spot becomes available.

- ❖ Waitlist priority is determined based on a first-come basis utilizing the date DSHS receives a complete referral packet and DSHS completes an eligibility determination for the person.
- ❖ Being added on the waitlist does not guarantee that a person will be accepted into the program.

RESOURCES

Acronyms

AAA	Area Agency on Aging
ABD	Aged, Blind, Disabled
AEM	Alien Emergency Medical
AFH	Adult Family Home
ALF	Assisted Living Facility
AOC	Administrative Office of the Courts
ARC	Adult Residential Care Facility
BCCU	Background Check Central Unit
CARE	Comprehensive Assessment and Reporting Evaluation
CFC	Community First Choice
COPES	Community Options Program Entry System
DSHS	Department of Social and Health Services
EARC	Enhanced Adult Residential Care Facility
ECS	Expanded Community Services
ESF	Enhanced Services Facility
ETR	Exception to the Rate/Rule
GCAP	Guardianship and Conservatorship Assistance Program
GOSH	Governor's Opportunity for Supportive Housing
HCA	Health Care Authority
HCA	Home Care Agency
HCBS	Home and Community Based Services
HCLA	Home and Community Living Administration
HCS	Home and Community Services
HEN	Housing and Essential Needs
HQ	Headquarters
IP	Individual Provider
LTC	Long-Term Care
LTC-NC	Long Term Care for Non-Citizens
LTSS	Long Term Services and Supports
MCS	Medical Care Services

MPC	Medicaid Personal Care
NGMA	Non-Grant Medical Assistance
OPG	Office of Public Guardians
PBS	Public Benefit Specialist
PNA	Personal Needs Allowance
R&B	Room and Board
RCW	Revised Code of Washington
SBS	Specialized Behavior Support
SDCP	Specialized Dementia Care Program
SER	Service Episode Record
SNF	Skilled Nursing Facility
WAC	Washington Administrative Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/2026	Emily Watts Becca Howard	• Updated MCS Program and included services available link as well an information on R&B • Updated LTC NC Program, no longer requires NGMA • Updated contact information	
7/2025	Annie Moua	• Update ALTSA to HCLA and DDA to DDCS	TBD
4/2025	Annie Moua	• Update template • Remove CFC from programs individuals on LTC-NC are not eligible for	

Chapter 7h – Appendices

Chapter 7h describes the various appendices that pertain to Home and Community Based Service (HCBS) programs, services, and case management activities.

Ask the Expert

If you have questions or need clarification about the content in these Appendices, please contact the expert(s) listed in each Appendix section.

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APPENDIX I: COORDINATION WITH DEVELOPMENTAL DISABILITIES COMMUNITY SERVICES (DDCS)

Ask the Expert

If you have questions or need clarification about the content in Appendix I, please contact:

Melissa Randles State Plan Services Unit Manager
360-407-1515 Melissa.Randles@dshs.wa.gov

The Developmental Disabilities Community Services (DDCS) strives to transform lives by providing support and fostering partnerships that empower people to live the lives they want. Individuals with developmental disabilities may be served by DDCS, Home & Community Services (HCS), the Area Agency on Aging (AAA) or a combination of these entities.

DDCS implements Community First Choice (CFC), Roads to Community Living (RCL) and Medicaid Personal Care (MPC) programs just like HCS and the AAAs. All administrations operate these programs using the same program rules (WAC). What is important to remember is that no individual can be on the same program with two different divisions/agencies.

The CFC and MPC programs are managed by DDCS for:

- individuals of all ages who have a developmental disability, and
- children who do not have developmental disabilities but who meet the functional eligibility criteria. This includes youth who are in foster care placements with Children's Administration up to their 21st birthday.

Determination of developmental disability under [Chapter 388-823 WAC](#) does not guarantee eligibility for, or access to, paid services. Clients must still meet the eligibility requirements for the service. Access is governed by capacity and/or funding, unless it is a State Plan service.

When DDCS determines that a person does not have the condition of a developmental disability, DDCS must coordinate access to other services including long-term care or other DSHS services for which the person may be eligible.

CFC and MPC services for adults are authorized by both HCS and DDCS under the same federal and state rules. Clients cannot be authorized for CFC or MPC from both HCS and DDCS at the same time. If HCS/AAA receives a request for services from an adult with a developmental disability, it is important to inform that individual of the availability of DDCS case resource management to assess, authorize and provide services. The individual may receive CFC or MPC services from HCS/AAA while completing the enrollment process for DDCS. Once DDCS eligibility has been determined, the HCS/AAA worker should coordinate with the DDCS case resource manager to transfer the case to DDCS. **This coordination must be completed without a disruption of services to the client.**

Coordination/transfer of client services between DDCS and HCS/AAA may occur for the following reasons:

- Adult DDCS clients and applicants may request HCS/AAA services;



- Adults with disabilities who are determined to be DDCS clients may also gain access to services from HCS/AAA that are not available from DDCS (like Adult Day Health). While adults may receive COPEs waiver services from HCS and state-only funded services (like employment services, State Supplementary Payment (SSP) program or Individual & Family Services) from DDCS at the same time, they can only be enrolled in one waiver at any given time.
- Adults with developmental disabilities receiving HCS/AAA services may apply to DDCS for services if they are not already DDCS enrolled.

Communicate with a DDCS case resource manager when there is a need to transfer or coordinate services:

- DDCS will authorize client services available through DDCS once a determination of developmental disability has been made.
- HCS/AAA will be the primary case manager in CARE when authorizing nursing facility or HCS waiver services (such as COPEs) to DDCS clients.
- Clients do not have to disenroll with DDCS to receive HCS services.
- HCS/AAA may refer clients to DDCS for a determination of developmental disability, but long-term care services will be initiated or continued by HCS/AAA pending the DDCS determination. Services must not be interrupted during the transition from HCS/AAA to DDCS for on-going service delivery.
- Developmental disability determination decisions by DDCS may be appealed by the client, but not by department staff.

During the DDCS eligibility determination process, the CARE record for an active HCS/AAA client must be transferred to DDCS.

- DDCS will add the HCS/AAA case manager to the DDCS team in CARE so both DDCS and HCS/AAA will have access to the client's CARE record and assessment.
- HCS/AAA will be able to authorize social service payments as needed.

Process for a DDCS client requesting services from HCS/AAA

1. Referral received from DDCS case resource manager or DDCS client;
2. **Functional Eligibility** – Complete LTC assessment in CARE to establish functional eligibility;
3. **Financial Eligibility** – Notify financial on a 14-443 in Barcode of the DDCS transfer so the client's financial record can be obtained from the DDCS LTC Specialty Unit. If the client is a MAGI client on N05 coverage group, there is no need to send a 14-443 to financial since they do not manage MAGI clients;
4. Authorize services once all program requirements are met;
5. Remember that a client can only receive MPC or CFC services from one agency at any given time. DDCS cannot authorize MPC or CFC for the same time period that HCS has an open ProviderOne (P1) social service authorization and vice versa.

Process for non-DDCS enrolled children turning 18 and transferring to HCS/AAA

Children who do not meet DDCS eligibility criteria, but have personal care needs are case managed through DDCS until they are 18 years old unless they remain in an extended foster care placement. As



long as the youth (age 18, 19 or 20) is in foster placement, DDCS retains the case and continues to provide case management related to MPC and CFC services. At age 18 or upon leaving foster care, between the ages of 18 and 21, if the client requests to continue receiving personal care services, a referral must be made to HCS for LTC eligibility and ongoing case management. Once eligibility has been established, the MPC or CFC services will be transferred from DDCS to HCS without disruption.

Functional Eligibility –

1. 2 months prior to the client's 18th birthday, the DDCS case resource manager will:
 - a. make a referral to HCS, and
 - b. notify other agencies [e.g., Children's and Health Care Authority (HCA)] as appropriate of the transfer.
2. 30 days prior to the client's 18th birthday, HCS will:
 - a. complete the functional assessment in CARE,
 - b. confirm the qualified provider,
 - c. accept the transfer from DDCS, and
 - d. authorize services on or after the 18th birthday. The case will be transferred per the usual process to the AAA for ongoing case management, if appropriate.
3. For non-DDCS enrolled clients who remained in foster care after the 18th birthday and are now leaving foster care between the ages of 18 and 21 and continue to need personal care services,
 - a. the DDCS case resource manager will:
 - i. make a referral to HCS, and
 - ii. coordinate with Children's Administration throughout the transition.
 - b. The HCS worker will:
 - i. determine LTC eligibility,
 - ii. confirm client's choice of qualified provider,
 - iii. authorize services after the 18th birthday, and
 - iv. transfer the case per the usual process to the AAA for ongoing case management, if appropriate.
 - c. DDCS and HCS will coordinate to ensure the transition of services for the client is as seamless as possible and to ensure there is **no disruption of services** to the client and no duplication of service payments to the provider(s).

Financial Eligibility –

Working with financial systems will be different depending on the program under which the individual is receiving services. When the individual needs to apply for Medicaid through HCS, and is not already on SSA/SSI, then a Non-Grant Medical Assistance (NGMA) determination will need to be made. See [Appendix IV: Non-Grant Medical Assistance \(NGMA\)](#) for more information.

When the HCS case manager receives the case, notify the financial unit about the change of case management and ask to be added to the AREP screen in ACES.

- **Foster Care** – Youth can choose to stay in this program until they are age 21. Financial eligibility does not need to be established until they leave the program or turn 21 years of age, whichever comes first.

- If notified by the client or Children's Administration that they are leaving the program prior to the 21st birthday, notify financial on a 14-443 of the referrals. If appropriate, fast track to prevent a disruption of services.
- Notify financial 60 days prior to 21st birthday of the need to send a financial packet and determine financial eligibility.
- **Children's Health Insurance Program (CHIP)** – Children remain eligible on this medical program until they are 19 years of age as long as required premiums are paid.
 - Verify financial eligibility at review time;
 - Notify financial 60 days prior to 19th birthday of the need to coordinate transfer of the financial record from the MEDS unit within HCA.
- **Medicaid (Title 19)** – Children remain eligible on this medical program until they are 19 years of age.
 - Verify financial at review time;
 - Notify financial 60 days prior to 19th birthday of the need to coordinate transfer of the financial record from the DDCS LTC Specialty Unit and/or HCA.
- **Undocumented Children (State Funds only)** – Children remain eligible on this medical program until they are 19 years of age.
 - For youth needing LTC services from HCS upon aging out of this program, DDCS must make a referral to HCS at least six (6) months prior to the 19th birthday to allow adequate time for intake and eligibility determination.
 - Verify financial eligibility when file is transferred from DDCS. Financial eligibility is determined by the DDCS LTC Specialty Unit.
 - Terminate services on the 19th birthday. There are no other Medicaid services available.
 - Refer to community resources.
 - Authorize services once all program requirements are met.

APPENDIX II: ESTATE RECOVERY

Ask the Expert

If you have questions or need clarification about the content in Appendix II, please contact:

Amanda Aseph Office Chief – Financial Eligibility & Policy
360-725-3406 Amanda.Aseph@dshs.wa.gov

The state of Washington's Estate Recovery Program was enacted July 27, 1987. In 1993, federal law mandated that all states enact estate recovery programs.

State law, [RCW 43.20B.080](#), requires staff to fully disclose in advance, both verbally and in writing, the terms and conditions of estate recovery to all persons offered long-term care services subject to recovery of payments. **All Home and Community Living Administration (HCLA) services except Adult Protective Services (APS) are subject to recovery.**

The state does not place a lien on assets or try to recover against an estate until the death of the medical assistance recipient with the exception of a recipient permanently residing in a medical institution who is required to pay participation. The state will defer recovery until the death of a

surviving spouse, a registered domestic partner, and/or while there is a surviving child who is under age 21, blind, or disabled.

Estate recovery program recovers the cost of long-term care services and related hospital and prescription drug services from a recipient's estate. Federal and State laws also allow states to recover all Medicaid costs. The estate recovery laws have changed several times since the program was enacted. The department recovers from estates according to the law in effect at the time the services were received. Effective January 1, 2014, the estate recovery rules have been amended to no longer include all Medicaid services as subject to recovery. The estate recovery handout ([DSHS 14-454](#)) has been amended.

To meet disclosure requirements, you must provide the following documents to all prospective and new clients and verbally explain both the estate recovery program and the community service options available:

- [WashingtonLawHelp.org info on Estate Recovery for Medical Services Paid for by the State](#) and;
- Home and Community Services (HCS) publication: [Medicaid and Options for Long-Term Care Services for Adults \(DSHS 22-619x\)](#)
- [Estate Recovery Information Sheet](#)
- [Estate Recovery Repaying the State for Medical and Long Term Care \(LTC\)](#) DSHS form 14-454

Services Exempt from Recovery

- Services received prior to 7/26/87, when the Estate Recovery Program was enacted;
- Services received prior to 7/25/93, specific criteria in [WAC 182-527-2746](#);
- Adult Protective Services provided to a frail elder or vulnerable adult and paid for only by state funds.

Assets Not Subject to Recovery

- Certain properties belonging to American Indians/Alaska Natives (explained in [WAC 182-527-2746](#));
- Government reparation payments specifically excluded by federal law as long as such funds have been kept segregated and not commingled with other countable resources and remains identifiable.

Recovery Process

- The Office of Financial Recovery (OFR) administers Estate Recovery collections for the Department of Social and Health Services (DSHS).
- DSHS recovers from the estate of a deceased client. "Estate" includes all real property (land or buildings) and all other property (mobile homes, vehicles, savings, other assets) the client owned or had an interest in when the client died. A home transferred to a spouse or to a minor, blind or disabled child prior to the client's death, is not considered part of the client's estate. This is a legal transfer under Medicaid rules and does not affect the client's eligibility.
- DSHS recovers from estates according to the estate recovery law in effect at the time the services were received.



- DSHS will file a lien or make a claim against property that is included in the deceased client's estate. Prior to filing a lien against real or titled property, the department shall give notice and an opportunity for a hearing to the probate estate's personal representative, if any, or any other person known to have title to the affected property.
- DSHS will defer recovery:
 - While there is a surviving child, who is less than 21 years of age, blind or disabled, per [Chapter 182-527 WAC](#).
 - Until the death of a surviving spouse (if any). When the surviving spouse dies, recovery action will be taken against property in which the deceased client had an interest in at the time of death.
 - If the client's heirs would experience undue hardship, and they meet the undue hardship criteria specified in [Chapter 182-527 WAC](#).

Resident Personal Funds Held by a Facility

Within 30 days after the resident's death, the nursing facility or community residential facility (Adult Family Home, Adult Residential Care, or Assisted Living) must convey the resident's personal funds held by the facility to the Office of Financial Recovery (OFR) or to the individual or probate jurisdiction administering the resident's estate. OFR may authorize release of funds to pay for burial costs, either before or after it receives the funds.

Prepaid Burial Plan or Contract

DSHS can recover from the balance of funds in a prepaid funeral service contract or plan that is not used to pay for burial expenses if the plan or contract is sold by a funeral home or cemetery regulated by the state. This includes prepaid funeral service contracts sold by a funeral home and funded through insurance.

Funeral plans or trusts established by a lawyer or sold by an insurance agent are not affected by this law.

Discovery of Decedent's Estate

The primary sources from which OFR finds out about a decedent's estate are:

- ACES Computer reports. ACES produces a report monthly of medical recipients who have died. Form letters generated from these reports are mailed to the recipient's last known address as shown on the report. The letter asks survivors or estate handlers to answer questions related to estate assets and whether probate has been or will be filed.
- The Superior Court Office Management Information System (SCOMIS) report is sent to OFR from the Office of the Administrator for the Courts. The report lists monthly probate and non-probate filings for each county.
- As of 7/1/95 state law requires the personal representative of the probated estate and the notice agent of the non-probated estate to send a copy of the notice to creditors to OFR.
- Current Washington law allows parties to dispose of debts and personal property in estates that are valued under \$100,000.00 by affidavit of successor instead of probate/non-probate. As of 7/1/95, the person claiming to be a successor of the decedent is required to send a copy of the affidavit of successor to OFR.

Interest Assessed on Past Due Debt

The recovery debt becomes past due and accrues interest at a rate of one percent per month beginning nine months after the earlier of the filing of the department's creditor's claim in the probate, or the recording of the department's lien.

APPENDIX III: RESOURCES

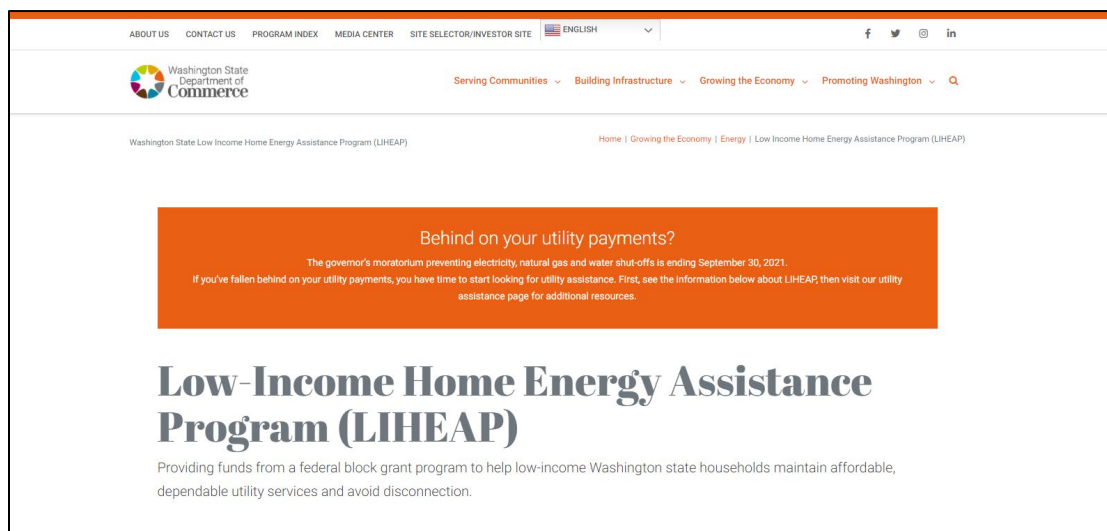
[HCLA Service Comparison Chart](#)

[ACES and RAC codes cheat sheet for all core programs \(i.e., CFC, MPC, HCBS waivers, etc.\)](#)

[Social Service Authorization Manual \(SSAM\)](#)

[Medicaid Programs – LTSS Chart \(ACES coverage group cheat sheet\)](#)

[Low-Income Home Energy Assistance Program \(LIHEAP\) – Cooling Options for Low Income Households](#)



To apply for LIHEAP, contact the LIHEAP provider in your community. Each agency has its own process for scheduling appointments. Consult the [Washington State Department of Commerce LIHEAP](#) website frequently asked questions on eligibility, the services that are available, and who to contact in the community.

With LIHEAP, people can acquire heating or cooling units, pay bills, and receive assistance with repairing or replacing unsafe, inoperative or dysfunctional systems. And people in counties impacted by wildfire smoke may qualify for assistance to receive air purifiers if there is an emergency wildfire proclamation in place.

APPENDIX IV: NON-GRANT MEDICAL ASSISTANCE (NGMA)

Ask the Expert

If you have questions or need clarification about the content in Appendix IV, please contact:

Annie Moua HCBS Waiver Program Manager
509.590.3909 Anne.Moua@dshs.wa.gov

Effective January 1st, 2014, clients under 65 years of age no longer need to be determined disabled in order to access medical coverage as long as the household's countable income is below 133% of the FPL. Disability must still be determined if the client is under 65 years of age and needs to access HCBS waiver services, regardless of income.

Blindness or disability is already established for clients who receive SSI or Social Security Disability benefits. Clients who are 18 – 64 who do not receive SSI/SSDI must have their disability determined via the Non-Grant Medical Assistance (NGMA) Program.

Disability through the NGMA process is completed by a Department of Disability Determination Services (DDDS) adjudicator. Eligibility is determined based on the SSI disability criteria ([WAC 182-512-0050](#)):

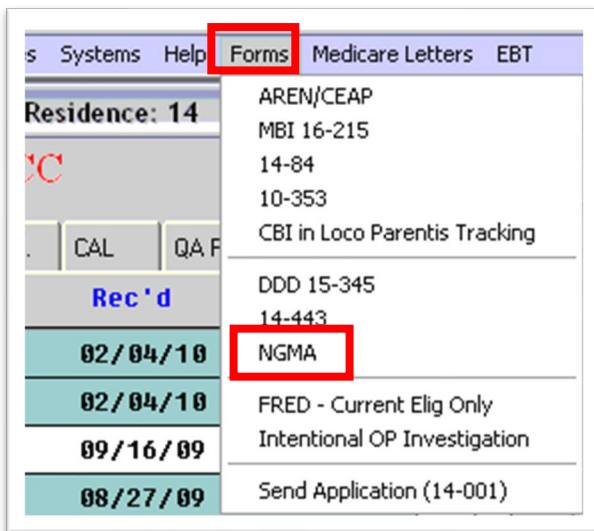
- Blind (as defined in [WAC 182-512-0050](#)); or
- Disabled – the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

To determine if a NGMA is needed, look at the SSI criteria (aged, blind or disabled):

1. Clients who are on SSI/SSA Disability, blind, or 65 or older, are already categorically related and a NGMA is NOT needed:
 - a. Determine if a financial application has been submitted (unless already on Medicaid), and
 - b. Authorize services – use Fast Track if appropriate.
2. For clients under age 65 who appear to meet SSI disability criteria, use the NGMA process to determine the disability. Clients who do NOT appear to meet SSI disability criteria still have the right to pursue NGMA if they wish. Explain the program criteria for severity and durational requirements to clients. If the client wishes to continue, complete the packet. If the client withdraws, notify the financial services specialists within 5 days and refer the client to other community resources or access state-funded resources if appropriate.
3. A client who receives MAGI-based medical coverage must be determined disabled using the **NGMA process** if they need to access waiver services. However, a NGMA is not needed in order to authorize MPC or CFC services.

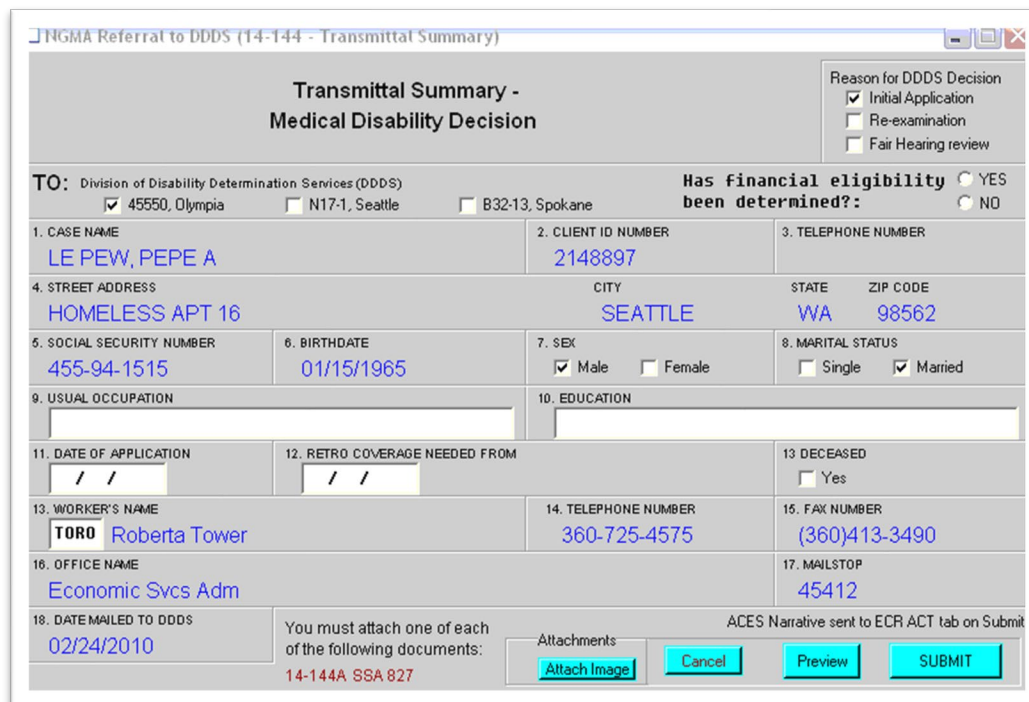
Instructions for Completing NGMA Referral in Barcode

The NGMA transmittal form can be accessed from the “Forms” menu of the Electronic Case Record (ECR).



Forms	Medicare Letters	EBT
AREN/CEAP		
MBI 16-215		
14-84		
10-353		
CBI in Loco Parentis Tracking		
DDD 15-345		
14-443		
NGMA		
FRED - Current Elig Only		
Intentional OP Investigation		
Send Application (14-001)		

When you select “NGMA” from the menu you should see the following screen:



Transmittal Summary - Medical Disability Decision

Reason for DDS Decision
☒ Initial Application
☐ Re-examination
☐ Fair Hearing review

TO: Division of Disability Determination Services (DDDS)
☒ 45550, Olympia ☐ N17-1, Seattle ☐ B32-13, Spokane

Has financial eligibility been determined?: ☐ YES ☐ NO

1. CASE NAME: LE PEW, PEPE A
2. CLIENT ID NUMBER: 2148897
3. TELEPHONE NUMBER: [blank]

4. STREET ADDRESS: HOMELESS APT 16
CITY: SEATTLE
STATE: WA
ZIP CODE: 98562

5. SOCIAL SECURITY NUMBER: 455-94-1515
6. BIRTHDATE: 01/15/1965
7. SEX: ☒ Male ☐ Female
8. MARITAL STATUS: ☐ Single ☒ Married

9. USUAL OCCUPATION: [blank]
10. EDUCATION: [blank]

11. DATE OF APPLICATION: [blank]
12. RETRO COVERAGE NEEDED FROM: [blank]
13. DECEASED: ☐ Yes

14. WORKER'S NAME: TORO, Roberta Tower
14. TELEPHONE NUMBER: 360-725-4575
15. FAX NUMBER: (360)413-3490

16. OFFICE NAME: Economic Svcs Adm
17. MAILSTOP: 45412

18. DATE MAILED TO DDS: 02/24/2010

You must attach one of each of the following documents:
14-144A SSA 827

Attachments:

ACES Narrative sent to ECR ACT tab on Submit

At the top right hand corner of the screen are checkboxes to indicate whether this is an Initial Application, Re-examination, or a Fair Hearing review.

On the first line of the transmittal summary there are checkboxes to indicate where the Transmittal Summary should be sent. This will be pre-selected based on the client's office of record. You may change this location by selecting a different checkbox.

Financial Eligibility for NGMA must be determined before the Transmittal Summary can be sent to DDDS. Indicate Yes or No that eligibility has been established.

Boxes 1-6 contain information from ACES for the client selected. This data may not be changed through this form. If the information about the client is incorrect, ACES must be updated first.

Box 7 and 8 will be pre-selected from information via an ACES interface. This information may be corrected by changing the checkbox selected.

Box 9 and 10 allow input for Usual Occupation and Education respectively. These are not mandatory fields.

Box 11 is for the current date of application.

Box 12 is for the requested retro medical time period. Retro medical may not be requested more than 3 months prior to a medical application.

A date must be entered into number 12, Retro Medical Coverage. If retro medical is not needed or requested, enter today's date in field number 12.

Requesting Retro Medical from a Previous Application

Example: The client applies for medical on 2/12/2010 and wishes to have retro medical considered back to 6/1/2010.

If these dates are entered into fields 11 and 12, an invalid date popup warning will appear.



An additional application date box will appear. Enter the date of the application that the retro medical is being requested for. The retro medical coverage date cannot be more than 3 months prior to the original application date.

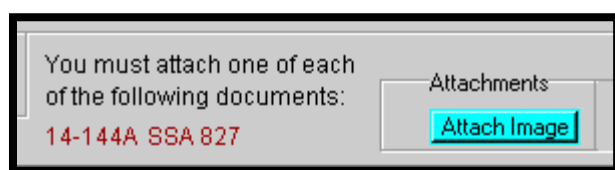
11. DATE OF APPLICATION	12. RETRO COVERAGE NEEDED FROM ORIGINAL APPLICATION DATE:
02/12/2010	06/01/2009 / /

Box 13 has a checkbox to indicate if the client is deceased.

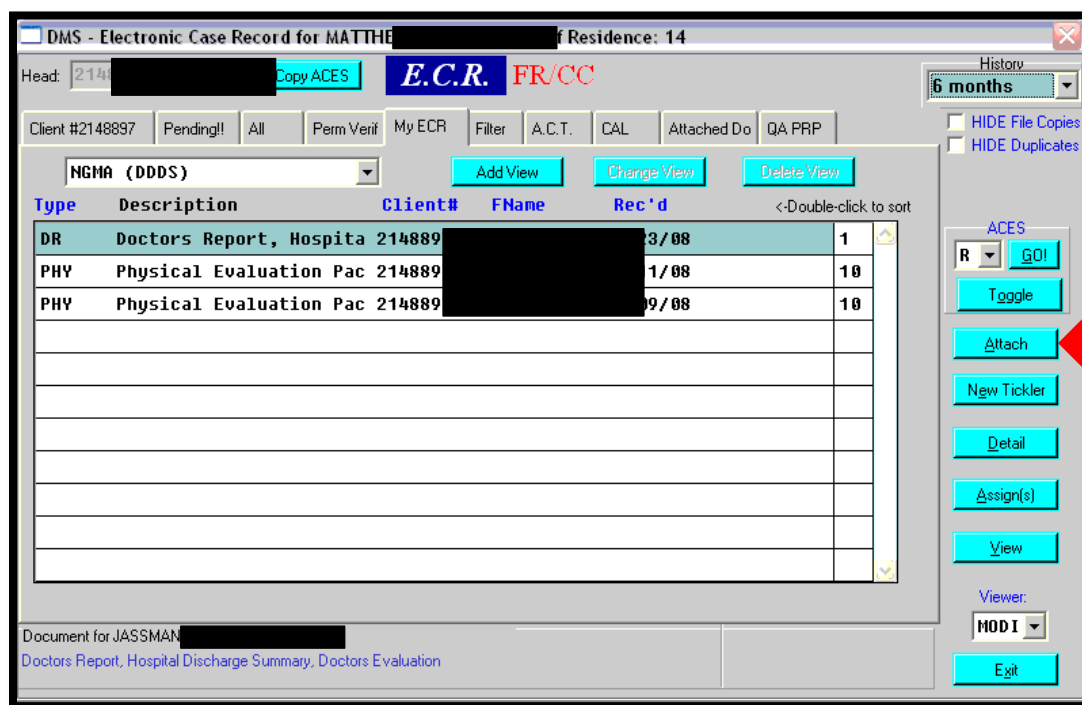
Boxes 14 through 19 include information about who sent the form and the date it was sent to DDDS. Only box 14 can be changed.

Attaching Documents

Certain documents must be attached to the Transmittal Summary before the document can be submitted to DDDS. This is done by clicking the 'Attach Image' button at the bottom of the screen. The documents that must be attached are listed in red to the left of the button.



When the 'Attach Image' button is clicked, the ECR will open and the My ECR tab will be on top. The NGMA (DDDS) filter will be pre-selected with the NGMA document types.



Highlight the documents that you would like to attach to the NGMA Transmittal Summary. On the right hand side of the ECR there will be a new button above the 'New Tickler' button. Once you have all of the documents highlighted, click the 'Attach' button.

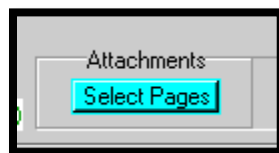
You may go to the 'Attached Docs' tab to see which documents have been attached.

Hit the ECR's 'Exit' button to return to the NGMA screen. If the documents have been attached the document types should have changed from red to green.

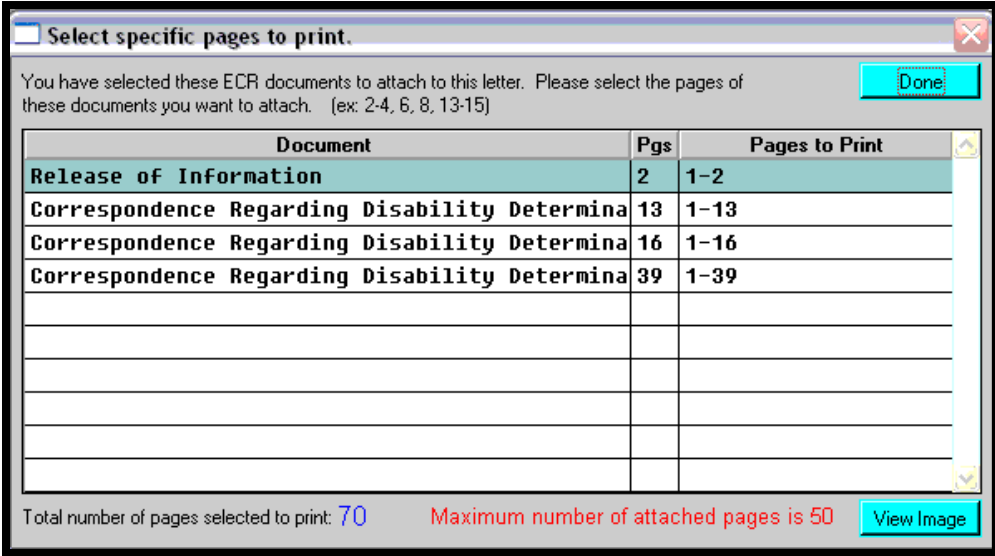
If there are more than 50 pages in the documents that are attached, a warning message will appear.



When the popup is closed the Attach Image button will be replaced with a 'Select Pages' button.



Clicking the 'Select Pages' button will open a new screen listing all of the documents attached with the number of pages for each document.



☐ Select specific pages to print.

You have selected these ECR documents to attach to this letter. Please select the pages of these documents you want to attach. (ex: 2-4, 6, 8, 13-15) Done

Document	Pgs	Pages to Print
Release of Information	2	1-2
Correspondence Regarding Disability Determina	13	1-13
Correspondence Regarding Disability Determina	16	1-16
Correspondence Regarding Disability Determina	39	1-39

Total number of pages selected to print: 70 Maximum number of attached pages is 50 View Image

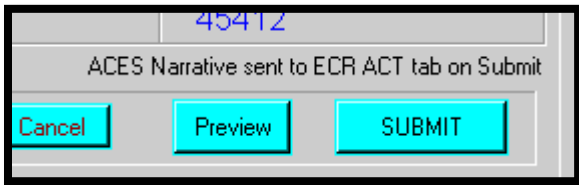
The total number of pages for the documents attached is listed at the bottom of the screen. To only attach a few pages of the document, select the document by highlighting the line the document is on. You may view the document by clicking the 'View Image' button at the bottom of the screen.

Enter the page numbers for the document in the Pages to Print column.

Correspondence Regarding Disability Determina	16	1-16
Correspondence Regarding Disability Determina	39	5-6

When finished, click the 'Done' button. Then click the 'Submit' button again.

Once everything has been completed on the Transmittal Summary screen, you may preview the document or submit the document.



Submitting the document will create a NGMA document with an assignment to the appropriate DDDS office. You will be asked to click OK to commit the form to the ECR.

APPENDIX V: ONGOING ADDITIONAL REQUIREMENTS (OAR)

Ask the Expert

If you have questions or need clarification about the content in Appendix V, please contact:

Annie Moua HCBS Waiver Program Manager
509.590.3909 office Anne.Moua@dshs.wa.gov

Definition from the Economic Services Administration (ESA) Social Services Manual: An "**Ongoing Additional Requirement**" is a benefit that is needed by a person that maintains their independent living situation or allows them to live in an environment that is as independent as possible.

Ongoing Additional Requirements (OAR) may provide financial assistance to eligible individuals for costs associated with:

- Restaurant meals
- Home delivered meals
- Laundry
- Service animal food
- Telephone

- Internet
- Transportation
- Dentures
- Optometrists visit for eyeglasses
- Eyeglasses
- Hearing aid(s)
- Veterinary cost for service animals
- Boarding for service animals

Eligibility and Authorization Process

OAR eligibility is determined by the HCS/AAA Social Service Specialist (SSS)/Case Manager (CM) or DDCS Case Resource Manager (CRM). A request for OAR from the client can start from the SSS/CM/CRM or the Public Benefit Specialist (PBS).

1. PBS staff will notify SSS/CM/CRM using the DSHS 07-104 when a client is requesting OAR through the PBS.
2. SSS/CM/CRM will use the OAR Service Request Decision screen in Barcode to document pending, approved, and denied OAR service requests when a client requests or the SSS/CM/CRM determines a need for OAR.
 - a. SSS/CM/CRM must select one service typer per OAR request in the Barcode OAR Service Requestion Decision screen.

NOTE: OAR ETR requests are to be sent to the SSS/CM/CRM's supervisor. The ETR will automatically be routed to Evelyn Acopan, CSD Social Services Program Manager, after the supervisor reviews and approves the ETR request.

When an OAR service request is **approved**:

1. A begin date is required. This date will be no more than three (3) months from the current month.
2. An end date is required. This date will be no more than 24 months from the begin date.
3. An amount authorized must be entered. This amount must not be more than the approved service limit.
 - a. The approved service type cannot exceed the monthly or annual limit.
 - b. Do not allow monthly approval for service that are a one-time payment.
4. Barcode will auto-generate an **OAR1 tickler** to the assigned HCS PBS or DDCS PBS pool when an OAR service request has been approved by the SSS/CM/CRM.
 - a. Tickle Name: OAR1
 - b. Tickle Subject: OAR has been approved
 - c. Tickle Details: include client name, begin and end dates, service type, one-time or ongoing and amount.
5. PBS will issue OAR benefits in ACES and ACES will issue a letter and document in the ACES narrative.
6. SSS/CM/CRM will get a Barcode **OAR2 tickler** when an approved OAR service needs to be reviewed.



- a. Barcode will auto-generate an **OAR2 tickler** at approval and is set to ready to work 45 days prior to end date for each approved service.
 - i. Tickle Name: OAR2
 - ii. Tickle Subject: OAR review is needed
 - iii. Tickle Details: Review OAR service for: include client name, begin and end dates, service type, one-time or ongoing and amount.

When an OAR service request is **denied**:

1. One denial reason must be selected. That denial reason is inserted into an open letter.
 - a. Reasons to choose from:
 - i. Max Benefit Received - You already received the maximum benefit in a 12-month period
 - ii. Duplicate Service - The service you requested is covered by another program
 - iii. Unnecessary Service - The service you requested does not affect your health, safety or ability to continue to live independently
 - iv. Missing Information - You didn't provide sufficient verification to support your need
 - v. Funds Exhausted - Program funding has been exhausted
 - vi. Need not confirmed - At review, we weren't able to confirm you need additional services to continue to live independently
 - vii. Other - Text box to insert explanation
 - viii. ETR denied by HQ - An Exception to Rule was submitted and denied by Headquarters.
 1. For ETR denials, staff need to insert text in the letter based on the ETR decision in Barcode
2. When an OAR request is denied, an Open letter must be sent.

When an OAR service request is **pending**:

1. Select "Pend" and "Save".
2. The status will be displayed as "pending" until SSS/CM/CRM completes the final decision and either approves or denies the OAR service request.
 - a. SSS/CM/CRM name and the date the OAR request is saved will be displayed on the OAR request.
 - i. There is an optional space for SSS/CM/CRM to indicate date "Information Request letter" was sent and information due date.
3. A Barcode **OAR3 tickler** will need to be manually created with the information below. The ready to work date will be the next day after the information due date entered.
 - a. Tickle Name: OAR3
 - b. Tickle Subject: OAR Information Due
 - c. Tickle Details: Review OAR notes and client ECR for: include client name and due date. Finalize OAR request.

OAR benefits are not approved if:

1. The assistance the individual is requesting is available to them through another program, or

2. The individual lives in a licensed Adult Family Home (AFH), Assisted Living Facility (ALF), or Enhanced Services Facility (ESF).

WAC 388-473-0010 – What are ongoing additional requirements and how do I qualify?

An individual may qualify for OAR if he/she is active in one of the following programs:

- (a) Temporary assistance for needy families (TANF), or tribal TANF;
- (b) State family assistance (SFA);
- (c) Pregnant women assistance (PWA);
- (d) Refugee cash assistance (RCA);
- (e) Aged, blind, or disabled (ABD) cash assistance;
- (f) Housing and essential needs (HEN) referral; or
- (g) Supplemental security income (SSI).

Authorization of OAR benefits occurs only when it is determined the item is essential to the client. The decision is based on proof the client provides documenting of:

- a. The circumstances that create the need; and
- b. How the need affects the client's health, safety, and ability to continue to live independently.

Benefit Review Cycle

The following review cycle table shows when the need for OAR is reviewed:

REVIEW CYCLE	
Program	Frequency (Months)
TANF/RCA/SFA/PWA	6 Months
ABD	12 Months
HEN	12 Months
SSI	24 Months
All	Any time need or circumstances are expected to change

WAC 388-473-0020 – When do we authorize meals as an ongoing additional requirement?

Additional requirement benefits for meals will be authorized when all the following conditions are determined to be true:

- (a) You meet the criteria in [WAC 388-473-0020](#);
- (b) You are physically or mentally impaired in your ability to prepare meals; and
- (c) Getting help with meals would meet your nutrition or health needs and is not available to you through another federal or state source, such as the Community Options Program Entry System (COPES), Medicaid Personal Care (MPC), or informal support, such as a relative or volunteer.



The department decides whether to authorize this benefit as restaurant meals or home-delivered meals.

- Restaurant meals are authorized when:
 - (a) You are unable to prepare some of your meals;
 - (b) You have some physical ability to leave your home; and
 - (c) Home-delivered meals are not available or would be more expensive.
- Home-delivered meals are authorized when:
 - (a) You are unable to prepare any of your meals;
 - (b) You are physically limited in your ability to leave your home; and
 - (c) Home-delivered meals are available.

WAC 388-473-0040 – Assistance for service animals as an ongoing additional requirement.

A "service animal" means any dog or miniature horse, as discussed in [RCW 49.60.040](#), that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability.

Benefits authorized for food for a service animal if it is decided the animal is necessary for the client's health and safety and supports their ability to continue to live independently.

Benefits authorized for future veterinary care for a service animal if it is decided that a service animal has a medical necessity that would require treatment so that the service animal can continue to do the work or task the animal has been trained to perform. Payment for past veterinary bills is not allowed.

Boarding for a service animal for a maximum amount of \$300.00 a year is authorized if it is determined that the client needs medical or mental health care and is in a licensed facility in which the service animal cannot reside and there is no one who can provide care for your service animal.

WAC 388-473-0050 – Telephone and internet services as an ongoing additional requirement.

Benefits for telephone services are authorized when it has been determined that without a telephone,

- a. The client's life would be endangered, you could not live independently, or you would require a more expensive type of personal care, and
- b. The client has applied for telephone assistance through a federal program.

NOTE: telephone services are meant only for landline assistance.

Benefits for internet services are authorized when is it has been determined:

- a. Without internet services, the client could not live independently, or they would require a more expensive type of personal care; and
- b. The client has applied for low-cost internet and need assistance paying the monthly bill.



NOTE: The client is not eligible for benefits for telephone or internet services if they are receiving these services free of charge.

WAC 388-473-0060 – Laundry as an ongoing additional requirement.

Benefits for laundry are authorized when it has been determined that you:

- Are not physically able to do your own laundry; or
- Do not have laundry facilities that are accessible to you due to your physical limitations.

WAC 388-473-0070 – Transportation as an ongoing addition requirement.

Assistance for transportation costs as an ongoing additional requirement may be authorized when it has been determined that the client needs assistance:

- a. Getting to and from appointments; or
- b. Taking care of activities to continue living independently.

WAC 388-478-0050 – Payment standards for ongoing additional requirements and WAC 388-473-0080 – Medically related items or services as an ongoing additional requirement.

The payment standards for OAR are as follows:

- Restaurant meals: \$390.00 per month
- Laundry: \$20.84 per month
- Service animal food: \$50.00 per month
- Home delivered meals: The amount charged by the agency providing the meals
- Telephone: \$4.00 per month
- Internet: Up to \$30.00 per month
- Transportation: \$40.00 per month
- Dentures: \$1,800.00 in a 12-month period
- Optometrists visit for eyeglasses: \$200.00 in a 12-month period
- Eyeglasses: \$240.00 in a 12-month period
- Hearing aid(s): \$1,000.00 in a 12-month period
- Veterinary cost for service animals: \$200.00 annual limit
- Boarding for service animals: \$300.00 annual limit

Clarifying Information for WAC 388-473-0040 regarding Service Animals

What is a service animal?

The [Americans with Disabilities Act \(ADA\)](#) defines a [service animal](#) as any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability. If they meet this definition, animals are considered service animals under the ADA regardless of whether they have been licensed or certified by a state or local government.



Service animals perform some of the functions and tasks that the individual with a disability cannot perform for him or herself. Guide dogs are one type of service animal, used by some individuals who are blind. This is the type of service animal with which most people are familiar. But there are service animals that assist persons with other kinds of disabilities in their day-to-day activities.

Reminder:
A service animal is not a pet.

Some examples include:

- Alerting individuals with hearing impairments to sounds.
- Pulling wheelchairs or carrying and picking up things for individuals with mobility impairments.
- Assisting individuals with mobility impairments with balance.

Case Worker Responsibilities regarding Service Animals:

1. Use the following criteria to determine if the individual's need for a service animal qualifies as an Ongoing Additional Requirement.

The animal:

- a. Must help the individual with a sensory, mental, or physical disability.
- b. The training does not need to be formal, but the animal should be trained to help the person with tasks related to the disability. Do not ask for proof of training.

EXAMPLE 1: The client indicates the dog is to help with the blindness to get around. If the use of the animal in assisting the client seems questionable, you can request verification from the client's medical professional that the animal provides assistance with the disability.

EXAMPLE 2: The dog is used to calm down the client. It seems questionable. You can ask the client to provide a statement from the treating doctor, psychiatrist, or other medical professional on how the animal helps the client with their disability.

2. When it has been determined that the above conditions are met, you may approve Ongoing Additional Requirements by using the Barcode OAR Service Request screen.

ADDITIONAL HELPFUL INFORMATION

- Per [WAC 388-478-0050](#), standards that say "in a 12 month period" are services that can be issued less than the maximum amount based on client need. If less than the maximum is issued the remaining up to the maximum amount is available if needed during that 12-month period.
- The [Ongoing Additional Requirements](#) section of the CSD Social Services Manual states under the "Clarifying Information - WAC 388-478-0050" section (2): "The following services are issued at a set standard amount as described in WAC even if the need is less: restaurant meals, laundry, service animal food, telephone, transportation, veterinary cost for service animal. **For**



other services, determine amount based on need not exceeding maximum standard amount (this would include dentures).”

- Regarding issuances, [WAC 388-473-0010](#) states that OAR benefits are issued by, “Increasing your cash assistance benefit if you receive cash assistance or issuing a cash benefit if you are a HEN referral or SSI recipient.” Also, [WAC 388-412-0025](#) includes information on how a client receives their benefits – SSI recipients get OAR benefits via warrant (check) since there is no assistance unit through CSD to be able to issue via EBT card.

APPENDIX VI: REQUESTING FUNDING FROM THE MANAGED CARE ORGANIZATION (MCO) FOR BEHAVIORAL HEALTH PERSONAL CARE (BHPC)

Information and Instructions for MCO-funded BHPC Wraparound Support Services is located in [Chapter 22a](#) of the LTC Manual.

RESOURCES

Related WACs and RCWs

Appendix I: Coordination with Developmental Disabilities Community Services (DDCS)

[Chapter 388-823 WAC](#) Developmental Disabilities Administration Intake and Eligibility Determination

Appendix II: Estate Recovery

[Chapter 182-527 WAC](#) Estate Recovery and Pre Death Liens
[WAC 182-527-2746](#) Estate recovery—Asset-related limitations
<https://apps.leg.wa.gov/wac/default.aspx?cite=182-527WAC 388-96-384> Liquidation or transfer of resident personal funds

[Chapter 43.20B RCW](#) Revenue Recovery for Department of Social and Health Services
[RCW 43.20B.080](#) Recovery for paid medical assistance—Rules—Disclosure of estate recovery costs, terms, and conditions

[Chapter 74.39A RCW](#) Long-Term Care Services Options—Expansion
[RCW 18.39.250](#) Prearrangement contracts—Trusts—Refunds
[RCW 18.39.255](#) Prearrangement contracts—Insurance funded—Requirements
[RCW 68.46.050](#) Withdrawals from trust funds—Notice of department of social and health services' claim
[RCW 70.129.040](#) Protection of resident's funds—Financial affairs rights

Appendix IV: Non-Grant Medical Assistance (NGMA)

[WAC 182-512-0050](#) SSI-related medical—General information

Appendix V: Ongoing Additional Requirements (OAR)

[WAC 388-473-0010](#) What are ongoing additional requirements and how do I qualify?
[WAC 388-473-0020](#) When do we authorize meals as an ongoing additional requirement?
[WAC 388-473-0040](#) Food for service animals as an ongoing additional requirement
[WAC 388-473-0050](#) Telephone and internet services as an ongoing additional requirement
[WAC 388-473-0060](#) Laundry as an ongoing additional requirement
[WAC 388-473-0070](#) Transportation as an ongoing addition requirement
[WAC 388-473-0080](#) Medically related items or services as an ongoing additional requirement
[WAC 388-478-0050](#) Payment standards for ongoing additional requirements

Resources

[Ongoing Additional Requirements PowerPoint](#)

Acronyms

AAA Area Agency on Aging

ADA	Americans with Disabilities Act
APS	Adult Protective Services
BHO	Behavioral Health Organization
BHPC	Behavioral Health Personal Care
CARE	Comprehensive Assessment and Reporting Evaluation
CFC	Community First Choice
CHIP	Children's Health Insurance Program
COPEs	Community Options Program Entry System
CTS	Community Transition Services
DDCS	Developmental Disabilities Community Services
DDDS	Department of Disability Determination Services
DSHS	Department of Social and Health Services
ECR	Electronic Case Record
HCA	Health Care Authority
HCBS	Home and Community Based Services
HCLA	Home and Community Living Administration
HCS	Home and Community Services
LTC	Long-Term Care
LTSS	Long Term Services and Supports
MCO	Managed Care Organization
MPC	Medicaid Personal Care
NGMA	Non-Grant Medical Assistance
OAR	Ongoing Additional Requirements
OFR	Office of Financial Recovery
P1	ProviderOne
RCL	Roads to Community Living
RCW	Revised Code of Washington
RSW	Residential Support Waiver
SER	Service Episode Record
SCOMIS	Superior Court Office Management Information System
SSA	Social Security Administration
SSAM	Social Service Authorization Manual
SSI	Supplemental Security Income
SSP	State Supplementary Payment
WAC	Washington Administrative Code
WTAP	Washington Telephone Assistance Program

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
7/2025	Annie Moua	• Update ALISA to HCLA and DDA to DDCS	TBD
4/2025	Annie Moua	• Update template • Update Appendix V: OAR – provide clarifying information	H25-010

		• Minor formatting updates and updated links	
10/2024	Annie Moua	• Added OAR ETR process	H24-062
04/2024	Annie Moua	• Update to Appendix V: OAR – addition of several OAR benefits, eligibility expansion, and new authorization process through Barcode OAR Service Request Decision screen.	H24-018
05/2023	Victoria Nuesca	• No content change • Advising that information and instructions for appendix VI on MCO-funded BHPC Wraparound Support Services is now in Chapter 22a of the LTC Manual • Update to the contacts for the different appendices and links	
01/2021	Jamie Tong Kelli Emans	• MCO funded BHPC support clarification and instructions regarding wraparound support and ESF services.	
10/2020	Victoria Nuesca Jamie Tong	• New template revision and updated policy related to MCO funding of wraparound support.	H20-094
09/2019	Jamie Tong	• Update to Appendix VI – criteria, policy and instructions for requesting and authorizing funding from BHO/MCO	H19-050

Residential Services

Chapter 8 gives an overview of residential services to include licensing requirements, contract types, and determining eligibility for a residential setting. The chapter also provides information on Community Integration, Specialized Dementia Care Program, resident rights and bed holds.

Ask the Expert

If you have questions or need clarification about ALF or AFH content in this chapter, please contact:

Emily Watts, MSW
(360) 725-3426 office

Residential Policy Program Manager
Emily.Watts1@dshs.wa.gov

If you have questions or need clarification about Resident Rights or Home & Community Based Setting Rules, please contact:

Dr Elizabeth Griffin, EdD, MSW, CDP
(360) 725-3200 office

HCBS Training & Compliance Specialist
Elizabeth.Griffin@dshs.wa.gov

If you have questions or need clarification about DDCCS content in this chapter, please contact:

Paula Costa
(360) 915-4126

Specialty State Plan Residential Program Manager
Paula.Costa@dshs.wa.gov

If you have questions or need clarification about Enhanced Services Facilities, please contact:

James (JD) Selby
(360) 890-2640 office

Residential Support Waiver Program Manager
James.Selby@dshs.wa.gov

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LICENSING REQUIREMENTS FOR RESIDENTIAL SERVICES

All residential facilities provide a package of services including personal care services and room and board. There are three types of licensed residential settings: Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities.

The Residential Care Services Division (RCS) of Home and Community Living Administration (HCLA) is responsible for licensing and monitoring all Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities in Washington State.

Adult Family Home (AFH)

A residential home in which a person or persons provide personal care, special care, and room and board to more than one, but not more than eight adults, who are not related by blood or marriage to the person or persons providing the services.

Adult Family Home may also be designated as a specialty home (on their AFH license) in one or more of the following three categories: Developmental Disability, Mental Illness, and Dementia when they meet all certification and training requirements. See [Chapter 388-76 WAC](#) for more information on Adult Family Home licensing requirements and [Chapter 388-112A WAC](#) for residential training requirements.

Note: When a Medicaid resident is related to the AFH provider and is residing in a licensed and contracted room; the CM/SSS must authorize AFH services using the daily rate based on CARE classification (the same as an unrelated resident).

Assisted Living Facilities (ALF)

A facility for seven or more residents, with the express purpose of providing housing, basic services (assistance with personal care and room and board) and assumes the general responsibility for safety and well-being of the residents. See [Chapter 388-78A WAC](#) for more information on Assisted Living Facility licensing requirements.

Enhanced Services Facilities (ESF)

An Enhanced Services Facility provides 24-hour personal care and behavior support services to a maximum of sixteen residents who have complex personal and behavioral care needs that exceed the capacity of other residential settings. See WAC [Chapter 388-107 WAC](#) for more licensing requirements. For additional information on ESF please see LTC Manual [Chapter 7f](#) for information.

Note: Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities may choose to serve private pay residents, Medicaid residents, or a combination of both.

CONTRACTS

Contract Types

If a residential provider wants to serve a Medicaid resident, the provider must also have a current Assisted Living, Adult Residential Care, Enhanced Adult Residential Care, Enhanced Services Facility, or Adult Family Home contract with HCLA. The types of contracts are listed below.

The **Assisted Living Facility (ALF)** contract requirements are outlined in [WAC 388-110](#). There are three types of assisted living contracts:

- [Adult Residential Care \(ARC\)](#)
- [Enhanced Adult Residential Care \(EARC\)](#)
- [Assisted Living Services \(AL\)](#)

There are three Assisted Living Subcontracts:

- [Enhanced Adult Residential Care - Specialized Dementia Care:](#)
EARC-SDC contracts are available only to Assisted Living Facilities with a designated separate dementia care unit and ALFs dedicated solely to the care of individuals with dementia that have been approved by HCLA to deliver SDCP services.

The Specialized Dementia Care Program (SDCP) is based on Standards of Care specified in [WAC 388-110-220](#) (3). DSHS contracts with licensed and qualified assisted living providers throughout all regions in the State to provide Specialized Dementia Care Program in Assisted Living Facilities. Services are provided in:

- A facility dedicated solely to the care of individuals with Alzheimer's disease/dementia; or
- A designated, separate unit/wing dedicated solely to the care of individuals with Alzheimer's disease/dementia located within a larger facility.

For more information on the Specialized Dementia Care Program in EARC-SDC/ALF, go online to: [Specialized Dementia Care Program in Assisted Living Facilities](#).

- Expanded Community Services (ECS) – see LTC Manual [Chapter 7f](#) for more information

- Community Stability Supports (CSS) – see LTC Manual [Chapter 7f](#) for more information

Memory Care Certification

In 2025, Washington state lawmakers enacted a certification requirement prohibiting assisted living providers to operate or maintain a memory care facility or memory care unit within this state without a certification for memory care services. The requirement took effect July 1, 2026. If an assisted living provides the Specialized Dementia Care Program, they are required to be Memory Care Certified (MCC). MCC is displayed on the ALF Locator and is also a searchable criterion. If a provider does not maintain their MCC, Residential Care Services may enforce remedies as outlined in [WAC 388-78A-3160](#) Authorized enforcement remedies. Case managers do not need to make any payment adjustments to a provider not being listed as having MCC. Any stop payment, stop placement or termination of licensing will follow the current process with RCS.

The **Adult Family Home** requirements are outlined in [Chapter 388-76 WAC](#). There are two types of Subcontracts in AFH:

- Expanded Community Services (ECS)
- Specialized Behavior Support (SBS)

****Please note in the past there was an HIV/AIDS specialty contract. This contract is no longer available, but two AFHs remain, and they are eligible to receive the published HIV/AIDS rates [Three Cedars (Tacoma) and Sean Humphries (Bellingham)]. No other facilities in the state may receive the HIV/AIDS rate.**

The **Enhanced Services Facilities** contract requirements are outlined in [Chapter 388-107 WAC](#) and LTC Manual [Chapter 7f](#).

Contract Requirements

AL, ARC, EARC, EARC-SDC, AFH, and ESF contracts are legal agreements between contractors and HCLA. The contract describes the contractor's legal obligations and responsibilities in the statement of work and conditions for receiving payment for services provided.

Facility requests to voluntarily withdraw a Medicaid contract.

If the residential facility is requesting to voluntarily withdraw their Medicaid contract, but continues to provide personal care services, the facility's voluntary withdrawal from participation is not an acceptable basis for the transfer or discharge of residents of the facility. The facility is required to maintain a Medicaid contract as outlined in [RCW 18.20.440](#) to permit the following residents to remain in the facility and not transfer or discharge them:

- Residents who were receiving Medicaid on the day before the effective date of withdrawal (except as described in [RCW 70.129.110](#), Disclosure, transfer, and discharge requirements), and



- Residents who have been paying the contractor privately for at least two years and who will become eligible for Medicaid within 180 days of the date of withdrawal.

To ensure the resident's rights are protected, the contractor may not evict a resident without (1) complying with the transfer and discharge requirements under [RCW 70.129.110](#) and (2) using any appropriate legal processes, including but not limited to unlawful detainer in [RCW 59.16](#) prior to evicting a resident.

Note: If you receive a written or verbal request from a facility for a voluntary withdrawal of a Medicaid contract, forward a copy of the written request to the HCLA Contract Unit or have the facility contact the HCLA Contract Unit directly. By [RCW 18.20.440](#) (5), the facility must give the department and its residents 60 days' advance notice of the facility's intent to withdraw from participation in the Medicaid program.

Change of Ownership (CHOW)

There may be times when there is a Change of Ownership, and the new licensee does not enter into a Medicaid contract which may result in the discharge or transfer of residents:

- [RCW 18.20.440](#) does not apply to assisted living facilities that change ownership.
- Instead, [WAC 388-78A-2785](#) requires the facility to give 90 days' notice to the residents of a facility undergoing a change of ownership if the change is anticipated to result in the discharge or transfer of any residents.
- If the facility does not want to participate in a state Medicaid program, the CM/SSS's will assist residents to move and terminate the Medicaid payment effective the day prior to the move or the same date as the contract termination date.
- If the new owner wants to participate in the Medicaid program, the facility will be asked to sign a Medicaid contract to be paid for Medicaid residents.

Expired Contracts

The HCLA contract department will send the contractors a notice 2-3 months before the contract expires. If the contractors do not renew their contract within 30 days prior to the expiration date, or the contract ends during the mid-month, the authorization in ProviderOne will have a taxonomy error and not be payable to the contractors.

Case Managers/Social Service Specialists **who receive an error message in ProviderOne may need to review the taxonomy error in the ProviderOne authorization to determine whether an expiring**



contract is the cause of the payment error. If so, the CM/SSS will need to notify the contractor of their expiring contract and have the contractor renew their contract before payment can be re-authorized.

Note: The contractors cannot admit new Medicaid residents until they have a signed Medicaid contract in place. For existing Medicaid residents, the contractors will not be able to receive payment until their contracts are renewed and are in signed status.

Medicaid Contract Requirements in Residential Facilities

This chart (below) shows what is required in each licensed facility type as required by contract.

REQUIREMENTS BY LICENSE and/or CONTRACT					
MEDICAID SERVICES AVAILABLE IN ADULT FAMILY HOMES AND ASSISTED LIVING FACILITIES	Adult Family Home License	Assisted Living Facility (ALF) License			Enhanced Services Facility License
	AFH contract (ECS)(SBS)	ARC Contract	EARC Contract (ECS) (SDC) (CSS)	AL Contract (ECS) (SDC) (CSS)	ESF Contract
Facility Assessment	Yes	Yes	Yes	Yes	Yes
Negotiated Care Plan (NCP)	Yes	N/A	N/A	N/A	N/A
Negotiated Service Agreement (NSA)	N/A	Yes	Yes	Yes	N/A
Person Centered Service Plan (PCSP)	N/A	N/A	N/A	N/A	Yes
Personal Care and Supervision	Yes	Yes	Yes	Yes	Yes
Medication Administration	Yes w/RND	Yes w/RND	Yes	Yes	Yes
Medication Assistance	Yes	Yes	Yes	Yes	Yes
Room & Board	Yes	Yes	Yes	Yes	Yes
Activities	Yes	Yes	Yes	Yes	Yes
Private apartment-like unit	No	No	No	Yes	No
Private bathroom	No	No	No	Yes	No
Private kitchen area	No	No	No	Yes	No
Personal care supplies	No	No	Yes	Yes	No
Awake staff 24 hours a day	No	No	Yes w/SDC & CSS	Yes w/SDC & CSS	Yes
Secured accessible outdoor area with environmental & safety requirement	No	No	Yes w/SDC	Yes w/SDC	No
Staff training	Yes	Yes	Yes	Yes	Yes
Coordinate Behavior Support & Team Meetings	Yes w/ ECS and SBS contract	No	Yes w/ECS & CSS	Yes w/ECS & CSS	Yes
Individual Crisis Plan	Yes w/ ECS and SBS contract	No	Yes w/ ECS & CSS	Yes w/ECS & CSS	Yes
6-8 hours of additional staff time per day	Yes w/SBS contract	No	No	No	No
Quality Improvement Committee	No	Yes	Yes	Yes	Yes

Note regarding Assessments: Prior to admitting Medicaid clients in ALF, AFH, ESF; CM/SSS are required to complete CARE Assessment to determine functional eligibility. Provide a copy of assessment details and service summary to the provider. The following assessments are required in these facilities.

Assisted Living Facilities (ALF) are required by ([WAC 388-78A-2060](#)) to complete their own preadmission assessment using a Qualified Assessor ([WAC 388-78A-2080](#)) prior to admitting any resident and complete a full assessment ([WAC 388-78A-2090](#)) at least annually or when the NSA no longer meets the resident's care needs.

Adult Family Home (AFH) are required to obtain a written assessment that contains accurate information about the prospective resident's current needs and preferences before admitting a resident to the home ([WAC 388-76-10330](#)). The AFH assessment must be completed by a Qualified Assessor ([WAC 388-76-10150](#)) or the department case manager/social service specialist for Medicaid residents ([WAC 388-76-10345](#))

Enhanced Services Facility (ESF) must have an initial person-centered service plan developed for each resident prior to admission to the ESF ([WAC 388-107-0110](#)). The plan must include immediate specific support needs and directions to staff and caregivers relating to those needs. The residents must give written informed consent to the content of the plan. The initial comprehensive person-centered service plan must be completed within 14 days of the resident's move-in date, as outlined in ([WAC 388-107-0120](#)).

All residential contracted providers (except ESF) are required to update the assessment at least annually, when there is a significant change in resident's physical or mental conditions, when the NSA/NCP no longer reflects the current needs of the resident, and at the resident's request ([WAC 388-78A-2100 \(ALF\)](#) and [WAC 388-76-10350 \(AFH\)](#)). For those residents who are receiving Residential Support Waiver (RSW) services, residential providers must also include a Behavior Support & Crisis Plan and provide Behavior Monitoring documentation as requested. ESF is required to update the assessment every 180 days ([WAC 388-107-0080](#)) or when there is a significant change in resident's conditions.

Negotiated Care Plan (NCP), Negotiated Service Agreement (NSA), or Person-centered service Plan (PCSP)

All providers, except ESF, must develop and complete the NCP/NSA within 30 days of the resident's admission. The initial comprehensive person-centered service plan for ESFs must be developed and completed within 14 days of the resident's admission. The NCP/NSA must be reviewed and revised at least annually, when there is a significant change in resident's physical, emotional, mental, behavioral functioning; or any time it no longer addresses the needs and preferences of the resident. Please reference the LTC Manual [Chapter 7f](#) for additional documentation requirements for RSW participants.

For detailed information regarding Adult Family Home Negotiated Care Plan refer to [WAC 388-76-10355](#) through [388-76-10385](#); Assisted Living Negotiated Service Agreement [WAC 388-78A-2130](#) through [388-](#)

[78A-2160](#)); and Person-centered service plan for Enhanced Service Facility [WAC 388-107-0110](#) through [388-107-0130](#).

Nursing Services Available in Each Licensed/Contracted Residential Setting

NURSING SERVICES AVAILABLE IN EACH LICENSED, CONTRACTED SETTING					
Services Provided	Assisted Living Facility	Adult Residential Care	Enhanced Adult Residential Care	Adult Family Home	Enhanced Services Facility
Intermittent Nursing Services (INS)	Yes	No	Yes	*No	Yes
	Daily Rate, provided by facility	n/a	Daily Rate, provided by facility	n/a	Daily Rate, provided by facility
Nurse Delegation	Yes	Optional	Yes	Optional	Yes
	Daily Rate, provided by facility	Contracted RN	Daily Rate, provided by facility	Contracted RN	Daily Rate, provided by facility
Waiver Skilled Nursing	No	Yes	Yes	Yes	No
	n/a	*DDCS Only	Contracted RN	Contracted RN	n/a
24-hour Nursing Services	No	No	No	No	Yes
					Daily Rate, provided by facility
Nursing Services	Yes	Yes	Yes	Yes	Yes
	Referral to Nursing Services Staff, no additional payment				

* Adult Family Home (AFH) may provide intermittent nursing services if the provider is a licensed nurse or use a contracted nurse with a current license in the state of Washington to provide nursing services ([WAC 388-76-10405](#)).

Intermittent Nursing Services

Intermittent Nursing Services may include, but is not limited to: Medication administration, Administration of health treatments, Diabetic management, Nonroutine ostomy care, Tube feeding Nurse delegation consistent with Chapter [18.79](#) RCW.

- Assisted Living Facilities (ALF), and Enhanced Adult Residential Care (EARC's) are required to have intermittent nursing contract so nursing staff is in place to provide nursing care to meet the needs of residents ([WAC 388-78A-2310](#)).
- Adult Family Home may provide intermittent nursing services if the provider is a licensed nurse or use a contracted nurse with a current license in the state of Washington to provide nursing services ([WAC 388-76-10405](#)).
- Enhanced Services Facility (ESF) are required to have a licensed nurse on-site in the facility 24 hours per day, with a Registered Nurse on-site in the facility at least 20 hours per week. Nursing services will be provided as necessary ([WAC 388-107-0240](#)).
- Adult Residential Care facilities are not required to provide intermittent nursing services by contract.

Nurse Delegation

Nurse Delegation is provided by a registered nurse delegator who assesses a client to determine whether they are in a stable and predictable condition; then teaches, evaluates the competency and supervises limited nursing tasks to nursing assistants or home care aides who meet the requirements of a certified home care aide, nursing assistant certified and/or nursing assistant registered in the State of Washington ([WAC 388-76-10405](#)).

In Adult Family Homes (AFH), the cost of nurse delegation can be covered by the MPC, CFC or RSW program. AFH providers may choose to admit or retain residents requiring nurse delegation. Nurse delegation can occur in ALFs and EARCs, but it is not a reimbursable function. Since ALF and EARC have intermittent nursing services by contract, their nursing staff may delegate if they choose ([WAC 388-110-150](#) and [WAC 388-110-220](#)).

Note: Refer to LTC Manual [Chapter 13](#) for additional information regarding Nurse Delegation.

24-hour nursing services

Enhanced Services Facility (ESF) is required to always have a licensed nurse on-site. A Registered Nurse is on-site in the facility 20 hours per week and on-call the remainder of the week to meet any specific nursing needs that cannot be addressed by the licensed nurse on-site ([WAC 388-107-0240](#)).

Waiver Skilled Nursing

This waiver service is available in all waiver settings if it does not duplicate a service that is already provided by contract or another source. Skilled Nursing Services provide direct skilled intermittent nursing tasks to clients. Registered nurses, or Licensed Practical nurses under the supervision of a RN, may provide skilled treatment that is beyond the amount, duration, or scope of Medicaid-reimbursed home health services as provided in [WAC 182-551-2100](#).

Nursing Services

Nursing services are available in all residential settings, when the service does not duplicate a service that is already provided by contract or another source. The frequency and scope of the nursing services is based on individual need as determined by the CARE assessment and additional collateral contact information ([WAC 388-106-0200](#), [WAC 388-106-0300](#), and [WAC 388-107-0070](#) for ESF). Services include:

- (a) Nursing assessment/reassessment,
- (b) Instruction to client or providers,
- (c) Care coordination, file review and referral to other health care providers,
- (d) Skilled treatment only in the event of an emergency that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse and/or,
- (e) Evaluation of health-related care needs affecting service plan and delivery.

Note: For additional information regarding Nursing Services refer to LTC Manual [Chapter 24](#)

DETERMINING PROGRAM ELIGIBILITY FOR RESIDENTIAL SETTING

All Medicaid clients must meet the functional and financial eligibility program requirements before admitting to the facility or converting to Medicaid. Eligibility is determined simultaneously between the Public Benefit Specialist for financial eligibility and by CM/SSS for functional eligibility. Individuals who do not qualify for CFC, RSW or RCL can only move into a contracted AFH or ARC. The following chart shows which residential facility types can be offered to clients based on the financial program they are eligible for:

PROGRAM AVAILABLE IN EACH CONTRACTED FACILITY					
Program	AFH	ARC	EARC	AL	ESF
Community First Choice (CFC)	Yes	Yes	Yes	Yes	No
DDA Waivers	Yes	Yes	No	No	No
Medicaid Personal Care (MPC)	Yes	Yes	No	No	No
New Freedom	No	No	No	No	No
COPES Waivers	Yes	No	Yes	Yes	Yes
Residential Support Waivers	Yes	No	Yes	Yes	Yes
Roads to Community Living (RCL)	No	Yes	Yes	Yes	No
State-funded Medical Care Services (MCS)	Yes	Yes	No	No	No



Referring to CBHS Supportive Supervision and Oversight

For Community Behavioral Health Supports (CBHS) see the LTC Manual [Chapter 22d](#) for information, eligibility and referral process.

Authorizing/Determining the payment rate for residential services.

Authorization for residential services should be entered/complete prior to the client being admitted to the residential setting.

1. Prior to authorizing payment to a provider; the CM/SSS must obtain the client's approval on the plan of care (Refer to LTC Manual [Chapter 3](#)). The CARE Assessment is not complete until it is moved to current. This includes assessments that are completed for a resident converting from private pay to Medicaid in a residential setting. The client must also be financially eligible for residential services or on Fast Track.
2. The CM/SSS must verify the correct amount of the daily rate identified in the CARE Classification for the geographic location of the provider. Current payment rates for Adult Family Homes and Assisted Living Facilities can be found at: [Office of Rates Management](#).
3. Supplementation of the Medicaid rate is only allowed by exception in some limited circumstances. Please see the [Supplementing Medicaid Rate](#) information in this chapter.

Capital Add-On & Bridge Rate

ALFs with an assisted living contract may receive an additional payment amount called a Capital Add-on Rate. The HCLA Rates staff determines if an ALF qualifies for the Capital-Add-on rate annually, each July. Once set, these rates will be active through the State Fiscal year (July 1 – June 30). The CM/SSS will receive notification from headquarters of qualifying facilities and are responsible for adjusting the payment rates for Medicaid residents. ALFs may receive Capital-Add-on Rate for both Medicaid residents when in a shared room. Details on the Capital Add-On program can be found in [WAC 388-105-0035](#). A current list of Capital Add-On providers can be found through the [Office of Rates Management](#) page under "Home and Community."

ALFs with an assisted living, adult residential care, enhanced adult residential care and/or a specialized dementia care contract may receive an additional payment amount called the Bridge Rate. The HCLA Rates staff determines if an ALF qualifies for the Bridge Rate annually using the same methodology as the Capital Add-On rate. **Funding for the Bridge Rate is allocated by the legislature in the biennial budget and may end on June 30 of any year if not funded for the following State Fiscal year.** A current list of Bridge Rate provider can be found through the [Office of Rates Management](#) page under "Home and Community."

ALFs with an assisted living contract may receive both the Capital Add-On Rate and Bridge Rate, these facilities will receive both add-ons for their residents authorized for assisted living services (Service Code: T2031).

Residential Rate Adjustment Capital Add-On and Bridge Add-On on CARE Plan Screen

This field allows Case Managers to track adjustments to the residential rate. The personal care adjustments field is enabled when the planned setting selected is residential.

If the client is receiving personal care in a residential setting and there are adjustments to their rate, they must be calculated and documented in this field. Adjustments will be printed on the Service Summary.

Options available include:

- Bridge Add-on
- Capital Add-on
- Capital Add-on + Bridge rate

Capital Add-On & Bridge Rate Reason Codes

- Staff must begin authorizing new services for October 1, 2025, forward using the new reason codes.
- “Capital Add-On” in Assisted Living Services [T2031] authorizations for residents at facilities that qualify for the Capital Add-On rate and “Capital Add-On and Bridge Add-On” in Assisted Living Services [T2031] authorization for residents at facilities that qualify for both the Capital Add-On rate and the Bridge Add-On rate.
- “Bridge Add-On” in Adult Residential Care Services [T1020, U2] and Enhanced Adult Residential Care Services [T1020, U3] authorization for residents at facilities that qualify for the Bridge Add-On rate.
- Staff will continue to include the specialized dementia care reason codes in Enhanced Adult Residential Care – Specialized Dementia Care Services [T1020, U4] authorization for residents on the Specialized Dementia Care Program.

The Capital Add-On & the Bridge rate are not included on the PAN as they are an incentive for the facility and not based on eligibility criteria for the resident.

COMMUNITY INTEGRATION

Under federal rules, individuals who live in residential settings must have opportunities to engage in community life and not be isolated from their community or other people who do not live in a residential facility.

In contracted AFHs, the Collective Bargaining Agreement provides an increase to the daily rate for community integration of Medicaid residents who have an assessed need for assistance to access and participate in the local community. This does not include PACE clients. To be considered community integration, activities must:

- Be individualized and chosen by the resident based on their interests and preferences,



- Include opportunities to engage in the community with other community members, and
- Occur in the resident's local community.

See [AFH Provider Community Integration FAQs](#) for more information.

If there is a cost to the activity, the cost of the activity is covered by the resident or with assistance from the resident's friends, family, or other community resources.

Activities Not Included Under Community Integration:

- Medical and dental appointments
- Essential shopping
- Adult Day Health
- DDA Community Inclusion and employment services.

Community Integration Eligibility Criteria in AFHs:

To be eligible for Community Integration an individual must be assessed in the comprehensive assessment reporting evaluation tool (CARE) as needing assistance to access and participate in activities in the community.

If the client's current assessment does not reflect the need for assistance with community integration and the client is requesting assistance with community integration; the CM/SSS can create an Interim assessment to include the CI rate adjustment and the CI mileage reimbursement prior to the next annual assessment due date.

- AFH Providers must include documentation of the resident's choice to participate in community integration activities in their Negotiated Care Plan (NCP) when the need is also identified in the resident's CARE assessment.

Community Integration Reimbursement:

Adult Family Home providers must provide services to residents with an assessed need for support to access and participate in the community and will receive an adjusted daily rate to provide four (4) hours of community integration per month.

The rate adjustment for community integration may include the following supports provided by the AFH:

- Assisting the resident to select what they want to do and where they want to go in the community.
- Assisting the resident to plan how they will get to the activity.
- Assisting the resident before the activity to solve any issues that may come up.
- Assisting the resident to become members of community organizations that interest them.

- Assisting residents to identify other people in the community who can accompany them at the event or provide support with transportation.
- Arranging for or providing transportation to and/or from the activity.
- Accompanying the resident during the event to provide personal care assistance.
- Looking for additional opportunities in which the resident may want to participate.

Note: Community Integration may be authorized for residents who receive:

- Specialized Behavior Support
- DDA Community Guide Service
- Expanded Community Services (Refer to LTC Manual [Chapter 7f](#) when authorizing ECS)

The AFH daily rate generated in CARE will include community integration when a resident:

- Has an unmet or partially met need for assistance with community integration; and
- Chooses to receive assistance with community integration from the AFH provider.

Does client want to participate in community activities?		
☒ Yes	☐ No	
Does client need assistance to plan, get to/from, or participate in community activities?		
☒ Yes	☐ No	
Who will help the client participate in community activities?		
☐ Informal	☒ AFH provider	☐ Both
Will a paid caregiver provide transportation in their own vehicle?		
☒ Yes	☐ No	

The AFH daily rate generated in CARE will NOT include community integration when a resident:

- Does not need assistance because their informal supports provide all the CI assistance needed,
- Can independently access the community and does not need assistance, or
- Does not want to access the community.
- When community integration is assessed as a need in CARE, the CI adjusted rate will be automatically calculated when the authorization is created in CARE. ***Do not attempt to add rate manually (exception: if client is a resident in an approved HIV/AIDS AFH, case manager should add the CI rate to the published HIV/AIDS rate).***

Residential		
Daily rate	Mileage can be authorized for...	CI included? ⓘ
\$155.55	Community Integration (100 miles)	Yes

- Community Integration rate adjustments and Community Integration mileage reimbursement are not available for PACE clients.

AFH Providers are expected to maintain documentation on the provision of assistance with community integration and this documentation must be made available to the CM/SSS upon request.

Community Integration Mileage Reimbursement

Adult Family Home providers who transport residents to access and participate in the community as authorized in the resident's CARE assessment will be reimbursed per mile driven for up to 100 miles per month, per participating resident based on the standard IRS mileage rate. This does not include PACE clients.

The Community Integration mileage reimbursement will be authorized when the AFH resident:

- Meets eligibility for Community Integration and the AFH provider or employee will be providing transportation in their vehicle; and
- Chooses to receive transportation from the AFH to and/or from community integration activities.

The Community Integration mileage reimbursement will NOT be authorized when the AFH resident:

- Does not need assistance because their informal support provides all the assistance needed,
- Can independently arrange for all transportation needs,
- Does not want to access the community, or
- Is not driven to and from chosen activities by the AFH provider or employee.

Medical Mileage Reimbursement

Reimbursement is available to an Adult Family Home Provider who transports a resident to medical providers as outlined in the Department's service plan generated by CARE. Reimbursement is available when Medicaid brokerage transportation will not meet the resident's needs.

- The AFH resident must have an assessed need for medical transportation as documented in the CARE service plan.

- Compensation will be paid on a per-mile-driven basis at the standard IRS mileage rate, up to a maximum of fifty (50) miles per month per resident.
- Mileage reimbursement for travel to medical appointments is different from Mileage reimbursement for community integration. Authorization for one does not preclude authorization for the other.
- Mileage reimbursement for travel to medical appointments is not available to AFH provider in the PACE program.
- Non-emergency medical transportation is a covered service under Apple Health. An AFH provider must not be authorized for medical transportation if that service is available through the Medicaid transportation broker.

Medical Escort Fee – [S5125, U1](#)

A medical escort means assistance and accompaniment provided to the resident for the duration of a medical appointment where the resident could not otherwise participate in the medical appointment without assistance, due to physical or cognitive challenges which must be identified in the CARE assessment and Negotiated Care Plan.

This service is used to assist a resident:

- Drive resident to appointment
- Accompany resident at the appointment, including waiting room
- Provide assistance at resident's request

In accordance with the CBA, AFH providers who provide a medical escort to accompany a resident to a medical appointment will be authorized for a medical escort reimbursement rate per hour up to a maximum of twenty-four hours (96 units) to be authorized for the entire plan period. Rates can be found on the [Office of Rates Management website](#).

The following conditions must be met for the AFH provider to be reimbursed for the Medical Escort Fee:

- CRM/SSS must document the resident's need for a medical escort in their CARE assessment. Identify the need for the medical escort on the Medical Transportation screen by answering the two questions and then selecting from the five options indicating what will be provided. Please include any pertinent caregiver instructions and clarifications in the comment box.
- The 96 quarter units are for provider time used to assist and accompany the resident to the medical appointment. It is separate from medical transportation.
- The CRM/SSS will SER the medical escort authorized for 96 units for the planned period.
- The adult family home provider must retain the medical documentation from each appointment in the resident's file and make it available to the HCLA/DDA staff upon request.
- The adult family home provider may not request additional Medical Escort quarter units for the current plan period.

If there is a Significant Change Assessment for **HCS residents only**, the annual assessment date could change. If it does, the SSS must:

- Confirm that the resident is financially eligible before extending the services for 12 months.



- End the Medical Escort authorization line according to the previous assessment plan period. In ProviderOne, using the Medical Escort Fee code S5125, U1 enter a new authorization line for 96 quarter units for the new plan period

If a resident receives Medical Escort in their current plan period and moves to a new AFH, the CRM/SSS will:

- SER the move-in date and assign Medical Escort to the new AFH.
- Determine the exact number of quarter units that the previous AFH claimed in the current plan period.
- In ProviderOne, using the Medical Escort Fee code S5125, U1 enter the authorization line to the new AFH in quarter units for the remaining units available for the plan period.

If CRM/SSS is concerned about the use of the Medical Escort payment to an AFH they should:

- Staff the concern with their supervisor. If needed:
 - DDCS CRM and supervisor can review the case with DDCS State Plan Residential Program Manager.
 - HCS CM/SSS and their supervisor can review the case with the HCS Residential Policy Program Manager.

Notes:

- AFH providers are not eligible for the medical escort fee if the resident is receiving one-on-one caregiver support during the time of the medical appointment.
- Reimbursement will be paid after providing a medical escort service to a Medicaid resident when all other means of escort have been exhausted.

SPECIALIZED DEMENTIA CARE PROGRAM

SDCP Eligibility Criteria

The eligibility for the SDCP program is defined in [WAC 388-106-0033](#). To be eligible for the SDC program an individual must be:

- Financially eligible for CFC as defined in [WAC 388-106-0277](#).
- May not be participating in the PACE Program or on a Residential Support Waiver (RSW).
- Functionally eligible for CFC as defined in [WAC 388-106-0277](#).
- Be assessed by the comprehensive assessment reporting evaluation tool (CARE) as having a cognitive Performance Score of 3 or above.
- Have a current or past with current intervention qualifying Behavior listed in [WAC 388-106-0033](#) or a self-performance code of supervision, limited assistance, extensive assistance or total dependence in eating.
- Have written or verbal confirmation from a health care practitioner of an irreversible dementia diagnosis (such as Alzheimer's disease, Frontotemporal dementia (Pick's disease), Lewy Body



dementia, Vascular dementia, multi-infarct dementia, Alcohol-related dementia, or Major Neurocognitive Disorder) or a diagnosis of Wernicke-Korsakoff syndrome.

Specialized Dementia Care Program Authorization

Any new authorizations for Specialized Dementia Care Program (SDCP) must have prior approval from HCLA headquarters staff. New authorizations do not include extensions of current services.

As the diagnosis is irreversible, CM/SSS also do not need to obtain any additional approvals for SDCP when a resident moves to another SDCP facility even if the resident moves to another setting type and then returns to a SDCP Facility.

SDCP Case Manager/Social Service Specialist Responsibilities:

- When a facility requests an SDCP approval for a current Medicaid client or a resident converting from private pay that resides in the EARC-SDC section of the facility, and meets the eligibility criteria; the client must not be referred to for the SDC program until:
 - A facility provides a copy of the NSA or NCP with clear documentation explaining what positive interventions and supports were used prior to moving a resident in an area that is restricted and explanation of less intrusive methods of meeting the need were tried that did not work.
 - Document approval from the resident or legal guardian to continue to reside in the SDC facility.
 - If a facility did not provide a copy of the NSA or NCP; CM/SSS will need to request a copy.
- The CM/SSS must review the NSA or NCP to make sure that the facility is following Code of Federal Regulations (CFR) [§441.301](#) (4)(F)(1) through (8) federal rules regarding the resident's rights and has documented any restriction or modification in the resident's Negotiated Service Agreement or Negotiated Care Plan. Send a copy to DMS.
- CM/SSS will need to complete initial CARE assessment for a conversion with documentation explaining what less intrusive methods and positive interventions of meeting the resident's needs that have been tried but have not worked. Or an Interim assessment if client is currently on Medicaid services. Note: If the Interim assessment created to add required documentations results in a change in CARE classification a face-to-face Significant Change assessment will need to be completed.
- ***To document the modification of the resident's rights for SDCP:***
The **Alzheimer's/dementia special care program** must be selected in the CARE/Treatment screen with the following documentation on the comment section explaining:



- The specific client need that is being addressed by moving the client to an area with delayed egress. (It is not acceptable to state see behaviors in assessment; the need must be specific to the client and identified).
 - The positive interventions and supports as well as their location that were used prior to address the need before moving the client in an area with delayed egress that were unsuccessful.
 - The informed consent of the resident/guardian agreeing to living in a setting with delayed egress. **Client must be asked regardless of cognition and response noted even when there is a durable power of attorney or power of attorney.**
- Verify that the Assisted Living Facility has a current EARC-SDC contract using the [ALF Locator for Professionals & Providers](#).
- Preference is that the CARE Assessment be finalized, however, to support and facilitate successful transition planning assessments may be approved in pending status.
 - When the assessment is approved in pending status it is the CM/SSS's responsibility to ensure the client is still eligible once the assessment is finalized and prior to authorizing services.
 - If the client does not transition to a SDC facility based on pending approval, the client will need additional approval in the future if they again consider moving to an SDC facility.
- Send the SDCP eligibility checklist form [DSHS 14-534](#) to SDCP@dshs.wa.gov.
- When the CM/SSS receives approval for SDCP authorization, the CM/SSS will need to send a copy of SDCP Eligibility Checklist form to DMS as part of client's record.
- Send a Planned Action Notice to the client or his/her representative of approval for Specialized Dementia Care Program using the SDCP rate.
- Complete the Financial/Social Services Communication 14-443 in barcode to notify Public Benefit Specialist of SDCP authorization rate approval.

Note: Federal rules also require periodic reviews to determine if the modification is still effective, necessary, or could be terminated. At annual review CM/SSS will need to:

- Re-assessed the need for and effectiveness of the restriction or modification with the resident; and
- The modification or restriction continues to be necessary and effective or
- Should be discontinued (e.g., in the SDCP, this documentation could include that the setting with restricted egress continues to be the appropriate setting to meet this resident's needs and that the resident benefits from the services provided in this setting).



For more detailed information regarding modification to a Medicaid resident's rights and where to documents modification in CARE; refer to the [Client Rights in HCBS Settings](#) in this chapter.

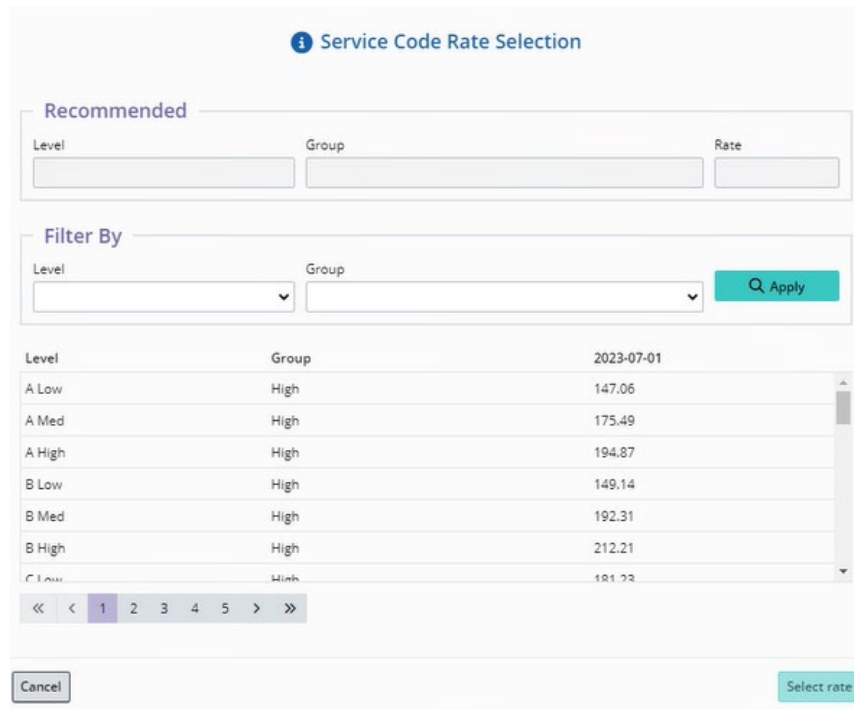
The approval process:

- When approved or denied, the SDCP Program Manager will post SERs in CARE and will also notify CM/SSS via-email of the approval or denied.
- When CM/SSS receives an approval for SDCP authorization, CM/SSS will need to send a copy of SDCP Eligibility Checklist form to DMS as part of client's record.
- Send a Planned Action Notice to the client or his/her representative of approval for Specialized Dementia Care Program using the SDCP rate.
 - Mark as "Approved" and check "other" in reason.
 - Write in SDC Program
 - In the "other comment" write "You are functionally approved for Specialty Dementia Care Program at a rate of \$X.XX."
- Complete 14-443 to notify Public Benefit Specialist of SDCP authorization rate approval.

SDCP Authorization Process:

- When authorizing SDCP service in ProviderOne; CM/SSS will need to use SDCP approval rate with:
 - RAC Eligibility 3052 – CFC-Specialized Dementia Care Program
 - RAC Eligibility 3002 – CFC plus COPES-Specialized Dementia Care Program
- Service code of T1020_U4 (Special Dementia Care Services).
- Select the Reason Code based on the service or rate of the SDCP being authorized:
 - Specialized Dementia Care
 - Specialized Dementia Care Enhanced
 - Specialized Dementia Care Acute Care – Reminder this rate is only for the facility the client discharges directly to from an Acute Hospital Bed. The rate does not continue if the client changes SDCP-ALF or any other settings.

Rates are now showing in CARE when you select the “Lookup rate” button on the authorization. To select the correct rate the CARE Classification Level and the Cost Service Area will be needed:



Level	Group	2023-07-01
A Low	High	147.06
A Med	High	175.49
A High	High	194.87
B Low	High	149.14
B Med	High	192.31
B High	High	212.21
C Low	High	181.73

If a resident transfers to another Specialized Dementia Care facility, the CM/SSS is not required to send another SDCP eligibility checklist. The CM/SSS will only need to check if the facility has EARC-SDC contract via the [ALF Locator for Professionals & Providers](#) unless:

- Client is requesting transition to SDC Enhanced Program from SDCP, or
- Client is discharging from an acute care hospital, and the acute care add-on needs approval.
- The department **will not approve retroactive payments** unless the resident is converting from private pay to Medicaid, the assessment has been completed and is currently showing the resident is eligible, and the resident was waiting for a Public Benefit Specialist eligibility determination that was delayed.
- It is permissible to authorize Fast Track on CFC with Specialized Dementia Care. When a client is eligible (and for Fast Track we are presuming eligibility), the client is eligible for all services they are assessed for.

The daily reimbursable rate for this service is set by the Legislature and based on an individual’s CARE Assessment Classification and the High Cost or Standard Cost Area they are receiving services. Rates can also be found at [Office of Rate Management](#) under Home & Community Services Rates Excel | PDF.

Personal care adjustments: Residential

This field is found on the Care Plan screen and allows CM/SSS to track adjustments to the residential rate. The personal care adjustments field is enabled when the planned setting selected is residential. If the client is receiving personal care in a residential setting and there are adjustments to their rate, they must be calculated and documented in this field. Adjustments will be printed on the Service Summary.

Options available include:

- Specialized Dementia Care Program - \$50
- SDCP Acute Hospital - \$60
- SDCP Enhanced - \$140

If the client is discharging from an Acute Care Hospital, then select both Specialized Dementia Care Program and SDCP Acute Hospital from the drop-down menu.

The SDCP Acute Care Add-On is not included on the PAN as the incentive is for the facility and not based on eligibility criteria for the resident.

DETERMINING ROOM AND BOARD

Determining a client's room and board towards the cost of their personal care.

Clients with income may be required to pay towards the cost of their Room & Board (R&B) as a part of Client Responsibility (CR). CR consists of three parts: R&B, Participation and Third-Party Resources. Clients may keep a personal needs allowance (PNA) for clothing and personal/incidental items. Refer to [Program standard for income and resources](#) for overview information on Client Responsibility (CR) and program standard for income and resources. Reference the [Social Services Authorization Manual \(SSAM\)](#) for information on how CR is applied to authorizations. This section will focus on residents served under medical programs, where the CM/SSS is responsible for determining only R&B.

Responsibilities when Case Managers are required to determine Room and Board

For clients whose medical program is maintained by HCA, or they are receiving Medical Care Services (MCS) and in a residential setting, the CM/SSS is responsible for determining the R&B. The chart below notes the ACES Medical Groups, where the CM/SSS determines R&B. All ACES Medical Coverage Groups used in Long Term Supports and Services (LTSS) may be found at the following link: [LTSS Medical Coverage Groups](#). The [Client Responsibility Notice \(DSHS 18-720\)](#) must be completed and sent to clients or client representatives. The CM/SSS enters the client's R&B on the Financial Screen in CARE. This takes the place of the PBS determining CR and entering it into ACES, the R&B entered by the CM/SSS will feed into ProviderOne and reduce the provider's authorization by the set amount. See [SSAM – Client Responsibility – Managing Client Responsibility](#) in CARE and the CARE Web Help for how to complete the [Financial Screen](#).

Medical Coverage Groups – CM/SSS determines R&B

ACES Medical Program	LTS Programs & Residential Settings
N01, N02, N03, N04, N05, N07, N23*	MPC – ARC or AFH CFC - AFH, ARC, EARC, ALF or EARC-SDC *N23 only covers MPC
N11 Children (age 19 & under)	MPC – ARC or AFH CFC - AFH, ARC, EARC, ALF or EARC-SDC
A01/A05/A24 State Funded (Not HCA Program)	Medical Care Services (MCS) – ARC or AFH
S30 Overall program eligibility is with DOH	MPC – ARC or AFH CFC - AFH, ARC, EARC, ALF or EARC-SDC
D01^b, D02^b, D26	MPC – ARC or AFH CFC - AFH, ARC, EARC, ALF or EARC-SDC
N24/N27	MPC – ARC or AFH
R03	MPC – ARC or AFH CFC - AFH, ARC, EARC, ALF or SDC- EARC-SDC

b – DDCS, for children only and foster care Must have disability, resource, and income determination for HCB Waiver services. (HCB Waiver services can be used for individuals on foster care if a disability determination has been established and coordinated between DDA and HCA foster care.) HCS does not have foster care indicated as a covered group in the HCS HCBS Waivers. For the D track clients that need an HCS HCBS Waiver, an 18-005 must be submitted for eligibility determination under HCS HCBS L22 rules.

Client's receiving SSI Categorically Needy (S01) or SSI-related Categorically Needy (S02) Medical and in Need of LTSS

S01 & S02 clients should be converted to an L-Track to receive LTSS. However, clients may start services while still on S01 or S02 as the HCS PBS transitions them to the L-Track. The CM/SSS should not have to determine R&B as the HCS PBS will enter it into ACES per the typical L-Track process.

CM/SSS responsibilities for R&B determination when Client's receiving ABD Cash Grant on Medical Care Services (MCS)

Clients on MCS fall under ACES Medical Groups A01, A05 and A24 and are held by the HCS PBS staff. For clients in ALF under an Adult Residential Care (ARC) contract, HCS PBS staff reduces the grant amount to the PNA and CM/SSS does not act. However, if the client resides in an AFH the CM/SSS determines the R&B amount and enters it into CARE.

CM/SSS Responsibility for R&B determination when a client is on ABD Cash Grant and a Medical Group held by HCA

Clients on any of the ACES Medical Programs listed above held by HCA and who also receive an ABD Cash, the CM/SSS determines the R&B amount only for those residing in an AFH. For clients in AL, EARC, ARC or EARC-SDC settings, Community Services Division (CSD) PBS staff reduces the grant amount to the PNA and CM/SSS does not act.

When and how do I report changes to CSD for clients with LTSS

There may be times when the ABD Cash Grant is coded incorrectly, a residential client has open food benefits or Ongoing Additional Requirements (OAR) benefits open([20 CFR 416.1121](#)). In those situations, the CM/SSS would report the errors to CSD. To report changes to CSD e-mail:

Listmaster Address: listmaster.csd@dshs.wa.gov.

Include the following in your email:

- Head of Household Name
- Client name, if different
- Client ACES ID
- Name of Facility and Facility Type - Please do not use acronyms as they may differ across departments.
- Address of Facility
- Summary of case action needed

Case Manager Responsibility for Income Changes and Room & Board Determination

(For DDCCS staff, please see DDCCS Policy 6.06 – Client Responsibility).

For HCS Staff:

- CM/SSSs will request clients, payees, and/or guardians report information regarding clients total income any time there is a change. Total income includes Earned Income and Unearned Income.
 - **Earned Income** includes salaries, wages, commissions, bonuses, severance pay, and other cash or in-kind payments received because of employment; net earnings from self-employment; earned income tax credits; tax refunds; payment for services performed in a sheltered workshop or work activities center; and certain royalties and honoraria ([20 CFR 416.1110](#)).
 - **Unearned Income** means income that is not earned, including annuities, pensions, Supplemental Security Income, Social Security benefits, disability benefits, Veteran's benefits, worker's compensation, Railroad Retirement annuities, unemployment insurance benefits, alimony and support payments, dividends, interest, and certain royalties, rents, death benefits, prizes and awards, gifts, tribal income and inheritances,

and support and maintenance in-kind ([20 CFR 416.1121](#)). For information on Tribal Income review [HCA Income Overview 1](#) and [HCA Tribal Income desk aid](#).

- Clients, payees and/or guardians may report client income by attestation, verbally or written. CM/SSS will note in SER the following as applicable and if written attestation is provided, submit the documents to DMS:
 - Total Gross Earned Income and source
 - Total Unearned Income and source
 - Allowable Exemptions as permitted
- CM/SSS will always encourage clients/payees and/or guardians to update income changes in the HPF.
- CM/SSSs will issue the [Client Responsibility Notice \(DSHS 18-720\)](#) each time the R&B amount is changed.
- For clients who do not report earned income changes timely, the CM/SSS will follow the guidelines in [SSAM Reimbursement Related to Client Responsibility](#).
- The HCS MAGI [Room and Board Calculator](#) can be found under **Resources** on the [Affordable Care Act Resources website](#). The calculator may be used to assist CM/SSSs in determining R&B and proration of R&B for partial months.

Verifying Income in ACES On-line (except ABD Cash Grant)

The MAGI income information in ACES can be updated directly by clients through the HealthPlanFinder (HPF), but the system does not show when or by whom the information was changed. Because of this, MAGI data in ACES may not be the most reliable source for verifying income, especially for clients that have earned income. HCA uses the client reported MAGI amount when determining whether the information is compatible with data sources at the time of review.

Verification of the most current information can be found by reviewing narratives by HCA workers as well as reviewing the Client Level Eligibility Results Screen and/or the Healthplanfinder Income screen.

Eligibility Results

Eligibility Calculation		Miscellaneous	
Total Gross Income	1000.00	Benefit Effective Date	11/23/2024
Allowable Deductions	0.00	Review Begin Date	01/2025
Net Income	1000.00	Review End Date	12/2025
Net Income Standard	1734.32	This standard is based on HH size in HPF.	
Premium Amount	0.00		
State Verified Net Income Amount	1000.00		
State Verified Net Income FPL Percentage	71		
Net Income FPL Percentage	72		
Compatibility Indicator	Reasonably Compatible - No Income (A)		
State Income Compatibility	Reasonably Compatible (Y)		
DSHS Verified Income FPL Percentage	0		
DSHS Program Compatibility	Not Reasonably Compatible - No Income (B)		

Healthplanfinder Income

Primary Language	English (EN)
Extra Help Needed	No (N)
Healthplanfinder Income of Child/Tax Dependent	
Healthplanfinder Earned Income	
Healthplanfinder Unearned Income: Pension or Military Benefits (MBI)	
Begin Date	12/01/2017
End Date	OnGoing
Lump Sum Received Date	
Income Amount	1000.00
Frequency Type	Monthly (MO)

If the HPF Income screen does not match the Client Level Eligibility Results Screen, then only use the Eligibility Results Screen. When the HPF Income screen has a green box or background, this indicates that the information is loaded from the HFP. If the background or box is blue, this indicates that the information was entered by HCS or CSD. As prior information is not removed, income entered by HCS or CSD may be past, this is why we use only the Eligibility Results Screen unless there is narrative, information or an open benefit from CSD to indicate the information is current.

If there are other members listed in the household this may mean the client has not updated their address with HCA. Please use caution and ensure client confirms income amounts for R&B as household income is used for MAGI eligibility.

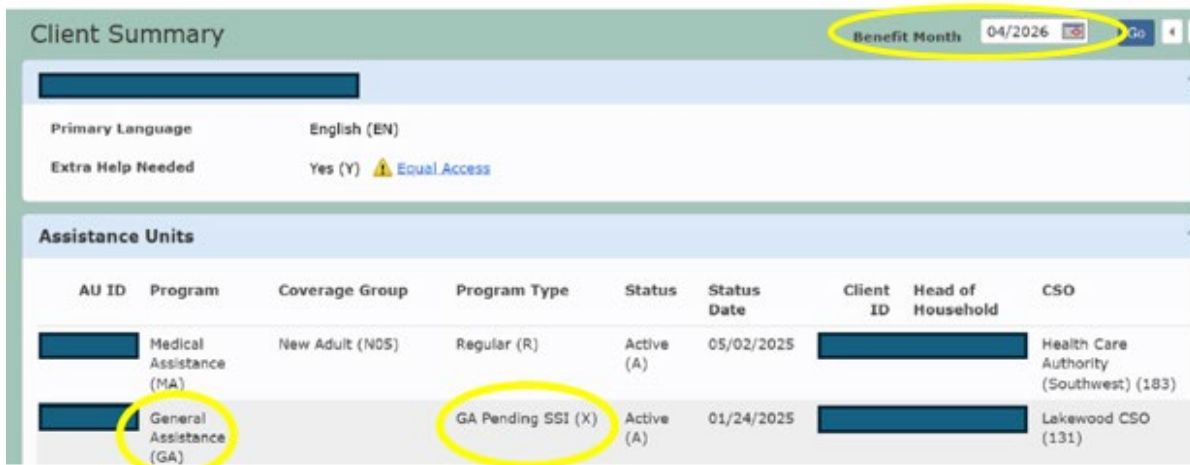
If the Earned or Unearned Income is in a green box, the information was pulled from HPF. If the Earned or Unearned Income is in a blue box, it was entered into ACES by HCS PBS or CSD. Always use information for HPF

CM/SSS responsibilities for reporting income changes to HCA when client refuses

It is the responsibility of the client, payee and/or guardian to report and update their income in the [Healthplanfinder](#). When a client reports a change in income, use the Information Sharing for HCS and DDCS document for instruction on to report income changes. Additionally, if a client indicates they have no intention of notifying HCA of a change in income and the change is expected to last two months or more and exceeds the Net Income Standard indicated on the Eligibility Results screen, CM/SSS may follow the instructions per the HCA document, [MAGI Information Sharing for HCS and DDCS](#) for reporting themselves.

Verifying ABD Cash Grant Amount

When a client is active on General Assistance (GA) there are two types, GA Pending SSI (X) or Unemployed (U), they receive a cash grant up to \$450.00. To verify the amount a client is receiving, click on the client's AU ID for General Assistance (GA). Review the Benefit Month in the upper right-hand corner as ACES displays a month ahead of the current month, you may need to adjust to the past or the future depending on the timeframe you are seeking.



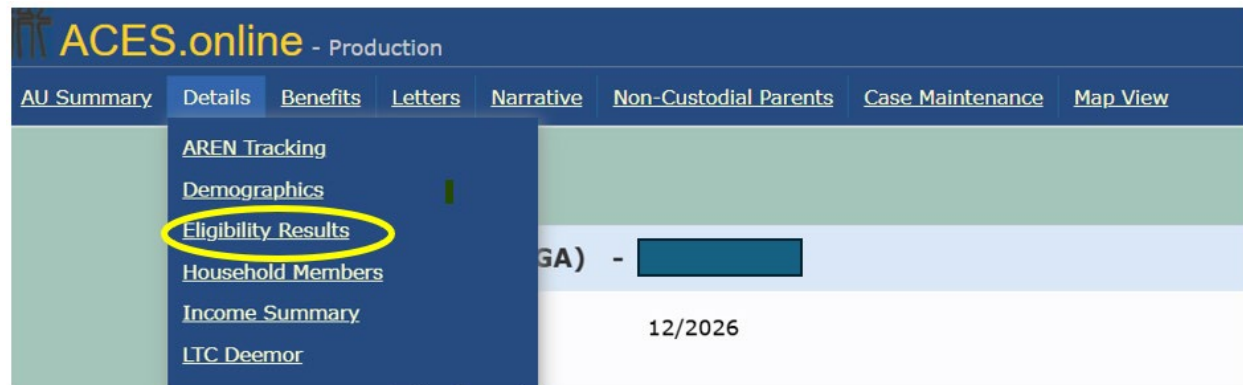
Client Summary								
Benefit Month 04/2026								
Primary Language		English (EN)						
Extra Help Needed		Yes (Y) Equal Access						
Assistance Units								
AU ID	Program	Coverage Group	Program Type	Status	Status Date	Client ID	Head of Household	CSO
	Medical Assistance (MA)	New Adult (NOS)	Regular (R)	Active (A)	05/02/2025			Health Care Authority (Southwest) (183)
	General Assistance (GA)		GA Pending SSI (X)	Active (A)	01/24/2025			Lakewood CSO (131)

This will take you to the AU Summary page.



Client ID	Name	Relationship	Alien Status	Financial Resp	Status	Paid Thru Date
[REDACTED]	[REDACTED]	Self/Head of Household (SE)	Federally Qualified (FQ)	Recipient (RE)	Active (A)	

From the AU Summary page, when you will then select Eligibility Results from the Details section.



Scroll to the bottom of the Eligibility Results page and it will give the grant amount to use for R&B as the Benefit Amount.

SUPPLEMENTING THE MEDICAID RATE

Supplementation of the Medicaid daily payment rate is an additional payment requested from a Medicaid recipient or a third-party payer by an Adult Family Home (AFH) contractor or a licensed Assisted Living (AL) contractor with a contract to provide adult residential care (ARC), enhanced adult residential care (EARC), assisted living (AL) services, or an enhanced services facility (ESF). By federal rule ([42 CFR 447.15](#)), the state must limit participation in the Medicaid program to only providers who accept the Medicaid state payment and client participation as payment in full.

Supplementation for services or items

The AFH, AL, ARC, ESF, or EARC contractor **may not** request supplemental payment of a Medicaid recipient's daily rate for services or items that are covered in the daily rate, and the contractor is required to provide:

- A. Under licensing [Chapter 388-76 WAC](#), [Chapter 388-78A WAC](#), [Chapter 388-107 WAC](#), and/or

- B. In accordance with his or her contract [Chapter 388-110 WAC](#) with the department; and
- C. As outlined in the resident's CARE plan.

Supplementation for a unit or bedroom

When a contractor only has one type of unit or all private bedrooms, the provider may not request supplementation from the Medicaid applicant/resident or a third party, unless the unit or private bedroom has an amenity that some or all the other units or private bedrooms lack e.g., a bathroom in the private bedroom, a view unit, etc.

A facility cannot request supplementation for a private room when the room is only large enough for one person.

Adult Family Homes are required to provide a minimum of 80 square feet for single occupancy rooms. Double occupancy rooms must be at least 120 square feet. More information on bedroom space in Adult Family Homes can be found in [WAC 388-76-10690](#).

Sleeping rooms within EARCs and ARCs must be no less than 80 square feet for a one-person room and no less than 70 square feet per person for a two-person room. Private units within an ALF must be a minimum of 220 square feet. More information on Resident Units can be found in [WAC 388-78A-3010](#).

When a contractor may request supplemental payment

- A. Before a contractor may request supplemental payments for items **not covered in the Medicaid rate**, the contractor must have a supplemental payment policy that has been given to all applicants at admittance and to current residents. The policy must be in accordance with [WAC 388-105-0050](#) and [WAC 388-105-0055](#) and must follow the department contract per [WAC 388-76-10205](#) and [WAC 388-105-0050](#). The Contractor may not request supplemental payment of a Medicaid recipient's daily rate for services, items covered by the Medicaid daily rate, move-in fees, and/or refundable or non-refundable deposits, in accordance with [Chapter 388-76 WAC](#), [RCW 70.129.030 \(4\)](#), [RCW 74.39A.901](#), this Contract, and the Client's NCP.
- B. The Contractor must disclose in the Admission Agreement per [WAC 388-76-10540](#) and the 'Policy on accepting Medicaid as a payment source' [WAC 388-76-10522](#), any changes that could occur if a resident becomes eligible for Medicaid funding. The Contractor shall refund to the Client, on a prorated basis, the amount prepaid for care of that Client if the Client becomes eligible for Medicaid funding or moves out of the home before the end of the month.



- C. If a family member or friend purchases additional items or services through the contractor that are not provided for under the Medicaid contract, he or she must pay the Contractor directly to avoid jeopardizing the resident's financial eligibility.

In all cases of supplementation, the contractor is required to notify the department case manager of the additional charges, what they are for, and who is paying them. Violations of the supplementation rules will be reported to the Complaint Resolution Unit (CRU). The CRU will investigate and refer to the Medicaid Fraud Unit if appropriate. The Complaint Resolution phone number is: **1-800-562-6078**.

Examples of supplementation

- 1) If a residential room is approved by Residential Care Services (RCS) for double occupancy and a Medicaid resident's family wants to pay extra for a private room, the contractor can charge extra if the facility has included this in their supplementation payment policy. The exception would be if the facility agreed in the NSA/NCP to provide a private room to meet the resident's needs. If the room is a single occupancy room, the provider is not allowed to charge extra for the room. The extra fee associated with a single occupancy room should be a reasonable amount. If the resident or family feels it is not a reasonable amount, they should be directed to call the CRU. If the family chooses to pay this extra amount, they must pay the provider directly.
- 2) In the case of a Medicaid client who is assigned participation greater than the cost of care, and the individual wishes to use their excess income to purchase additional care and/or services from the provider, the resident can use his own financial resources to hire additional assistance following the same guidelines for supplementation. The services must be above and beyond what the facility is already contracted to provide for any resident in the facility under their Medicaid contract. The facility cannot stop providing any current level of services to the resident nor have the person hired by the resident take over any services required under the contract and the client's CARE plan.
- 3) If a resident prefers a brand name incontinent brief rather than the generic brand the home provides. The client would be expected to pay the difference in price.

Note: When a Medicaid client is related to the AFH provider and is residing in a licensed and contracted room; the CM/SSS must authorize AFH services using the daily rate based on CARE classification (the same as an unrelated client).

CASE MANAGERS/SOCIAL SERVICE SPECIALISTS RESPONSIBILITIES

An AAA or HCS CM/SSS may assist a client to enter a residential facility. HCS provides initial and ongoing case management to all Medicaid clients in residential facilities. The CM/SSS is responsible for:

- Completing Initial, Annual, and Significant Change Assessments,
- Doing a 30-day contact,
- Assisting the client with identifying residential setting options,
- Coordinating admissions with providers,
- Reviewing the assessment, service summary, and negotiated service agreement/ negotiated care plan,
- Ensuring Client Rights,
- Requesting Necessary ETRs,
- Completing Bed Hold requests,
- Monitoring Social Leave,
- Coordinating with RCS, and
- If necessary, helping to coordinate a client's move.

NOTE: If a copy of the NCP or NSA has not been returned within 30 days but has been requested by the CM/SSS, make a report to the Complaint Resolution Unit (CRU) by phone at 1-800-562-6078 or [online](#). For those residents receiving Residential Support Waiver services, a copy of the Behavior Support and Crisis Plan are also required to be provided to the assigned case manager/SSS. See LTC Manual [Chapter 7f](#) for more information.

Assisting a client to move into a residential setting.

Prior to the move the CM/SSS must:

- Complete a CARE Assessment to determine functional eligibility.
- Discuss/Review with the client, and/or his/her representative the Client's Rights and Responsibilities [Form 16-172](#) and answer any questions about the client's rights and responsibilities. Have the client or the client's representative sign two copies of the form when completing the initial CARE assessment. File one copy in DMS and give the other copy to the client.
- Discuss with the client, and/or his/her representative, client's rights in HCBS settings and Long-Term Care Resident's rights as outlined in [Chapter 70.129 RCW](#) and the [Client's Rights Section of this chapter](#).



- Discuss with the client, and/or his/her representative about Medical/Social Leave Policy as outlined in [WAC 388-105-0045](#) and [WAC 388-110-100](#). For detailed information, refer to the Bed Hold and Social Leave Policy section of this chapter ([Bed Holds for Medical Leave](#)).
- Provide information to clients so they can make informed choices about residential options.
- Discuss with the client his/her preferences identified on the Care Plan screen in the CARE assessment and then assist the client in selecting a residential setting that will meet his/her needs. Document in the SER the client's choice of long-term care setting and provider.
- Ensure that the client meets the functional and financial eligibility for HCS programs.
- Coordinate with the HCS residential CM/SSS assigned to the facility. For details information refer to LTC Manual [Chapter 5](#).
- Review and provide copies of the Assessment Details and Service Summary to the provider prior to a client's admission and document in SER.
- Have the client approve and sign the Department's plan of care and inform the client and/or their representative of any client responsibility and room and board. Document plan approval in the SER. For addition information refer to LTC Manual [Chapter 3](#).
- Verify if the AFH/ALF is licensed and contracted by clicking the following link:
 - [AFH Lookup](#)
 - [ALF Lookup](#)

Verify Specialty Designation

Clients who have a developmental disability, mental illness, or dementia can only be served in facilities with a specialty designation. Case Managers/Social Service Specialists are required to verify if the provider has the correct Specialty Designation training by going to the RCS "AFH Look-Up" to verify if the provider has completed the Specialty Designation training. This look-up is not always up to date. *If the provider has proof of a certificate* but is not listed on the lookup as having completed the specialty designation, follow these steps:

1. To check for Mental Health or Dementia Specialty Training:

Go to the Providers and Professionals page on the HCLA website at:

<https://fortress.wa.gov/dshs/adsaapps/Professional/training/training.aspx>

- On Find a Training Class Section
- Check both boxes in the Mental Health and Dementia Specialty section, then click on **Find Instructors box** (at the bottom)



- Once you click on Find Instructors box, you will find the list of approved instructors in the training class search results section.
- Review the list to verify the name of the instructor who signed the certificate.

2. To check for Development Disability Specialty Training: To find Development Disabilities Specialty Training, please go [here](#).

Note: DDA, MH or Dementia. If the person who signed the certificate's name appears on the list of approved instructors, the CM/SSS will need to document in the client's SER verifying that the provider does have the specialty designation required to care for clients with Developmental Disability, Mental Health or Dementia diagnosis.

Adult Family Homes/Assisted Living Facilities Specialty Training Requirements must be the Manager Specialty Training. Manager specialty training is required for assisted living facility administrators (or designees), adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that serve residents who have one or more of the following special needs: developmental disabilities, dementia, or mental health per [RCW 18.20.270](#) and [RCW 70.128.230](#) and [WAC 388-112A-0400](#).

If a resident develops special needs while living in a facility without a specialty designation the provider, entity representative, resident manager and facility administrator (or designee) has 120 days to complete manager specialty training or developmental disability caregiver training, and demonstrate competency per [WAC 388-112A-0490](#).

Providers serving residents with different specialty needs. When providers serve two or more residents with different specialty needs, they must obtain a separate specialty designation for each of the specialty needs. CM/SSS are required to verify if the provider has the correct Specialty Designation training.

Providers serving residents that have more than one special need. When a provider serves a resident that has needs in more than one of the special needs areas, by [WAC 388-112A-0410](#), the AFH, ALF, or ESF must determine which of the specialty training classes will most appropriately address the overall needs of the resident and ensure that the appropriate specialty training class is complete. If additional training beyond the specialty training is needed to meet all the resident's needs, the AFH, ALF, or ESF must ensure additional training is completed.

If a resident has more than one specialty needs, CM/SSS must document in SERs which specialty training the AFH, ALF, or ESF has determined to meet all the resident's needs.



DSHS form [10-234a](#), Individual with Complex Behaviors (Home and Community Living Administration) applies to HCS and DDA clients in all residential settings. Send the original copy of the form to the provider and a copy to the Hub Imaging Unit (HIU) to become part of the client's record.

Note: Assisted Living Facilities are required by ([WAC 388-78A-2060](#)) to do their own preadmission assessment prior to admitting any resident. Adult Family Homes are NOT required to do the same. AFH providers are however required to obtain an assessment completed by the CM/SSS, or a qualified assessor that documents the prospective client's needs and preferences before admitting the client to the home, ([WAC 388-76-10330](#))

Once admission is approved the CM/SSS will need to:

1. Help coordinate the client's move, if needed.
2. Notify the Public Benefit Specialist of the date of admission, the program authorized, and any other pertinent information using the Financial/Social Services Communication [Form 14-443](#).
3. When client's responsibility and room and board is determined, authorize the payment in ProviderOne to the provider effective the day the client moves into the facility. Refer to [Social Services Authorization Manual](#).
4. Notify the receiving CM/SSS of the admission date to the new facility. Inform the receiving CM/SSS that a 30-day contact is required within that time frame. Refer to LTC Manual [Chapter 5](#) for additional clarification on when a 30 day visit is required instead of a telephone contact within 30 days of admission.
5. CM/SSS must complete the Individuals with Complex Behaviors (DSHS 10-234a) form for clients with challenging behaviors (assaultive, destructive, self-injuries, inappropriate sexual behaviors, or history of misdemeanor behavior). Refer to LTC Manual [Chapter 5](#); under resources for additional information.
6. Transfer the client's file and CARE assessment using instructions found in the Assessment Chapter of the LTC Manual [Chapter 3](#).

Assisting with community integration in AFHs

CM/SSS responsibilities include:

- Assessing the need for assistance with community integration,
- Assessing the need for assistance with community integration mileage reimbursement for AFH providers,
- Authorizing community integration mileage reimbursement for AFH providers, and
- Completing planned action notices.

ASSISTING A CLIENT WITH RELOCATION

Clients may be required to move for several reasons. This section outlines the responsibilities for RCS, HCS and providers when a facility is requiring residents to move.

When a client wants to move out of the facility, the facility will need to assist and coordinate the client's transfer or discharge. Clients may move at will and are not required to give notice.

RCS responsibilities

As a result of a facility inspection/survey, Residential Care Services can:

- (a) Issue a statement of deficiency.
- (b) Stop the admission of new residents into facilities. When RCS determines the need for a Stop Placement, they will notify appropriate local entities and governmental organizations of the decision.
- (c) Suspend or revoke a facility's license. When RCS decides to revoke or suspend the license of a facility, both HCS and RCS work together to ensure the transfer of Medicaid clients to another residential setting.
- (d) Close a facility.

Be aware that **notices from RCS are confidential** when related to potential or planned closures, License Revocations, and Summary Suspensions. Also note that the facility administration, clients and families will not be advised of pending action.

HCS responsibilities

When an ALF, AFH, or ESF is closed, HCS is responsible for assisting clients to relocate in a timely manner. Moving can be a stressful time for any client. When assisting a client to move, you may need to use other resources such as:

- A. The Long-Term Care Ombudsman Program,
- B. The regional RCS staff assigned to that facility,
- C. The RCS Complaint Resolution Unit,
- D. Your supervisor or Regional Administrator; and
- E. The headquarters Residential Program Manager.

Note: The above is for closure of a facility and not termination of the Medicaid Contract.

When a Medicaid client requests to move, you will need to:

- 1. Work with the facility staff.
- 2. When eligible, consider using the discharge resources if the client is moving to a less restrictive setting. See LTC Manual [Chapter 10](#) more information on relocation resources.



3. Coordinate with other CM/SSS, if necessary (e.g., DDA or BHA).

When a provider wants a client to move

1. Review or complete an assessment and review the current Negotiated Service Agreement/Negotiated Service Plan/ Person Centered Service Plan to determine if there is a legitimate reason for the move that is consistent with [RCW 70.129.110](#). For RSW service recipients, review the Behavior Support and Crisis Plan and the residential facility's behavioral monitoring documentation. If after reviewing/completing the assessment and reviewing the NSA/NCP/PCSP and other accompanying documentation:
 - a. You find the facility has tried to reasonably accommodate the client's care needs and the care needs still exceed the license or contract limit of the facility; you will need to coordinate the relocation of the client to a different setting. If necessary, contact the RCS District Manager to obtain clarification of any license or contract requirements.
 - b. You find there is no valid reason for discharge, and if the client wants to stay, try to resolve the issue with the provider. If you are unable to resolve the conflict, consult with your supervisor about referring the case to the Residential Care Services Complaint Resolution Unit at: **1-800-562-6078**. Also, let the client know he/she can contact the Ombudsman or file a complaint with RCS.
 - c. Ensure the client has received a Notice of Transfer or Discharge with information for appropriate legal counsel information and encourage or assist client to contact appropriate legal counsel.

Note: Be aware that periodically facilities may require the residents to sign new/revised admission agreements. Residents and informal supports should carefully read these agreements to ensure that rules surrounding reasons for eviction are still acceptable. Residential facilities cannot discharge a resident simply because their status changes from private pay to Medicaid unless it is spelled out in the admission agreement and resident signs agreeing to it.

Other situations where moving the client is problematic may occur when the:

- a. Client wants to move from the facility, and the family/alternate decision maker does not want the client to move, or
- b. Family or alternate decision maker wants the client to move and the client desires to remain in the facility. In these situations, refer the situation to the Ombudsman for resolution.

For any change in setting, you will need to update payment information:

1. The department does not pay for the last day of service if a client moves out of the facility unless the last day of service is the date of death.
2. The CM/SSS must terminate the P1 authorization line using the date before the client moved out of the facility.
3. Notify the Public Benefit Specialist via the electronic [DSHS 14-443](#) of the change in client residence, circumstance, date of the action and other pertinent information.

When a facility voluntarily closes or does not renew their contract:

[WAC 388-76-10615](#); [RCW 70.129.110](#); [RCW 18.20.440](#).

1. For facilities that have a large number of clients, develop a plan with the Regional Administrator to locate new facilities and relocate the clients. This effort may involve several CM/SSSs from around the region.
2. Work with the facility staff when transferring/moving a client.
3. If a client is moving to a less restrictive setting, consider using the residential discharge allowance for relocation. Follow the discharge allowance procedures outlined in LTC Manual [Chapter 10](#).
4. If the client is case managed by DDCS or BHHA, coordinate the move with other CM/SSSs.

For additional information regarding termination of a Medicaid contract, refer to section II. [Contract Types](#) of this chapter.

When the facility's license is suspended and/or revoked, or there is an involuntary closure:

1. The CM/SSS will need to coordinate with RCS to ensure the clients move in a timely manner.
2. Provide assistance in relocating private pay residents if they request it.

When there is a Stop Placement:

Get RCS approval for any clients who are hospitalized or in a nursing facility for a short stay and want to be readmitted to the facility with the Stop Placement. A private pay resident converting to Medicaid is not considered a new resident.

Provider responsibilities

Before transferring or discharging a client, the provider must:

1. First attempt, through reasonable accommodation, to avoid the transfer or discharge, unless agreed to by the client.
 - a. In SDCP contracted facilities, a provider is required to have a policy to obtain consultative resources to address behavioral issues for residents prior to discharge.



2. Notify the client and representative in writing, 30 days prior to the transfer or discharge date, unless:
 - a. There is an emergency per [RCW 70.129.110](#); or
 - b. The client has been in the facility for less than 30 days.
3. The client notification must provide information about legal resources and that subject to legislative appropriation (funding), clients have the right to legal counsel at public expense upon notice of transfer or discharge.
4. Notify the HCLA case manager and the Long-Term Care Ombudsman Program within three business days of issuing the notice.
5. Record the following in the client's record:
 - a. The reason for transfer or discharge,
 - b. The effective date of transfer or discharge, and
 - c. The location to which the client is transferring or discharging.
6. Refund any unspent participation within 30 days of the client's move. The provider and the client will receive correspondence from ProviderOne notifying them of the change in client responsibility. Providers are required to refund the difference between the amount paid and the new amount identified in correspondence to the client. If the client or client's family notifies you that they have not received the expected fund, report the incident to the RCS Complaint Resolution Unit at: 1-800-562-6078.

Residential Facilities, including ESFs, are required to:

- Document the significant changes in a client's condition in the NSA, NCP and PCSP and provide a copy a to the department CM/SSS. For RSW services recipients, a copy of the Behavior Support and Crisis Plan and any behavior monitoring documentation should also be included.
1. Notify a resident's next of kin, guardian, or other individuals or agencies responsible for, or designated by, the resident as soon as possible regarding:
 - a. A serious or significant change in a resident's condition.
 - b. The relocation of a resident to a hospital or other healthcare facility.
 - c. The death of a resident. In case of death, the facility must notify the coroner, if required by [RCW 68.50.010](#).
 2. AFHs should notify the CM/SSS by submitting DSHS form [15-558](#), Adult Family Home (AFH) Resident Significant Change Assessment Request if there has been a significant change in the client's care needs, whether or not related to a medical discharge.

When Notified of a Change in Resident Condition Case Managers/Social Service Specialists are required to:

- If requested by an ALF, AFH, or ESF, prior to completing a significant change; the CM/SSS must request a copy of the NSA, NCP, and/or PCSP from the facility with documentation of the changes in the client's care needs. For RSW participants, this would also include the Behavior Support and Crisis Plan and any behavior monitoring documentation. The CM/SSS will need to review the client's NSA, NCP, or PCSP to determine if the changes meet the criteria of a significant change as defined in [WAC 388-76-10000](#) for AFH, [WAC 388-78A-2020](#) for ALF, and [WAC 388-107-0060](#) for ESF.
1. Perform a Significant Change assessment if there has been a change in the client's condition that warrants a new assessment.
 2. If the new assessment results in a change to the daily rate, remember that the new payment cannot be made earlier than the date the assessment was finalized. Also, staff cannot authorize payment until they have obtained the client's consent, and the assessment is in **Current status**.

Refer to [Chapter 3](#) for additional information regarding Significant Change Assessments and Getting Approval on the Plan of Care.

For PACE clients, please note that each PACE organization is autonomous and has their own internal procedure for monitoring significant change requests. PACE contracted providers are to submit their significant change requests to the PACE organization, as the case management entity, not directly to HCS and then follow the prescribed communication protocol required by the PACE organization for those requests.

Reviewing the Negotiated Service Agreement/Negotiated Care Plan

Negotiated Plans between the resident and the facility.

Assisted Living Facility:

- The Assisted Living Facility (ALF) per [WAC 388-78A-2130 \(2\)](#) is required to develop a negotiated service agreement (NSA) for each resident using the resident's preadmission/full assessment and using the CARE assessment for Medicaid residents, within 30 days of the resident's admission. The NSA must include a list of the care and services to be provided, with details on the resident's preferences and choices, and how services will be delivered to accommodate these preferences and choices.

- The ALF per [WAC 388-78A-2120](#), is required to review and update each resident's negotiated service agreement (NSA) annually, when there is a significant change in resident's physical, mental, or emotional functioning, or when the negotiated service agreement no longer adequately addresses the resident's current care needs and preferences. The Assisted Living Facility (ALF) must involve the resident, the resident's representative to the extent he or she is willing and capable, the department's case manager/social service specialist for a Medicaid resident, and facility staff when developing the resident's negotiated service agreement.

Adult Family Home:

- The Adult Family Home (AFH) per [WAC 388-76-10355](#), is required to develop the negotiated care plan (NCP) by using the resident assessment, or CARE assessment for Medicaid residents. The NCP must include a list of the care and services to be provided, with details on the resident's preferences and choices, and how services will be delivered to accommodate these preferences and choices.
- Per [WAC 388-76-10360](#), the AFH must ensure the negotiated care plan (NCP) is developed and completed within 30 days of the resident's admission. When developing the NCP per [WAC 388-76-10370](#), the AFH must involve the resident, the resident's representative, professionals involved in the care of the resident, and the department case manager/social service specialist for Medicaid clients. Per [WAC 388-76-10375](#), the AFH must ensure that the negotiated care plan is agreed to and signed and dated by the resident and AFH provider.
- The AFH per [WAC 388-76-10380](#), is required to review and update each resident's negotiated care plan (NCP) annually, when there is a significant change in the resident's physical, mental, or emotional functioning, or when the negotiated care plan no longer adequately addresses the resident's current care needs and preferences, or at least every twelve months.
- For Medicaid clients ([WAC 388-76-10385](#)), the Adult Family Home must give the department case manager/social service specialist a copy of the negotiated care plan each time the plan is completed or updated, and after it has been signed and dated. The AFH has 30 days from the time the assessment is moved to current to return the NCP, regardless of the reason for the update. The AFH provider can send a copy of their negotiated care plan through email or fax to the department case managers/social service specialists.

Enhanced Service Facility:

- The Enhanced Service Facility (ESF) must develop an initial Person-Centered Service Plan (PCSP) as a replacement for the Negotiated Service Agreement/Service Plan for each resident prior to the admission as outlined in [WAC 388-107-0110](#), a Comprehensive Person-Centered Service Plan within 14 days of the move-in date per [WAC 388-107-0120](#), upon significant change in the client's condition, upon the



client's request, or at least every 180 days if there is no significant change in condition per [WAC 388-107-0130](#).

Case Managers/Social Service Specialist are required to:

- Review the NSA/NCP/PCSP for Initial, Annual, and Significant change assessments and compare it to the current CARE assessment. If the NSA/NCP/PCSP does not address all the client's current care needs, the CM/SSS must have a discussion with the Assisted Living Facility staff, Adult Family Home provider, or Enhanced Services Facility staff regarding how the client's current care needs will be met.
- If there are changes in the client's needs that would affect the CARE classification and/or change to the caregiver instructions, the CM/SSS must complete a Significant Change Assessment. For Residential Support Waiver service recipients, the Behavior Support and Crisis Plan are also required documents and should be provided to the assigned CM/SSS to incorporate into any face-to-face assessment. For additional information regarding RSW, reference [the LTC Manual Chapter 7f](#).

Send NSA/NSP/PCSP to the HIU:

- When the NSA/NCP/PCSP has been reviewed and finalized by the CM/SSS, make a copy and send the original back to the facility.
- Send the copy of the NSA/NCP/PCSP and required RSW documentation to the Hub Imaging Unit (HIU) to become part of the client's record.

Additional information regarding Residential Case Management Responsibilities can be found in LTC Manual [Chapter 5](#) – Case Management.

CLIENT RIGHTS

All residents living in licensed assisted living facilities, and adult family homes are protected by the rights granted in [Chapter 70.129 RCW](#), Long-Term Care Residents Rights. CM/SSSs need to be familiar with the rights outlined in [Chapter 70.129 RCW](#). As an CM/SSS, you are responsible for reporting any significant or repeated resident rights violations to the RCS Complaint Resolution Unit (CRU) for review and investigation. A provider's failure to respect these rights is a violation of licensing requirements.

ESF residents have specific rights, as outlined in [WAC 388-107-0190](#).

Abuse, Neglect, Abandonment, or Exploitation

All DSHS employees are mandatory reporters. When you have reasonable cause to believe that abuse, neglect, abandonment, or financial exploitation of residents in facilities that are currently



licensed/contracted (or required to be licensed/contracted) has occurred, you must report the concern to CRU. Residential Care Services (RCS) is responsible for the intake, screening, and investigation. In addition, under certain circumstances you are also required to call law enforcement. See the Adult Protective Services [APS Policy & Procedure](#) site for more information about mandatory reporting requirements.

Client Rights Violations

Single incidents, not classified as abuse, neglect, abandonment, or financial exploitation, may be handled through consultation and education with the provider or by involving the Long-Term Care Ombudsman Program. The Ombudsman program is responsible for protecting the rights of all residents and handling complaints from facility residents. The Long-Term Care Ombudsman can be contacted at **1-800-422-1384**.

CLIENT RIGHTS IN HCBS SETTINGS

The federal rules regarding Home and Community Based Settings (Medicaid contracted ALFs, AFH, and ESFs) mandate basic participant rights in all home and community-based settings. These are the rights listed in the federal rule:

- Full access to the greater community,
- Receive services in the community,
- Control over personal resources, and
- Autonomy and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact.

In addition, in provider owned and controlled residential facilities, participants have the right to have:

- A lockable entry door
- A choice of roommate
- Control of her or his own schedule
- Access to food at any time
- Visitors of their choice at any time
- Protections from transfers or discharges comparable to landlord tenant law

Documenting modifications to Client Rights:

Any time clients are not afforded all the rights required in federal rule, the rules require specific documentation. To meet these federal requirements with any modifications to a Medicaid resident's rights, the following conditions must be met and documented in the Negotiated Service Agreement, Negotiated Care Plan, or Person-Centered Service Plan and in CARE assessment. The documentation must include:

- Identify a specific and individualized assessed need for this restriction or modification (Example – Unsafe wandering behavior).
- The positive interventions and supports that were used prior to placing this restriction or modification on the resident.
- Less intrusive methods that have been tried but did not work to meet the need (What accommodations or strategies were made to address the behavior prior to this that did not work).
- A clear description of the restriction or modification.
- An assurance that the interventions and supports will cause no harm to the individual.
- The informed consent of the resident for the use of this restriction or modification.

Note: Prior to moving a resident to a facility or an area within a facility with delayed egress, the CM/SSS must ensure that all the conditions above are met and documented. If a facility is requesting the move, request a copy of their NSA/NCP/PCSP indicating the changes in the client's care needs with the above documentation. The CM/SSS must also document the reason for the move in the CARE assessment as described below.

Informed Consent Requirements:

Sometimes, modification or removal of a client's rights is necessary to implement services.

A common example of a modification of client rights occurs when a client verbalizes disagreement in any form to transition to a delayed egress facility. In such cases, the alternative decision maker (POA, agent or guardian/conservator) may only consent to the transition when the POA document or guardianship/conservatorship orders contain specific language and authorities, similar to the following:

1. Agent/Guardian/Conservator/Special Agent/Court Visitor has authority to use "Best Interest" decision making standard instead of "Substituted Judgement" decision making standard or the document references in RCW 11.130.330 *and*
2. Agent/Guardian/Conservator/Special Agent/Court Visitor has authority to establish the client's place of dwelling and who provides care to the client.

Without such language, the Department cannot accept consent from the alternative decision maker on behalf of the client for delayed egress facility transitions. For more information, please see [LTC Manual Chapter 3](#) – Getting Approval on the Plan of Care.

Full guardianship orders typically grant the level of authority outlined in subsection 1; however, "Limited" guardianship orders and Power or Attorney documents do not typically grant this level of authority without additional court intervention. Each document should be reviewed to determine the sufficiency of the agent's authority.

When modification or removal of a client's rights is necessary to implement services, often a court hearing is required to obtain an active order from the Administrative Office of the Courts (AOC) removing or modifying the specific right(s) and expanding the authority of the alternative decision maker.

- When seeking orders to expand authorities for POAs, motions are filed through the Uniform Power of Attorney Act outlined in [RCW 11.125](#).
- When seeking orders to expand authorities for guardianship or conservatorship, motions are filed through the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (UGA) outlined in [RCW 11.130](#).

Once an order of expanded authority is issued by the AOC, a copy must be received by the Department, attached to the original POA document or original guardianship/ conservatorship orders and scanned to DMS prior to the department accepting consent for delayed egress transition from the alternative decision-maker. When modification or removal of a client's rights is necessary to implement services, often a court hearing is required to obtain an active order from the Administrative Office of the Courts (AOC) removing or modifying the specific right(s) and expanding the authority of the alternative decision maker.

Where to document modifications to Client Rights in CARE:

The CM/SSS must provide clear documentation by explaining the reason for any modification to client rights in the most relevant location:

- In the intervention screen for a behavior, if the modification is relevant to any of the behaviors,
- In the comments/caregiver instructions section, if it pertains to the one of ADL or IADL screens,
- In the pertinent medical history screen or
- In the psych/social screen if there is no other applicable location,
- In the comments/caregiver instructions section if it pertains to the Specialized Dementia Care for Alzheimer's/dementia special care program.

Review the Plan and the need for modification:

Federal rules also require periodic reviews to determine if the modification is still effective, necessary, or could be terminated.

The plan must be reviewed and revised at least:

- Every 12 months, or
- When the client's circumstances or needs change, or
- At the client's request

Facilities must document the following in the annual NSA/NCP/PCSP and as indicated by a significant change in the resident's condition that the facility has reviewed the need for and effectiveness of the restriction or modification with the resident; and



- The modification or restriction continues to be necessary and effective **OR**
- Should be discontinued.

For example, for the Specialized Dementia Care Program, this documentation could include whether the setting with restricted egress continues to be the most appropriate setting to meet this resident's needs and that the resident continues to benefit from the services provided in this setting.

Note: If the client or client's family notifies you of any violation of HCBS rules, you must report the violation to the RCS Complaint Resolution Unit at: 1-800-562-6078.

EXCEPTION TO RULE

You may need to request an Exception to Rule (ETR) for some of your clients. ETRs for increases in the daily rate related to personal care must be approved by the HQ ETR committee. For related policy see [Chapter 3](#). All requests related to a daily rate increase must be completed on the ETR/ETP screen in the Client Details folder of CARE and processed electronically for review and approval. For instructions related to the functionality in CARE Web, refer to the CARE Web help files (Assessors Manual).

For AFH Provider post card notices about ETR requests; refer to LTC Manual [Chapter 3](#).

Bed Hold ETRs may be requested; please submit ETR requests to the AFH or ALF Policy Program Manager for consideration. For more information, see the [Bed Hold section](#) of this chapter.

RESIDENT CHOICE REGARDING ALF ROOM EXEMPTIONS

Physical Plant Exemptions in an AL Room

Only RCS may grant an exemption to the requirements provided in [WAC 388-110-140](#) in accordance with [WAC 388-78A-2820](#). If any of the items listed in [WAC 388-110-140](#) are not present in the Medicaid resident's room, and an exemption has not been granted by RCS, report this to CRU.

- According to [WAC 388-110-140, \(2\) \(a\), and \(b\)](#) a facility with an AL contract is required to provide each resident a private apartment-like unit that is a minimum of 220 square feet.

Examples of exemptions in Assisted Living settings are included below:

- Residing in a room that does not meet the physical plant requirements identified in WAC 388-110-140; or
- According to [WAC 388-110-140, \(2\) \(a\), and \(b\)](#) a facility with an AL contract is required to provide each resident a private apartment-like unit that is a minimum of 220 square feet.

The provider must offer the client a choice of units that meets contract requirements. The request to remain in a unit that does not meet the contract requirements or to share a unit must be the client's



choice. The client must be advised of the physical requirements (under WAC 388-110-140) that they are entitled to have.

When a client is residing in an exempted room, the CM/SSS will continue to authorize the ALF rate.

Sharing an AL Room

Residents residing in AL rooms are entitled to private units. Clients may choose to share their room with another resident, either related or unrelated.

Through June 30, 2022, when two clients are sharing a room, the CM/SSS will authorize payments for the EARC daily rate effective the day that the second resident moves into the shared room. **July 1, 2022**, the AL daily rate and the EARC daily rate are now equal. CM/SSSs do not need to make any authorization adjustment when two clients are sharing a room and will authorize the AL rate using the AL service code.

When two residents reside in a two-bedroom apartment-like unit, each resident has their own bedroom, and they share other amenities such as kitchen area with refrigerator, microwave oven, range or cooktop, bathroom, etc., the CM/SSS may authorize the AL rate using the AL service code.

Documenting Resident Choice:

Once the HCS CM/SSS has been notified that a client would like to share a room or is residing in a room that does not meet physical plant requirements, the HCS case manager will meet with the client or their representative to notify client of their room rights.

Use DSHS Form [15-447](#), Resident Choice Regarding Assisted Living Facility (ALF) Room Requirements (Home & Community Services) to document your discussion with the client and the client's choice regarding:

1. Residing in a room that does not meet the physical plant requirements,
2. Residing in a room that has been granted an exemption from RCS when the client is converting from private to public assistance.; or
3. Sharing an AL room with another resident.

When completing DSHS Form [15-447](#):

1. Enter the specific room number.
2. For a room that does not meet physical plant requirements:
 - a. Check which of the listed items are missing from that room.
 - b. Select the client's choice to remain in a room that does not meet the contract requirements for an AL under WAC 388-110-140 (listed on the back of the form)
3. When a client wishes to share an AL room with another resident:
 - a. Select the name of the resident that will be sharing the room



- b. If two Medicaid residents are wishing to share a room, separate forms will need to be completed for both clients.
4. Have the client sign the document.
5. Send the form to HIU to be placed in the client's file.

The Resident Choice Regarding Assisted Living Facility (ALF) Room Requirements (Home & Community Services) form only applies only to the specific room number and only for the resident(s) listed on the form. The agreement does not permit other Medicaid residents to occupy the room, nor does it permit the residents listed on the form to be relocated to another "non-qualified" room. If either resident chooses to relocate within the facility listed, arrangements should be made for each of them to move into a room that meets the Assisted Living Facility physical plant requirements.

The DSHS form [15-447](#) not required for married couples who request to share an apartment-like unit under an assisted living contract if both residents understand that they are each entitled to live in a separate private unit; and both mutually request to share a single apartment-like unit.

Note: If a facility wants to request more money for non-contracted room; please follow the [supplementation policy](#).

Documenting the client's approval in CARE:

1. Enter the room number in "ALF/ESF Room #" box located on the Residence screen in CARE.
2. For clients, including married couples, wishing to share an AL room, select "Shared Room in AL" Category and Type in the ETR/ETP screen. This selection documents the client's approval.
3. Submit the ETR request to the supervisor or SHPC for field review and approval.
4. Document in the SER the actions taken and the client's approval.

BED HOLD FOR MEDICAL LEAVE

For Clients on MPC, CFC, and CFC + COPES Waiver

Per [WAC 388-105-0045 \(2\)](#), residential facilities (AFH, ARC, EARC, or AL) are required to hold a client's bed for 20 days when the client needs short-term care for medical reasons in a nursing home or hospital.

Per [WAC 388-105-0045 \(6\)](#), a Medicaid resident's need for a short stay in a hospital or SNF must be longer than 24 hours before a bed hold can be authorized. This only applies to the following residential facilities: ARC, EARC, and AL.



Per [WAC 388-105-0045 \(5\)](#), Adult Family Homes (AFH) may be authorized Bed Hold for a Medicaid resident's need for a short stay in a hospital or SNF lasting less than 24 hours, as long as all other criteria are met.

Per [WAC 388-105-0045 \(8\)](#), if a resident is transitioned back to the residential setting and returns to the hospital, the Medicaid resident must be back in the residential setting 24 hours prior to being on medical leave again to begin a new 20-day hold period.

For Clients on the Residential Support Waiver (RSW)

For clients receiving services through RSW there are additional short-term care facilities that qualify for a bed hold. The client must be in the following settings and receiving a RSW service available in that setting.

Residential facilities (ESF, AFH with SBS or ECS contract, EARC with ECS or CSS contract, or AL with ECS contract) are required to hold a client's bed for 20 days when the client needs short-term care for medical reasons in a nursing home, hospital, Institute for Mental Disease (IMD) or inpatient behavioral health agency.

A Medicaid resident's need for a short stay in a nursing home, hospital, IMD or inpatient behavioral health agency must be longer than 24 hours before a bed hold can be authorized. This only applies to the following residential facilities: ESF, EARC with ECS or CSS contract, and AL with ECS contract.

Adult Family Homes (AFH) with ECS or SBS contract may be authorized Bed Hold for a Medicaid resident's need for a short stay in a nursing home, hospital, IMD or inpatient behavioral health agency lasting less than 24 hours, as long as all other criteria are met.

If a resident is transitioned back to the residential setting and then is transferred back to a nursing home, hospital, IMD or inpatient behavioral health agency, the Medicaid resident must be back in the residential setting for 24 hours prior to being on medical leave again to begin a new 20-day hold period.

What is an Institute for Mental Disease (IMD)

IMDs, or "institutions for mental diseases," are defined as hospitals, nursing facilities, or other institutions of more than 16 beds regardless of licensure that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, which includes SUD. For more information go to [HCA's Behavioral Health](#) page.



Notification Process for short-term Medical Leave and Return

- According to [WAC 388-105-0045 \(7\)](#), residential facility (ESF, AFH, ARC, EARC, or AL) contractors must notify the CM/SSS by e-mail, fax, or telephone within one working day whenever the resident is out of the facility for more than 24 hours on medical leave at an approved facility.
- Facilities may use the [Notice of Bed Hold](#) form (**DSHS 05-249**), to notify the CM/SSS of a client's discharge and return to the facility. This form can be faxed to (855)635-8305 or mailed to DMS at P.O. Box 45826 Olympia, WA 98599-5826.
- Timely notification of needs for short-term medical care remains critical in reducing overpayments.

Authorizing Bed Holds

When the department CM/SSS received notification from a facility reporting that the client is receiving short-term medical care; within two working days of learning of a client's transition, the CM/SSS must determine whether or not the client is likely to return to the residential facility by verifying with the short-term medical care provider, if stay may be less than 20 days.

1. If the client will likely return to the facility, the Residential CM/SSS will:
 - a. End Date residential services service line in P1.
 - b. End Date other open service lines in P1. Please note special instructions exist in the SSAM for Wellness Education, PERS Units/Add-ons, and Nurse Delegation.
 - c. Use DSHS 14-443 to send required notification to the Public Benefit Specialist.
 - d. Document all related bed hold actions in SER.
 - e. Once the client's outcome is known (meaning they have returned to the residential facility, died, or transferred to an alternate setting) then authorize the bed hold.
2. If the client has already returned to the facility, the Residential CM/SSS will:
 - a. Split the residential services service line in P1 as of the last full day prior to admission, then remove the dates the client receiving short-term medical care.
 - b. Split other open service lines in P1. Please note special instructions exist in the SSAM for Wellness Education, PERS Units/Add-ons, and Nurse Delegation.
 - c. Authorize the bed hold.
 - d. Use DSHS 14-443 to send required notification to the Public Benefit Specialist
 - e. Document all related bed hold actions in SER.
3. If the client is unlikely to return to the facility, the Residential CM/SSS will:



- a. End Date all open service lines in P1. Residential services should be ended as of the last full day prior to discharge from the residential facility. Other services may end on the date of discharge. Please note special instructions exist in the SSAM for Wellness Education, PERS Units/Add-ons, and Nurse Delegation.
- b. Notify the client and the provider of the department's decision to terminate payment. Document in the SER related actions taken regarding terminating the authorization of services.
- c. Notify the Public Benefit Specialist (PBS) by completing an electronic DSHS 14-443 in Barcode. The HCS PBS will receive this as an assignment on their To-Do-List and can review the action.
- d. Per federal HCBS rules, a client is entitled to the same eviction rights as any renter residing in a private unit. This is called out in HCBS settings rule- 42 CFR § 441.530, Section (a)(1)(vi)(A). [RCW 70.129.110](#) requires a provider to meet before discharging or transferring a resident the following, including first attempting through reasonable accommodations to avoid the transfer or discharge and giving at least 30 days' notice before the transfer or discharge. The transfer or discharge notice must contain specific information that is called out in WAC 388-76-10506(5) for AFHs, WAC 377-78A-2651(5) for ALFs and WAC 388-107-0161(5).

When a client is hospitalized and unlikely to return to the facility, please see LTC Manual [Chapter 9 Inpatient Hospital Assessments and Transitions](#) "What is the Role of Residential Case Managers in Transitioning Clients Back to Residential Settings?" for further instruction. The CM/SSS will be responsible for determining and processing an overpayment if the client does not return to the facility and the providers continue to claim for services. For detail information on an overpayment process; refer to [Social Services Authorization Manual](#).

What is the payment for Bed Hold?

From the:	The department:
Date of discharge through the 7th day	Pays 70% of the daily rate for ARC, EARC, ALF, and AFH. (WAC 388-105-0045) (4), (5)
8th through the 20th day	Payment reduced to \$11.66 per day for ARC, EARC, and ALF. \$15 per day for AFH, except ESFs, which are paid at 70% of the daily rate for days 1-20 (WAC 388-105-0045) (3). See current rates on the Office of Rates Management website . These rates are subject to legislative action.

Date of discharge through the 20 th day	Pays 70% of the daily rate for ESF (WAC 388-105-0045 (3).
21st day forward	No longer pays for the bed hold. The provider may seek a third-party payment and/or proceed with discharging requirements.

The date of discharge entered in the bed hold database is the date the client left the residential facilities (AFH, EARC, ARC, ALF or ESF) on medical leave.

- Bed Hold days are not processed until there is an outcome.
- In case of client's death, the last date of payment for bed hold is the day of death.
- Client Responsibility is never counted toward bed hold days.

SOCIAL LEAVE

Social Leave is defined as planned leave that is for recreational or socialization purposes, not for medical, therapeutic, or recuperative purposes nor for incarceration.

- HCLA permits Social Leave in all residential settings. Social Leave is limited to no more than **18 days per calendar year per [WAC 388-110-100](#) (2)**.
- Residential Facilities are responsible for self-reporting and self-tracking Social Leave for their clients.

When do I authorize this service and for how long?

If a client takes Social Leave and the residential provided notifies the CM/SSS; CM/SSS should: Maintain the current P1 authorization.

- Discuss with the provider how the client's personal care needs will be met while the client is out of the facility on social leave. Document in the SER actions taken relating to social leave.

Are Local Exception to Policies (ETP) allowed for Social Leave?

Evaluate whether there is a need for a local ETP and consider the following questions:

- Do the additional days meet the client's needs and desires?
- Is there a person willing and able to meet the client's care needs while the client is out of the facility?
- Is there a temporary service plan in place to meet the client's needs during his/her absence?
- If you determine the need for additional days, submit a local ETP in CARE for your Appointing Authority (FSA/RA) for review/determination.

RESOURCES

Rules and Policies

The following rules apply to clients receiving care in residential facilities. RCS and HCS work in partnership to provide quality service delivery in all residential care settings. HCS is responsible for the assessment and case management of residential clients; accurate payments to the providers and complying with state and federal regulations. RCS is responsible for the licensing, inspection, and surveying of all licensed Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities. HCS and RCS work together to resolve issues for residents.

RCW	
Chapter 70.129 RCW	LONG TERM CARE RESIDENT RIGHTS
Chapter 70.128 RCW	ADULT FAMILY HOMES
Chapter 70.97 RCW	ENHANCED SERVICES FACILITIES
Chapter 43.190 RCW	LONG TERM CARE OMBUDSMAN PROGRAM
WAC	
Chapter 388-76 WAC	ADULT FAMILY HOMES MINIMUM LICENSING REQUIREMENTS
Chapter 388-78A WAC	ASSISTED LIVING FACILITY LICENSING RULES
Chapter 388-107 WAC	ENHANCED SERVICES FACILITIES
Chapter 388-105 WAC	MEDICAID RATES FOR CONTRACTED HOME AND COMMUNITY RESIDENTIAL CARE SERVICES
Chapter 388-106 WAC	LONG TERM CARE SERVICES
Chapter 388-110 WAC	CONTRACTED RESIDENTIAL CARE SERVICES
Chapter 388-112 WAC	RESIDENTIAL LONG TERM CARE SERVICES (TRAINING)
Chapter 182-515 WAC	ALTERNATE LIVING – INSTITUTIONAL MEDICAL
Chapter 182-527 WAC	ESTATE RECOVERY

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
TBD	Emily Watts	- Updated Ask the Expert contacts - Added information on Memory Care Certified requirements - Added required RSW documents that are submitted with NSA/NCP - Removed AFH options for RCL - Added Residential Rate Adjustment Information for the Care Plan Screen - Expanded language on Medical Escort Fee and link Service Code Data Sheet - Removed SDCP-Plus references - Added information on when SDCP approval is necessary after initial approval	TBD
5/18/26	Emily Watts	- Updated requirements by license/contract chart - Updated determining R&B to include ACES Medical Program IDs, steps of determining R&B and how to contact CSD, if needed. - Updated bed holds for medical leave - Updated social leave policy - Added and updated Social Leave ETP process. - Update Informed Consent section	H26-019
9/03/2025	Anna Cavanaugh/ Emily Watts	- Remove Meaningful Day references - Update Capital Add-On and add Bridge Rate information - Updated Medical Escort Fee - Update transfer and discharge instructions - Removed Social Leave ETR process	H25-057
5/10/25	Anna Cavanaugh/ Emily Watts	- Added wording to SDC process to include approval of pending assessments - Added PACE process for monitoring significant change assessments - Added DSHS 15-558 Adult Family Home (AFH) Resident Significant Change Assessment Request to steps for monitoring significant change assessment requests.	H25-010

		- Added reference to Chapter 9a for further instruction when a client is hospitalized and not returning to facility - Updated Nursing Services Chart - Updated template and branding	
11/8/24	Anna Cavanaugh/ Emily Watts	- Update Medical Escort Fee rate & documentation - Clarified client cannot participate on RSW while on SDCP - Edit to CBHS to correct language	H24-062
8/7/2024	Emily Watts	- Addition of MCO Community Behavioral Health Support reference - Updating of SDCP to add Reason Codes - Updated all links to forms and chapters	H24-044
4/16/24	Emily Watts	- Update staff assigned - Removal of Meaningful Day - Reformatting to move SDCP items into one section. - Update on share ALF rooms	H24-018
10/13/2023	Emily Watts	- Revised formatting, including moving some items to the Appendix - Updated service area information for SDCP - Community Stability Supports (CSS) information added - Clarified SDCP Referral Process - Clarified HIV/AIDS rate information, including Community Integration - Clarified Meaningful Day Process - Added Revision History	H23-071
6/14/2023	Emily Watts	Updated contact information	H23-039
3/28/2023	Natalie Lehl	- Clarify room sizes - Update SDC guidance	H23-017
12/22/2022	Natalie Lehl	- Updated contact information - Added additional language to “Social Leave”	H22-064
9/14/2022	Natalie Lehl	- Updated guidance on Specialized Dementia Care Program referrals - Title change for MPC Calculator - Enhanced Services Facilities (ESF) subject matter expert name and contact information updated	H22-042
6/21/2022	Natalie Lehl	Removed use of “placement” throughout the chapter	H22-028



		Updated Specialized Dementia Care Program instructions	
4/12/2022	Natalie Lehl	- Adding Meaningful Day Program Manager - Update process for Meaningful Day approval (VI, E) - Meaningful Day Checklist added	H22-020



APPENDIX

AFH Providers FAQs about Community Integration

[Community Integration FAQs](#)



Inpatient Hospital Assessments and Transitions

The purpose of this chapter is to clarify inpatient hospital assessment activities to ensure smooth transitions to home and community-based services. The goal and focus of inpatient hospital assessment and transition activities is to:

- Proactively engage with individuals seeking long-term care (LTC) services to provide up to date information about Medicaid funded long-term care options.
- Assist and educate hospitals in working with Medicaid eligible patients to access long-term services and supports (LTSS) to avoid staying in the hospitals when they no longer need an inpatient setting.
- Prioritize assessment and expediting authorization of LTC services for individuals once they are referred for services and anticipate transitioning from the hospital to home and community-based services (HCBS).
- Develop rapport and supportive relationships with local inpatient hospital discharge planners and LTC providers in the community.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Jody Gasseling Inpatient Policy Systems Change Manager and RCL Enrollment Specialist
360.522.0456 Jody.Gasseling@dshs.wa.gov

Erika Gustafson Inpatient Policy Systems Change Manager
360.870.9794 Erika.Gustafson@dshs.wa.gov

For questions related to guardianship or decision making please contact:

Sarah Tremblay Guardianship Program Manager
564.999.1032 Sarah.Tremblay@dshs.wa.gov

Joshua Glasgow GCAP & Decision-Making Staffing Specialist
360.725.3706 Joshua.Glasow1@dshs.wa.gov



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Background

An inpatient hospital refers to a licensed healthcare facility that provides 24-hour healthcare for individuals who are admitted. Many inpatient hospital referrals are for individuals new to long-term care (LTC) services and will require a functional and/or financial eligibility determination. Achieving timely transitions to services is essential in reducing the number of days patients spend hospitalized when they no longer meet medical necessity. This chapter applies broadly to assessments completed in inpatient settings like acute care hospitals statewide as well as border hospitals, state hospitals and inpatient psychiatric facilities. Successful transition planning requires robust collaboration and partnership with HCS staff, hospitals, managed care organizations, service providers, and local communities. This collaboration aims to deliver suitable services and community options that respect client preferences and reduce healthcare costs while enhancing individual wellbeing and quality of life. Timely and coordinated assessment and transition planning requires a great deal of data collection, analysis and creative problem solving to ensure systems of care are aligned and responsive to the diverse and complex needs of each individual.

Assessing and Transitioning Clients from Inpatient Hospital Settings

HCS hospital assessments follow policy established in [Chapter 3](#) of the Long-term Care Manual. It is the goal of HCS that all hospital referrals for LTC receive a hospital assessment unless the individual:

- is discharged or the hospital withdraws a referral prior to an assessment being completed.
- refuses the assessment.

What Conditions Must Be Met for HCS to Conduct an Inpatient Hospital Assessment?

For HCS to conduct and complete an inpatient hospital assessment, the individual must meet the following:

1. Medically stable—the individual is close to baseline functioning and their immediate medical needs, treatments, and therapies have been achieved.
2. The individual, guardian, or legal decision maker is aware of the HCS referral and agrees to an assessment and HCS services. If there are questions on client's capacity, see "Obtain Plan Approval on Plan of Care" outlined in [Chapter 3](#).
3. Psychiatrically stable —the individual is close to baseline functioning and their immediate psychiatric needs, treatments, and therapies have been achieved, evidenced by no use of physical or chemical restraints in the past 72 hours prior assessment and transition.



- ❖ Medically Stable individuals for example, are not in ICU, their conditions are predictable and stabilized.
- ❖ For individuals on contact precautions like COVID-19, MRSA and other infectious diseases, staff will assess following established universal precautions and safety standards.
- ❖ HCS hospital case managers must meet with the individual requesting services, consult with informal decision makers/collateral contacts and review medical records to determine whether the individual has the ability to participate in CARE planning and consent for LTSS.

When is an Individual Not Ready for an Inpatient Hospital Assessment?

1. The individual declines to have an HCS assessment done to explore LTC options they might be eligible for, and this is documented in CARE.
2. Not medically stable-the individual still needs medical intervention and is not back to baseline functioning or no new baseline has been identified; immediate medical needs, treatments, and therapies are not yet in place or cannot be replicated in the community.
3. Not psychiatrically stable-the individual continues to require inpatient psychiatric services and are not back to baseline functioning or no new baseline has been established; immediate needs, treatments and therapies are not yet in place or cannot be replicated in the community.
4. Combative and/or behaviorally compromised e.g., client who is actively physically assaultive.
5. Being restrained or in seclusion in the last 72 hours, additional details are provided in Restraint Section.

What Assessments Need to Be Prioritized Among Inpatient Hospital Referrals?

At times inpatient hospital staff will notify HCS of the need to prioritize certain referrals. For such cases, the assigned HCS case manager will work with the hospital to determine the order of assessment based on urgency and eligibility.

A referral that is considered a priority may have the following conditions:

1. Medicaid Eligibility: Individuals who are already financially eligible for Medicaid long-term care services
2. Adult Protective Services (APS) Involvement: APS is actively engaged in the case.
3. Hospice: Hospice is involved, and they are requesting HCS to take the lead in finding a community setting.
4. Department of Corrections Referral: the referral originates from DOC who is requesting HCS to take the lead in finding a community setting for a client who is medically complex.
5. Imminent Transition: The individual's planned hospital transition is imminent; it is in a few days not weeks; or
6. Consent: The individual can consent to services or has a legal decision maker to consent to LTC.



What is the Role of HCS When Receiving an Inpatient Hospital Referral?

HCS is responsible for initiating functional assessments and financial eligibility determination of referred Medicaid applicants who have indicated a preference for community-based (home or residential) LTC services.

The HCS intake unit:

1. Receives and conducts an initial screening of the referral and/or long-term care service application (request for long-term care services).
2. Enters applicant in CARE following guidelines in [Chapter 3](#) of the Long-term Care Manual.
3. Assigns the case to the HCS case manager and
4. Performs case transfers when appropriate.

HCS case manager will:

1. Make contact as outlined in [Chapter 3](#) of the Long-term Care Manual.
2. Triage cases to determine the appropriate time for an assessment.
3. Update CARE screens:
 - a) **Acute Hospital referrals** will be added to the Acute Hospital Screen in CARE. This screen must be updated throughout their hospital stay, removing barriers to transition as they resolve.
 - b) **State Hospital transitions** will be added to the State Hospital/Hospital/E&T Screen in CARE upon transition to a LTC setting.
4. Complete an initial, initial/reapply or significant change assessment in CARE to determine care needs, and present appropriate service options to the client, family, and/or decision maker or guardian, and authorize personal care services within 30 days from the date of receipt of the referral.
5. Provide information about LTC services to hospital staff, clients, and families.
6. Discuss MAC/TSOA ([Chapter 30b](#)) as an option if the client declines HCS Services.
7. Assist with developing multiple potential transition plans into LTC settings concurrently, including finding a provider.
8. Identify, document, and address barriers to transition as early as possible.
 - a) For individuals requesting HCS residential settings who have challenging behaviors, you may complete [DSHS 10-234a](#) and provide to potential residential providers.
9. Collaborate with hospital staff on transition planning.
10. Coordinate with transitions of care planners at Managed Care Organizations (MCOs).
11. Utilize Fast Track ([Chapter 7a](#)) or offer Presumptive Eligibility (PE) ([Chapter 30e](#)) for community services, if appropriate.
12. Submit transfer requests to HCS intake unit or direct supervisor for clients who will be receiving long-term care services in their homes for ongoing AAA case management as soon as the:
 - a) Referrals for services are made.
 - b) Services are authorized.
 - c) Service plan is implemented.
 - d) Provider service contracts are arranged, if appropriate.
 - e) RAC are entered in CARE.
 - f) ProviderOne authorization is "error free" and in CARE.



- g) The client and provider have signed the service summary and returned it to the relevant HCS staff for review and signature.
- h) If Fast Track or PE has been used, the Medicaid application has been submitted with the appropriate documentation to the local financial worker.

Likewise, follow the above procedures outlined from 13 (a) through (g) for transferring client cases to an HCS Residential case manager for clients who will receive services in residential settings.

Acute Hospital: For clients who are discharged into the community before an HCS hospital assessment and/or LTC service plan is in place; the HCS case manager or supervisor will submit a transfer request for the individual to be followed up by the HCS in-home unit, or HCS residential unit to conduct an assessment and/or set up of services for appropriate LTC community options. When these cases are transferred it should be noted that they were transitioned from the hospital before assessment or service planning could be established and that these cases may need to be expedited by the receiving team.

What is the Role of HCS Case Managers in Determining an Individual's Ability to Consent to LTSS?

In addition to consulting with the hospital, the HCS case manager should interact with the individual to determine if they can consent to LTC services or can select a representative to provide consent. Case managers need to consider if there is an authorized representative (AREP), DPOA, or POA in place, or if other avenues such as guardianship or conservatorship should be considered.

Refer to [Chapter 3](#) for client consent and determining a client's ability to consent to LTSS services. If there are questions on how to proceed, staff with a supervisor.

What is the Role of AAA in Transitioning Clients Back to their Own Home?

AAAs are responsible for case managing clients returning to in-home services following an inpatient hospital stay.

1. For clients who were receiving in-home services prior to hospitalization, who are expected to return to this setting upon discharge, the AAA and their case management subcontractors will:
 - a) Follow assessment procedures established under [Chapter 3](#) of the Long-term Care Manual.
 - b) Continue to case manage the clients who were on CFC/COPES/New Freedom/MAC/TSOA long-term care services prior to hospitalization and provide reassessments/service plan changes.
 - c) Collaborate with hospital staff on discharge planning.
 - d) Coordinate with transitions of care planners at MCOs. [Chapter 22a](#)
2. For clients who were receiving in-home services prior to hospitalization and will not return to in-home services within 30 days of being hospitalized:
 - a) The AAA case manager will immediately staff client's status with HCS supervisor to consider transferring of case to appropriate staff. This should be done promptly to avoid delays.
 - b) Create a hospitalization transfer SER with the following information:
 - Hospital name
 - Admission date



- Current hospital social worker
 - Barriers to returning home
 - Date of staffing with Hospital Supervisor
 - Is the client decisional? (If not, who is the guardian/conservator or DPOA)?
 - What steps have been taken to maintain or allow the client to return to previous setting?
- c) Transfer cases to HCS as soon as it is known that the client will not be returning to in-home services and close all authorizations.
- d) HCS case manager will take over the case for all transition planning actions for clients transitioning from inpatient hospitals settings.
3. AAA case managers determine the need to transfer vs. retain hospital referrals for transition, in addition they:
- a) Provide information about LTC services to hospital staff, clients, decision makers, and families.
 - b) Assist with developing multiple transition plans into LTC care settings concurrently including finding a provider.
 - c) Identify and address barriers to transition as early as possible.
 - d) Collaborate with hospital staff on discharge planning.
 - e) Coordinate with transitions of care planners at MCOs

❖ If the AAA staff know the client is planning to transition to a skilled nursing facility, keep the case until the client admits then transfer the case immediately to HCS for case to be assigned to the NFCM assigned to that facility.

What is the Role of Residential Case Managers in Transitioning Clients Back to Residential Settings?

Residential Care Case Managers (RCCM) are responsible for case managing clients returning to their residential setting following an inpatient hospital stay. It is important to remember to end personal care services timely when notified a client has been admitted into the hospital.

1. For inpatient hospital clients who were receiving long-term care services in residential settings (AFH, AL, or ESF) prior to hospitalization and are expected to return to this setting upon discharge:
 - a) Follow bed hold policy outlined in [Chapter 8](#).
 - b) Follow established protocol for assessing and updating CARE assessments to reflect any changes to the client's care plan as outlined in [Chapter 3](#) of the Long-term Care Manual.
 - c) Continue to case manage the clients who were on CFC/COPES/New Freedom/ prior to hospitalization and provide reassessments/service plan changes.
 - d) The RCCM will authorize the service plan prior to transition.
 - e) Collaborate with hospital staff on transition planning.
 - f) Coordinate with transitions of care planners at MCOs. [Chapter 22a](#)



2. When clients are not expected to return to their previous residential setting, the residential unit will:
 - a) Staff the case with the receiving HCS supervisor, to discuss transferring of case. This should be done promptly to avoid delays.
 - b) Close all authorizations and notify providers of services ending.
 - c) Create SER documenting notification to providers of services ending.
 - d) Create a hospitalization transfer SER with the following information and transfer the case to an HCS hospital case manager.
 - Hospital Name
 - Admission date
 - Current hospital social worker
 - Barriers to returning to previous residential setting.
 - Date of staffing with Hospital Supervisor
 - Is the client decisional? (If not, who is the guardian/conservator or DPOA)?
 - What steps have been taken to maintain or allow the client to return to the previous setting?

What is the Role of Nursing Facility Case Management in Transitioning Clients Back to Skilled Nursing Facilities?

When an NFCM is unclear whether the client will return to the nursing facility, retain case management of the client for 30-days, or until the client transitions to another nursing facility. Upon admission into another nursing facility, the NFCM will transfer the case to the assigned NFCM of that center.

If the client is not going to be returning to a Nursing Facility, or has been hospitalized over 30 days NFCMs will:

1. Immediately staff the case with the receiving HCS supervisor,
2. Create a hospitalization transfer SER with the following information
 - Hospital Name
 - Admission date
 - Current hospital social worker
 - Barriers to returning to SNF setting.
 - Date of staffing with Hospital Supervisor
 - Is the client decisional? (If not, who is the guardian/conservator or DPOA)?
 - What steps have been taken to maintain or allow the client to return to the previous setting?
3. Transfer the case to an HCS supervisor for case assignment.

- ❖ If the RCCM staff know the client is planning to transition to a skilled nursing facility, keep the case until the client admits then transfer the case immediately to HCS for case to be assigned to the NFCM assigned to that facility.



What is the Role of Hospital Discharge Planners When Transitioning Clients to a Community Setting?

Hospital discharge planners are responsible for sending LTC financial applications to determine Medicaid eligibility for individuals as soon as it has been identified that they will need these services as part of their discharge plan. An HCS referral will need to be submitted when the individual is near ready to discharge to determine their functional eligibility for Medicaid LTC services. Hospitals may reference the [HCS Referral Guide](#) to determine when an individual is appropriate to refer to HCS.

In addition to implementing the hospital's coordination plan with the local office, discharge planners will:

1. Identify and communicate early on, barriers to discharging individual that is being referred for LTC services.
2. Prior to making a HCS referral, determine if the client is willing to accept long-term care services.
3. Submit a completed intake and referral form and financial application with valid applicant's location and contact information.
4. Pursue guardianship or conservatorship if client lacks the ability to consent to LTC services on their own and did not consent to authorizing a representative.
5. Work with client's family or authorized representative to create discharge plan, which may include setting up medical and mental health aftercare appointments and secure medical equipment for the client to use after discharge.
6. Provide status updates, clinical information, and access to pertinent information affecting transitioning planning.
7. Assist with locating long term care community options.
8. Coordinate with AAA and DSHS staff concerning referrals for long-term care services and schedule assessments.
9. Coordinate individual transitions with MCOs for services and supports.
 - Refer to [Chapter 22a](#) for additional information on how to coordinate with MCOs.

Acute Care Hospital Only

- ❖ If an acute care hospital is unable to identify a proposed guardian or conservator for court nomination, the hospital may submit a referral to the HCS Guardianship Program Manager for an eligibility determination for the Guardianship and Conservatorship Assistance Program (GCAP). See section below titled Guardianship and Conservatorship Assistance Program (GCAP) for information on GCAP referral process.
- ❖ For updates on any GCAP referrals or active case status, refer to the Guardianship/Conservatorship screen in CARE.

How is Coordination with Hospital Discharge Planners Done?

HCS unit supervisors or designated staff will maintain regular contact with each hospital and conduct in-service training when appropriate to disseminate updated information about LTC services. This will also ensure that HCS' presence is complementary to hospital discharge planning activities. The goal of HCS is



to nurture a positive working relationship with individuals and entities pertinent to the discharge planning process to ensure effective coordination and client outcomes. Barriers to transition individuals need to be identified and addressed early in the transition plan process. HCS designated staff will:

1. Communicate:
 - a) Clearly define and explain to discharge planners the role HCS/AAA has in assessing new clients and clients returning to the community.
 - b) Discuss all Medicaid long-term care services including MAC/TSOA referrals with hospital discharge staff for transition planning.
 - c) Develop a written hospital transition coordination plan between the local hospital(s) and HCS office to ensure these processes and activities are understood. At a minimum, the following information shall be provided to the hospital discharge planner:
 - Contact information for the local office.
 - Contact information for specific staff including back-up staff assigned to the hospital (if available).
 - Escalation contacts for the regions or designee outlined in [appendix I](#).
 - Procedures for case staffing individual cases that may require multi-system resources and support to transition.
 - d) Encourage hospital discharge planners to refer individuals appropriately as soon as it becomes apparent that community-based services are needed.
2. Provide the following forms and documents:
 - a) HCS intake and referral form and procedures (see [appendix II](#))
 - b) [LTC application](#) and procedures.
 - c) Policies for LTC assessment outlined in this chapter.
 - d) A request for data needed from hospitals by HCS hospital case managers (see information under assessment data and reporting section of this chapter).
 - e) Provide hospital staff with information on roles and HCS process for transitioning individuals out of hospitals and share the following link where a brief training can be accessed. [Hospital Staff Training: Partnering with Home and Community Services \(HCS\)](#)

To avoid delays with transitioning individuals:

- ❖ Hospital staff, or the patients, will need to submit an application if the individual does not already receive Medicaid benefits.
 - For applicants under the age of 65 who do not have Medicare coverage they can apply with Health Care Authority online at: [Washington Healthplanfinder](#).
 - For applicants over the age of 65, or younger but receive Medicare benefits, they can apply online with DSHS online at: [Washington Connection](#).
 - When submitting application to DSHS, Hospital staff will follow additional instructions documented in [appendix III](#) to Expedite Acute Care Hospital Applications.
- ❖ Hospital staff, patients or family must submit the HCS Intake and Referral form.

What is the Role of Medicaid Managed Care Organizations in Transitioning Clients to a Community Setting?

Managed Care Organizations (MCOs) are responsible for transitional care services which require them to work with appropriate staff at any hospital to implement safe, comprehensive transition plan(s) that assures continued access for medically necessary covered services which will support the client's recovery and prevent readmission.

MCOs also have a responsibility to work with HCS to coordinate services and assist in transition planning to help ensure coordinated efforts. They are responsible for the following activities to assist in transition planning:

1. Arranging for DME approval and delivery.
2. Assigning a PCP for the client to see post discharge.
3. Assisting in finding community transition settings.
4. Negotiating contracts with SNFs and paying for SNF stays that meet rehabilitative or skilled criteria.
5. A written discharge plan, including scheduled follow-up appointments, provided to the Enrollee and all treating providers; Formal or informal caregivers shall be included in this process when requested by the Enrollee.
6. Ensuring timely access to follow-up care post transition and to identify and re-engage Enrollees who do not receive post discharge care.

MCOs have the following responsibilities after discharge:

1. Organizing post-discharge services, such as rehabilitative or skilled home care services, after-treatment services, and occupational and physical therapy services.
2. Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following discharge.
3. For Enrollees at high risk of re-hospitalization, the MCO ensures the Enrollee has an in-person assessment by the Enrollee's PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge. The assessment must include follow-up of discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage to appropriate referrals;
4. Scheduling outpatient Behavioral Health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge.
5. Follow-up to ensure the Enrollee saw his/her provider; and
6. Planning that actively includes the Enrollee and family caregivers and support network in assessing needs.

❖ Medicare Advantage and Dual-eligible Special Needs Plans (D-SNP) also have a requirement to participate and implement transition care activities. Refer to [Chapter 22a](#) for information about MCO contacts or visit the [Cross System Care Coordination](#) webpage.

Who Else May Be Involved in Inpatient Hospital Transition Activities?

1. Developmental Disabilities Administration case manager and/or DDA Nursing Care Consultant:
 - a) Triage referrals and determine functional eligibility by assessing the client's care needs.
 - b) Assist with developing transition plans into long-term care settings.
 - c) Provide information about long-term care services and support to hospital staff, clients, and families.
 - d) Coordinate with hospital staff for transition planning.
 - e) Collaborate with HCS case manager when needed to assist with developing client's care plan.
2. DDA PASRR Team—for Pre-Admission Screening Residential Referral eligibility determination.
3. Other service providers authorized by HCS e.g., community choice guides, supportive housing providers etc.
4. Public Benefit Specialists—Determine client's Medicaid financial eligibility.
5. Guardian/Conservator or sometimes Court Visitor: Participates in transition planning and decision making.
6. State Hospital Treatment Team- clinical team at state hospitals responsible for transition planning.

- ❖ Coordination and/or transfer of client services between DDA and HCS may occur for several reasons. Follow instruction in [Chapter 7h](#) of the long-term care manual appendix I for details.
- ❖ If the client needs services only provided through DDA (such as SOLA or Supportive Living) consult with DDA regional management prior to determining eligibility for LTC services.

How are ETR Requests for Eligible Inpatient Hospital Clients Processed?

Personal Care Exception to Rule (ETR):

1. ETRs are reviewed and decided based upon individualized needs for assistance with personal care and how those needs differ from many clients in the same classification group.
2. ETR requests should include how additional funds requested through the ETR will be used by the provider to meet the client's individual personal care needs.
3. ETRs can be denied at the local level if the CM/SSS does not think the client's needs differ from the majority. If the request is denied locally, the client will receive documentation of this decision which includes contact information for the client to request a HQ ETR Review.
4. Personal Care ETRs will be processed within three business days of receipt by the Headquarters ETR Committee.

- ❖ Follow the detailed ETR process outlined in [Chapter 3](#) of the Long-term Care Manual for personal care and other ETR types.
- ❖ Additional information on ETRs can be found on the [ETR Personal Care](#)

What are Some Examples of Frequent Barriers to Inpatient Hospital Client Assessment or Transition Planning?

1. Pending Guardianship: This occurs when hospital staff indicate the client does not have capacity to make their own decisions and yet the same client has not been deemed incompetent by court of law. An assessment will be completed and wait for consent from client or client's legal representative for plan approval, unless otherwise noted in court orders.
2. Client refusing to receive HCS services.
3. Lack of family or social supports to assist with the application process
4. Use of restraints or seclusion
5. Lack of readily available specialized community resources for individuals who have medical and behavioral complexities.
6. Financial eligibility: Client is unable to provide the required financial verification documents necessary to make financial eligibility determination.
7. Client's medical and psychological condition is not conducive for having an assessment.
8. Lack of adequate documentation.
9. Intermuscular (IM) medication that are "pro re nata" (PRN) or scheduled daily that cannot be replicated in a community setting.

- ❖ If Case Managers are needing assistance with transitions resources, refer to the [Transition Academy](#).
- ❖ Case Manager can also utilize the Pre-Discharge Checklist, [DSHS 20-331](#).

What is HCS Guidance About Use of Restraint in Inpatient Hospital Settings?

The Centers for Medicare and Medicaid (CMS) have published federal rules to uphold patient's rights when it came to the use of restraints or seclusion in hospital settings.

A-(0159) A restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

A-(0160) A drug or medication is considered a chemical restraint when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Use of restraints in a hospital setting:

Restraints are allowable in this setting; it must be for the shortest duration possible. Patients in Acute hospital settings have the right to be free from physical and mental abuse, restraints, and seclusion. Restraints may only be used to ensure immediate physical safety of the patient, staff, and others.

Additionally, consider the requirements outlined below when restraints are used. The section titled [Hospital Federal Regulations](#) includes further guidance that supports and expands on these requirements. Cannot be used for routine fall prevention (A-0154).



- May only be used when less restrictive interventions are ineffective (A-0164).
- Each order for restraints must be for no more than 4 hours up to a 24-hour period before a new order is needed (A-0171).
- Restraints must be discontinued at the earliest possible time regardless of the order (A-0174).
- Must be ordered only by an attending physician or licensed practitioner that is responsible for the patient's care (A-0168).
- Cannot be a standing or PRN (as needed) order (A-0169).
- A licensed physician responsible for the patient's care must:
 - See a patient face to face within 1 hour after the initiation of the restraint (A-0178).
 - Assess the patient following the use of restraints (A-0172).
 - Assess the patient within 1 hour to identify the immediate situation, reaction of the patient, behavioral condition, and identify the need to terminate the restraint or seclusion (A-0179).

Reminder: HCS/AAA cannot assess, or transition clients being restrained, Long Term Care settings cannot restrain clients.

Examples of Interventions that are Not Considered Restraints in an Acute Care Hospital setting: Please note, these examples are from CMS regulations and can be found [here](#) under A-0161.

- **Orthopedically prescribed devices.**
- **Surgical dressings or bandages.**
- **Protective helmets.**
- A **mechanical support** such as a neck, head, or back braces.
- A medically necessary **positioning or securing device** used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures is not considered a restraint.
- Use of an **IV arm board** to stabilize an IV line is generally not considered a restraint.
 - However, if the arm board is tied down (or otherwise attached to the bed), or the entire limb is immobilized such that the patient cannot access his or her body, the use of the arm board would be considered a restraint.
- Many types of **hand mitts**.
 - However, the following can be considered a restraint:
 - Pinning or otherwise attaching those same mitts to bedding or using a wrist restraint in conjunction with the hand mitts.
 - If the mitts are applied so tightly that the patient's hand or fingers are immobilized.
 - If the mitts are so bulky that the patient's ability to use their hands is significantly reduced
- **Recovery from anesthesia** that occurs when the patient is in a critical care or post anesthesia care unit is considered part of the surgical procedure; therefore, medically necessary restraint use in this setting would not need to meet the requirements of the regulation.
 - However, if the intervention is maintained when the patient is transferred to another unit or recovers from the effects of the anesthesia (whichever occurs first), a restraint order would be necessary, and the requirements of standard (e) would apply.
- Other methods that involve the **physical holding** of a patient for the **purpose of conducting routine physical examinations or tests.**

- Siderails to **protect** the patient **from falling out of bed**.
- To permit the patient to **participate in activities without the risk of physical harm** (this does not include a physical escort).

Hospitals have a responsibility to use the least restrictive alternative. As a mandatory reporter, if you are concerned that a patient is being improperly restrained you should staff with your supervisor to determine if a Department of Health report should be made.

Managing and Transferring Inpatient Referrals

When Would HCS Accept a Hospital Withdrawal of a Client Referred for LTC Services?

If the hospital and the client (if able to communicate their choice at the time) agree to withdrawal the HCS referral due to client not being near ready for discharge (pending guardianship except when pending through GCAP services, not medically or psychiatrically stable, etc.), the CM will take the following actions:

1. SER mutual decision for withdrawal of referral
2. Enter outcome in the CARE hospital screen
 - **Acute Hospital** will select withdrawal
 - **State Hospital** will select inactive
3. Refer to [Chapter 27](#) on when a PAN is required.
4. Send a 14-443 to financial stating “the LTC request was withdrawn, please redetermine for non-LTC medical. CARE is being inactivated.” Financial will determine Medicaid eligibility and if client qualifies, the case will be sent to the CSO.
 - Omit the 14-443 for MAGI
5. Inactivate the case in CARE.
6. As soon as a new HCS referral is received, verify with financial status of eligibility, and create a new entry in the acute care or state hospital screen with a new referral date.

- ❖ Every referral must have a distinct referral date, even if the client was previously withdrawn and is re-referred for services. Enter the record in the acute hospital screen with a **new referral date**.
- ❖ If an individual is pending appointment of a contracted guardian or conservator through GCAP services, the referral is not to be withdrawn due to pending guardianship.

When Would a Hospital Referral for Transition Be Inactivated?

Some individuals who are referred to access LTC services may not have a transition plan in place due to reasons such as not being financially eligible for services, not being medically stable, psychiatrically stable, or guardianship is not in process, and/or among other barriers that may be identified through case staffing.

The HCS case manager will:

1. Offer ongoing support to the client, family and /or representative by addressing concerns regarding care in community-based settings.
2. For medically complex individuals, consult with the HCS Nursing Care Consultant (NCC) or AAA Registered Nurse case manager.
3. Offer other services such as Adult Day Health, Skilled Nursing, RN Delegation or Private Duty Nursing
4. Continue to support all efforts towards reducing or eliminating barriers to a less restrictive setting.
5. If after 4 months (except in the case of Acute Hospital GCAP eligible clients) the client has not made any progress towards transition planning:
 - a) Conduct a staffing with the unit supervisor to review the status of the case including what has been done, and
 - b) May inactivate the client in CARE using the “No Current Discharge Plan” code.
 - c) Advise the hospital when it would be appropriate to re-refer the individual.
6. For a client who refuses HCS services, does not apply, has been determined not to be financially eligible, HCS has lost contact, or client has been determined not to be a good fit for HCS services through the challenging/complex case protocol, the HCS case manager will inactivate the case immediately.

❖ Cases resulting in the termination of GCAP services for reasons including but not limited to; a client leaving hospital against medical advice, identification of less restrictive guardian/conservator, or no identified contracted guardian/conservator identified may be inactivated in CARE by the assigned HCS case manager using the “No Current Discharge Plan” code after Guardian/Conservator screen is finalized by GCAP staff.

How are Transitions from Inpatient Hospitals to a Nursing Facility Done?

1. Hospitals may discharge patients to a nursing facility without prior authorization from HCS (refer to [Chapter 10](#) of the Long-term Care Manual for NFCM relocation.)
2. Hospital staff will facilitate the nursing facility admission from the hospital.
3. The hospital discharge planner or nursing facility must still notify the HCS hospital case manager of pending admissions to SNFs to appropriately transfer cases to NFCMs.
4. HCS staff will not have to complete initial CARE assessments for individuals (Medicaid and non-Medicaid) who have been identified as meeting the Pre-Admission Screening & Resident Review (PASRR) criteria prior to discharge from the hospital (refer to [Chapter 10](#) of the Long-term Care manual for details.)

❖ If a client needs Expanded Behavior Supports (EBS) to support a transition to a SNF, refer to [Chapter 10](#) for process on how to make a referral.

How are Transitions from Inpatient Hospitals to Transitional Care Units/In-Patient Rehab and Long-Term Acute Care Centers (LTAC) Done?

When an individual transitions to In-Patient Rehabilitation (IPR) outside a hospital or to a Long-term Acute Care (LTAC) Hospital, HCS considers that transition a hospital discharge and are no longer considered inpatient.

When the transition to IPR is located within a hospital, this is not considered a hospital discharge.

1. Conduct a CARE assessment for clients who have applied for LTC services and are ready to transition to community settings.
2. If the client is transitioned to the transitional care setting prior to assessment, conduct the assessment at the transitional care setting.

- ❖ When a client transfers from an acute hospital to LTAC, this is considered a transition. The discharge outcome on the acute hospital screen for this client is “Other medical facility.”
- ❖ When a client is referred from LTAC to HCS for LTC services, do not add the referral to the acute care hospital CARE screen.

How are Transfers outside the Region for Clients in Inpatient Hospitals Done?

When a client is transferring to a different region while still in the hospital, the following should be done:

1. Conduct a case staffing with a supervisor to confirm need for transfer.
2. HCS hospital supervisor in charge of a transferring case must transfer the case in CARE and Barcode to the intake unit of the client’s destination region while the case is still open, or
3. The supervisor at the region making the transfer may request intake at the destination region to assign the case or contact the intake supervisor to facilitate the transfer.
4. When the intended location is to transition the client is outside the local HCS office, notify the receiving office and staff the case before final arrangements to transition the case are in place.
5. When a hospital discharge is imminent and a CARE assessment has been conducted, the HCS hospital case manager may keep the case and put services in place before making the transfer.

How are Hospital Assessments for Clients Referred by Hospitals or LTAC With HCS Agreements, Near Washington State Borders Done?

HCS Hospital case managers are responsible for assessing out of state Washington residents in border acute care hospitals or LTACs:

1. When the individual has submitted a LTC application for financial eligibility and is pending Medicaid and;
2. The individual has been referred to HCS for a functional assessment for LTC services by a border acute care hospital or LTAC, and;
3. When the individual is a Washington resident and is planning to return to the state;
4. Follow procedures established in [Chapter 3](#) of the Long-term Care Manual for CARE assessments.

What is the Process for Submitting Non-Grant Medical Assistance (NGMA)

MAGI-based clients are not part of the Aged, Blind, Disabled population and therefore if waived services are needed a NGMA will need to be complete to determine eligibility. Please see [Chapter 7h](#) for a detailed process of how to complete a NGMA. Case managers should consider the location of the client they are working with and follow outlined processes below.

Acute Hospital: Social Service Specialist may submit Hospital Certification of Potentially Disabling Condition (HCA form 19-0054) along with NGMA packet to move forward with transition planning. This document allows the PBS to approve waiver eligibility for 90 days while Department of Disability Determination Services (DDDS) completes a full review. Send the following to Financial Policy Analyst (FPA)

- Client Name
- ACES ID
- DDS Office submitted to:
- Facility Name:
- Date 19-0054 submitted:
- Date NGMA sent:
- Reason for request to expediate NGMA:

State Hospital/Residential Treatment Facilities/Local Psychiatric Facilities: Complete and submit the NGMA packet. In addition, an email to the Financial Policy Analyst (FPA) and the SHDD Public Benefits Coordinator (PBC) with the following information in order to request DDDS to expedite the NGMA application.

- Client Name
- ACES ID
- DDS Office submitted to:
- Facility Name
- Date NGMA sent:
- Reason for request to expediate NGMA:

What is the Role of Case Managers When Assessing a Client with a Known Legal History?

Documentation of criminal offenses:

Investigating or determining whether a client has a record of criminal justice system involvement is not necessary to determine whether a client is eligible for services but may be relevant to care planning and service delivery.

Case managers should use the following guidelines for documenting disclosed criminal behavior and offenses as part of a CARE assessment. It may be necessary to ask clarifying questions to the individual you are assessing to better understand the nature of a charge or conviction that is disclosed or known.

The CARE assessment is not intended to be a complete record of criminal activity or legal involvement; documentation should be relevant to care planning.

Why is legal history included?

The purpose of including any information about the client's potential, or actual criminal history, is so that a provider is aware of the client's needs and able to evaluate whether they want to take on the duty to care for the client and can meet their obligation to protect other clients. It is not about providing the provider with a detailed criminal history of each potential client

Limitations on sharing criminal history information from a law enforcement agency:

If you have criminal history information from a law enforcement agency it may include convictions as well as pending charges and dispositions other than convictions. For these records you can include and disclose to providers information about convictions and pending charges without restriction. For other arrests and dispositions of charges included in the criminal history report, only certain information can be disclosed.

Charges that meet special criteria and should be documented:

1. If an incident occurred within the last 12 months and the person is still being processed by the criminal justice system (i.e. is on parole)
 - a) The charges:
 - Resulted in an acquittal for not guilty by reason of insanity (NGRI);
 - Resulted in a dismissal for incompetency under 10.77 RCW (civil conversion)

How and where to document convictions/pending charges/charges that meet special criteria:

1. The case manager should include documentation in the safety screen under the legal comments section so that it is visible to a provider.
2. If known the CM should indicate:
 - a) the date of the crime
 - b) the nature of the crime the individual was convicted of
 - c) indication of who the crime was committed against.

How to document criminal behavior and history disclosed by the client/family/notes or other:

If the information you have is reported by another source, such as a provider, a family member, or the client themselves, the case manager is not responsible to confirm this information and can include the information in the CARE assessment.

If you are unsure if the information is true or not, don't document information as fact, rather indicate in CARE that the information has been reported by client/family/notes or other.

If you are documenting any legal history add the following in the comment field of the legal section:

Any criminal history information about the client included in the assessment details is for information only. The department has not conducted a comprehensive background check, nor has it independently verified information reported to it by third parties, including the client. Therefore, any information about the client's criminal history included in the assessment details may be incomplete or inaccurate.

What is the Involuntary Treatment Act (ITA)?

Individuals experiencing a behavioral health crisis may present as a risk to themselves or others or be unable to care for their basic need of health and safety. The involuntary Treatment Act (ITA) provides the statutory framework for civil investigations, evaluations, detention, and civil commitments of individuals experiencing a mental disorder or a substance use disorder whose symptoms are so acute that the individual may need to be treated on an involuntary basis. For additional information pertaining to the ITA process reference [HCA Involuntary Treatment Act](#) or [Acute Behavioral Health and ITA](#).

What Additional Steps to Take When Transitioning an Individual on an ITA (Civil Commitment)?

1. Request ITA Documents from Local Psychiatric Facility (LPF) or Hospital:
 - a) Court orders are official legal documents that confirm a client is under involuntary treatment pursuant to a civil commitment. Orders issued under an ITA must clearly specify the type and duration of detainment, which may include 120-hours, 14-days, 90-days, 180 days, or if they have a revocation of an LRA.
 - b) If a client was detained under the ITA process, but has switched to voluntary status, HCS will still need to obtain a copy of the ITA documents.
 - c) ITA documents must be signed by a judge or court commissioner.
2. Request any relevant Behavioral Support Plans or Risk Management Plans.
3. Upload Documents to Data Management System (DMS): The case manager will send ITA petition, court orders, and any relevant LRA documentation to Barcode via email.

The process identified in this section will need to be repeated at any time a new ITA or Less Restrictive Alternative (LRA) is issued. Please refer to Chapter [71.05](#) RCW for more information regarding the legislative process.

What is the Role of HCS Case Managers when Receiving a Referral from the Office of Public Defense?

HCS intake may receive a referral from OPD requesting a CARE assessment be completed for individuals residing at Eastern State Hospital and Western State Hospital. OPD will be representing the client in court and will bring forward potential setting options the client may be eligible for upon discharge. Home and Community Services has an obligation to complete a CARE assessment when requested by OPD.

If a referral is received, the Case Manager will:

1. Notify the State Hospital treatment team of the referral received from OPD and schedule the assessment.
 - a) If the treatment team is in support of transition, state hospital initiates next steps for discharge.
 - b) If the treatment team is not in support of the transition, the treatment team will present this at court. HCS performs the CARE assessment and continues transition planning.



Instruction for OPD Assessment Disclaimer

Since referrals from OPD may not be supported by the treatment team or may not indicate the client is ready to transition to the community. If the treatment team does not agree or the client is not on the active discharge list, follow the process below to print special instructions on the CARE assessment:

CARE plan Main screen:

1. Select **Eastern State Hospital or Western State Hospital** for "Client location at time of assessment". For clients residing at Maple Lane Campus, **please select Western State Hospital** from the drop-down box. This will ensure the OPD disclaimer language populates to the assessment.
2. Selecting this from the location drop down, then populates the question:
 - a) Print OPD referral disclaimer on the Assessment details?
 - b) **Select:** "Yes" to display the following disclaimer to print on the Assessment Details:
"The attached assessment is not an endorsement or recommendation by the Department of Social and Health Services that the person is ready or appropriate for discharge from an inpatient setting. DSHS uses the CARE tool to assess a person's current ability to perform "activities of daily living" which include bathing, bed mobility, dressing, eating, locomotion, medication management, toileting, transferring, and person hygiene. The assessment is not performed by psychiatric professionals, nor is it a substitute for clinical or legal determinations under chapters 71.05 and 10.77 RCW of a persons readiness for discharge from an inpatient setting, a persons readiness for a less restrictive alternative or conditional release, or whether a person poses a safety risk to the public or themselves. Instead, it is a point in time evaluation of functional eligibility for DSHS services as required by the Medicaid program."

While assessment is pending:

1. Notify OPD that a CARE assessment has been completed and relay the results of the functional eligibility assessment. Inquire about the following:
 - a) is OPD requesting that referrals be sent to providers, OR
 - b) is the request for functional eligibility determination only?
2. If a request is made for referrals to be sent, send referrals.
3. Continue working with the treatment team and MCO through cross-system meetings to determine next steps and what services may be available to the client.
4. If the court determines that discharge will occur, a new assessment may be appropriate. Follow Chapter 3 guidance on when a new assessment is warranted, once the state hospital has completed all required transition steps.

What Is Intensive Residential Treatment (IRT) and What is the Referral Process?

Intensive residential treatment (IRT) is a Medicaid Behavioral Health service for individuals discharging or diverting from state hospitals or long-term hospitalizations into residential settings. IRT teams are the primary mental health provider who provide intensive mental health care to individuals in residential settings to support their transition to a lower level of care. IRT is not available in all Counties. For additional information reference the Health Care Authority (HCA) [Intensive residential treatment \(IRT\) teams](#).

For clients wanting to transition to Passages, in Spokane County:



- Send referrals to Lisa Taylor-Tussey ltaylortussey@passagesfs.org, include the MCO liaison

For clients wanting to transition to Emerald City in Pierce, Spokane and King Counties:

- Send referrals to Emerald City IRT- irt@emeraldcity.health, include MCO liaison

Special Considerations for State Hospital and other BHHA Facility Transitions

Transitions from Behavioral Health Habilitation Administration (BHHA) facilities including both Eastern and Western State Hospitals as well as the state hospital- Residential Treatment Facilities (RTF), Olympic Heritage Behavioral Health and Maple Lane. Case Managers will follow all inpatient assessment and transition process and policy.

What Additional Documentation Should I Receive to Assess a Client?

As of 2/15/2026, BHHA facilities will be responsible for completing and submitting the [HCS Form 20-340: Individualized Community Transition Planning Summary Form \(ICTPS\)](#) in advance of an assessment being conducted.

1. The ICTPS form must be completed for every new HCS referral and provide the HCS case manager with pages 1 & 2 of the form.
2. HCS case manager will initiate the Behavior Snapshot section of the ICTPS and will collaborate in person when possible with the facility to complete the document to accurately capture recent and historical behaviors.
 - a) This may involve coordinating with other members of the patient's treatment team to provide relevant behavioral information on the form and incorporated into the CARE Assessment.
 - b) The HCS case manager can request the availability of inpatient staff to complete the Behavior Snapshot section together directly following the in-person assessment.
3. Upon Completion the ICTPS should be scanned into DMS for retention. For more information see [What Information Is Needed by HCS Hospital Case Managers to Conduct an Assessment?](#)

What is a Public Benefits Coordinator?

The Public Benefit Coordinator (PBC) is available to provide the following pre-and/or post transition assistance for an individual transitioning from a state hospital:

- Coordination with the financial department
- Coordination with the Division of Disability Determination Services (DDS) for disability determinations needed (through the NGMA referral process) to access HCS waiver services
- Assistance with any necessary or available payee options
- Public benefit related matters such as accessing Medicaid or Social Security benefits

Determination for Aged, Blind, Disabled Cash Assistance

For clients residing at Western State Hospital (WSH), Eastern State Hospital (ESH), State Hospital-Residential Treatment Facility (SH-RTF) or who have diverted from the state hospital require a



determination for Aged, Blind, or Disabled (ABD) cash assistance, the assigned HCS Public Benefits Specialist (PBS) will reach out to the assigned ICMS Social Service Specialist (SSS) by 14-084/DID referral.

Refer to SH/SH-RTF [ICMS Case Management for SHDD Referrals](#) to determine the appropriate ICMS worker (CSO SSS or HCS PBC) to contact for ABD determinations.

If the client is approved for ABD cash after they discharge, they will be appointed an SSI facilitator within DSHS who will help them meet their ABD cash requirements to file for SSI.

Supplemental Security Income (SSI) Facilitation

SSI facilitation is not needed while clients reside at WSH, ESH, or SH-RTF because clients do not qualify for SSI while in residence.

- SSI facilitation will be provided by the local CSD SSI Facilitator if the client discharges without HCS services.
- SSI facilitation will be provided by the SHDD Public Benefits Coordinator (SHDD PBC) or an HCS SSI facilitator (Region 2 only) if the client discharges with HCS services.

If an ABD cash recipient discharges with HCS services, the SHDD PBC or assigned HCS SSI facilitator will contact the client to discuss their ABD cash requirements, discuss their options on how to file for SSI, and pursue a signed Interim Assistance Reimbursement Agreement (IARA) (if needed). A signed IARA will be needed along with a client's SSI application packet so the state can recoup funds from a client's SSI retroactive payments for any ABD cash benefits issued during the SSI application process.

The SHDD PBC or assigned SSI facilitator will track the client's SSI claim progress in ICMS and provide ongoing assistance to the client's SSI/SSDI application, which may include any follow-up on approval, appeal, or denial of their SSI claim. The SHDD PBC will continue to provide SSI facilitation while a client remains active on ABD cash or until a final determination has been made on their SSI application.

ESH Clients Only

- ❖ ESH clients placed on discharge planning go through the ESH pre-release program with the SSA office where the ESH Financial Recovery Enforcement Officer (FREO) assists clients with applying for SSI/SSDI benefits prior to discharge from ESH.
- ❖ When an ESH client discharges with HCS services, the SHDD PBC will review SSA crossmatches (such as SOLQ, BENDEX, or SDX) and coordinate with ESH FREO staff to determine if SSI/SSDI applications have been submitted prior to discharge. The SHDD PBC will provide ongoing SSI facilitation after discharge and obtain the signed IARA from the client (if needed).

State Funded Long-Term Care for Non-Citizens

If the SHDD Public Benefit Specialist (PBS) identifies an individual who is either diverting or transitioning



from the state hospital needs a Non-Citizen Long Term Care (NC-LTC) slot, a referral should be made to SHDD Public Benefits Coordinator (SHDD PBC). The SHDD PBC will make referrals to HCLA HQ to place individuals on the NC-LTC waitlist or to allocate the individual a slot.

Washington Civil Discharge Settlement

Per the Washington Civil Discharge Settlement Agreement, “The goal of the Settlement Agreement is to avoid costly and time-consuming litigation on behalf of individuals who are or will be civilly committed at Western or Eastern State Hospital.” The parties to the settlement agreement are Disability Rights of Washington (DRW), the Health Care Authority (HCA), and the Department of Social and Health Services (DSHS). As a result of the settlement, there are specific metrics that must be met when planning for a transition to a home and community-based setting.

What is a Forensic Patient?

A forensic patient is a person who is receiving mental health treatment within the legal system because they are involved in a criminal case.

Not Guilty by Reason of Insanity (NGRI)

A defendant is found not guilty by reason of insanity and acquitted of the charge(s) against them when the court determines the person was not able to tell right from wrong due to their mental state at the time of the offense. These types of forensic patients typically experienced severe symptoms of mental illness at the time of the offense, which gravely impaired their capacity to perceive reality or think clearly. For additional information see [BHHA NGRI](#)

State Hospital – Residential Treatment Facilities (SH-RTFs)

These facilities were created as a part of the state’s Behavioral Health transformation investment in community-based mental health. State Hospital Residential Treatment Facilities (SH-RTFs) promote person-centered psychiatric care for those individuals who are civilly detained on 90 and 180 day holds. They are managed by the Behavioral Health and Habilitation Administration for individuals transitioning from the State Hospitals for competency restoration. These facilities permit patients to receive care in smaller facilities allowing them to receive treatment in their communities closer to home, their families, and their support systems.

Assessment Data & Reporting

What Information Is Needed by HCS Hospital Case Managers to Conduct an Assessment?

1. Information needed from hospitals.
 - a) Submit a complete financial application prior to the date of the assessment or at the time of sending an intake referral form.
 - i. For applicants under the age of 65 who do not have Medicare coverage they can apply with Health Care Authority online at: [Washington Healthplanfinder](#).
 - ii. For applicants over the age of 65, or younger but receive Medicare benefits, they can apply online with DSHS online at: [Washington Connection](#).



- iii. When submitting application to DSHS, Hospital staff will follow additional instructions documented in [appendix III](#) to Expedite Acute Care Hospital Applications.
 - b) Client specific information needed from the hospital: To determine functional eligibility, establish the level of care, and develop a service plan for community providers, hospitals are requested to fax, email, or print and make available at the nurses' station the following information for the HCS hospital case manager on the date of the assessment. This information is not on the Medicaid application and having it promptly assures timely completion of assessment:
 - i. Demographic /face sheet
 - ii. Progress notes from physicians, nursing, physical therapy (PT), occupational therapy (OT), speech and other therapies
 - iii. Admission notes on client's health, physical and psychiatric conditions
 - iv. List of current diagnoses
 - v. History & Physical (H&P)
 - vi. Current wound care notes including treatments.
 - vii. Care Plan and/or Behavior Support Plan (BSP) and/or Treatment plan when applicable
 - viii. Last 7-day medication administration records (MAR)
 - ix. Behaviors and interventions (i.e., client wanders and needs to be redirected, yelling, and screaming, assaultive behaviors)
 - x. Known sexual offender status, or related legal issues
 - xi. Social work/ discharge planning notes including date of medical clearance for discharge.
 - xii. Guardianship/ DPOA copy (if applicable)
 - xiii. Current Durable Medical Equipment (DME) used by client for the assessment (hospital staff to coordinate any future need for DME post discharge)
 - xiv. Any information critical to a successful transition plan.
 - c) HCS has established agreements with several acute care hospitals to access Electronic Health Records (EHR). If needing access to EHR system contact your Regional Acute Hospital Program Manager.
2. Notice of change of client condition
- a) When there is a change in the client's condition or the client transitions prior to the assessment, the hospital staff must notify the HCS hospital case manager immediately to appropriately utilize the assessment time slots.
3. Considerations for patients in restraints
- a) To speed up transitions into LTC services, hospitals are requested to transition individuals from restraints prior to assessment and maintain the individual without restraints for prospective providers. The current HCS policy is for clients to be free of physical and chemical restraint for 3 consecutive days prior to assessment and any transition.



Use of Electronic Health Records (EHR)

HCS maintains read-only access agreements with hospital systems permitting the review of electronic health records solely for care coordination and transition planning.

Appropriate use of EHR:

Staff should not be printing, saving, or sending documents from the electronic health record. The only exceptions are:

1. If you have consent from a client, it may be appropriate to print the following documents:
 - a. POA, guardianship or other legal documents.
 - b. Medical documentation for NGMA applications.
 - c. Involuntary Treatment Act (ITA) - civil commitment orders and Least Restrictive Alternative (LRA) order or the Conditional release (CR) agreement.
2. If you have printed any of the above documents, send them to DMS.

❖ For acute hospital assessors who do not have access to the EHR system (or new staff), medical records need to be requested directly from the hospital. Records should be shredded after work is complete.

What is the Transition Discharge and Planning System (TDPS)?

The Transition and Discharge Planning System (TDPS) is one of the primary systems utilized by the Behavioral Health and Habilitation Administration (BHHA) and Home and Community Services (HCS) to support assessment, transition planning, and discharge coordination for individuals who may require HCS long-term services and supports following discharge from a BHHA facility. TDPS is an electronic health record (EHR) system that contains protected health information (PHI) and other confidential client information. The same standards, safeguards, and procedures that apply to other HCS electronic health record systems apply when accessing and documenting in TDPS.

As part of HCS's responsibilities, staff are required to document early engagement activities, complete required assessments, and update transition planning information within established timeframes. HCS is also responsible for maintaining accurate and timely documentation within the **HCLA (AL TSA) Activities** tab to support coordination of services and compliance with HCS policy and practice expectations.

TDPS was implemented as part of the state's response to the Civil Discharge Settlement Agreement and continues to serve as a shared system supporting discharge planning across multiple divisions. Specific TDPS tabs require ongoing updates by HCS Social Service Specialists (SSSs) and Public Benefit Specialists (PBSs) throughout the assessment, eligibility, and discharge planning process. Timely and accurate documentation in TDPS supports effective coordination with BHHA and other partners to facilitate safe, appropriate, and timely transitions to community-based long-term services and supports. For more information and TDPS instructions, please see: [The Transition Discharge Planning System](#)



What Information Must Be Reported and Tracked For Hospital Referrals?

The **Acute Care Hospital** CARE Web Screen outlines required information that needs to be reported about acute care hospital referrals and transition activities.

1. HCS hospital case managers or designated staff at regional offices will follow instructions outlined in the [CARE Web Help Screen](#) for Acute Care Hospital to document client barriers, transition plan, and document updates on client progress to transition out of acute care hospitals.
2. To access the acute care hospital screen HCS hospital case managers (assessors) /staff must be granted access depending on the need for use. Access is granted by designated regional staff.

The **State Hospital/Hospital/Evaluation and Treatment (E&T)** CARE Web Screen outlines required information that tracks referrals and outcomes for clients transitioning from state hospitals and local psychiatric facilities, regardless of their Involuntary Treatment Act (ITA) status.

1. HCS case managers or designated staff at regional office will follow instructions outlined in the CARE Help screen to document the discharge status and delay reason, referral submitted and if the client meets criteria.
2. Case Manager will need to document post transition evaluations in the outcome section for 30 days, 6 months and 12 months.

- ❖ Case Manager input and data tracking provides information on a statewide level that is used to respond to leadership, legislative, and constituent inquiries and identify potential policy and appropriation requests to address gaps.

MANAGEMENT OF COMPLEX HOSPITAL CLIENT TRANSITIONS

What is Length of Stay (LOS) in Inpatient Hospital Settings?

For HCS, length of stay refers to the period of time a client continues to stay in the hospital from the date of HCS referral to the time client transitions.

What Additional Transition Strategies Should Be Applied to Complex Client Referrals?

This process outlines strategies to be utilized with hospital clients whose transition to community settings is hindered by significant barriers making it more likely for the individual to remain in the hospital more than 30 days past the date of referral to HCS. For such individuals:

1. The initial CARE assessment will be completed within 7 days from the date of referral or from the date the client is stable and predictable.
2. When no community option is available for a client after 60 days from the date of referral to HCS, additional contact requirements will be followed:
 - a) Face-to-face contact at the hospital every other month and documented in a SER. Document in SER if the client has had any care plan changes or document if care plan remains the same, what transition efforts are being made etc.

- b) Document contact conversations weekly that occur with the family, collaterals, and hospital staff.
- c) The HCS case manager will review the medical records and determine if the initial assessment no longer meets the client's care needs and follow assessment and care planning policy outlined in [Chapter 3](#) of the Long-term Care Manual.
- 3. Complex case coordination and case staffing requirements for clients who are still hospitalized 30 days or more past referral:
 - a) Conduct case staffing with local office supervisor on a weekly basis.
 - b) Send at least weekly updates to hospitals for coordination purposes per local policies and procedures.
 - c) Increase communication efforts with hospital discharge planners, community partners, and community choice guides to help assist with transition efforts.
 - d) Follow case staffing and escalation procedures established by the local office, Region, and HQ as outlined in this chapter to provide additional support and resources for transition options.

- ❖ Utilize the HCS Screening Tool in [Appendix IV](#) to escalate cases
- ❖ Utilize Case Staffing Referral Template [Appendix V](#) to document and submit case staffing requests.
- ❖ Utilize the Specialized Settings referral form in [Appendix VI](#).
- ❖ Utilize the [Transition Academy](#) for additional resources.

How is A Complex Client Case Escalated?

The following table outlines when and how complex cases will be escalated for Individuals across all inpatient settings. There are various staff resources available to assist with complex staffing, for details and who to contact please refer to [Appendix VII](#)

Who/ when to Escalate	What is involved and what needs to be done
Escalation from HCS to Hospitals	➤ Each hospital identifies how it would like issues to be escalated when they are not able to be resolved at the discharge planning level. ➤ HCS will be provided with discharge planning /case manager contacts or other designees for each hospital. ➤ When there are difficulties in utilizing the identified escalation path, the HCS local office/regional designee will contact their Program Manager in HCS.
Escalation within HCS	➤ Follow local office and regional escalation procedures with designated staff. At a minimum, follow the escalation steps outlined below. ○ Supervisor will use escalation Screening Tool (see appendix IV) when staffing with



Who/ when to Escalate	What is involved and what needs to be done
	the CM to determine if an individual's case needs to be escalated to further support a transition plan. This tool can be used at any point in the case management process; early use is recommended. ○ If a client screens in via the escalation screening tool: ▪ Staff with cross-system partners ▪ Refer client to regional escalation staffing or directly to HQ if determined appropriate.
Escalation with Cross System Partners	➤ If client screens as complex, follow regional protocol and HQ guidance to staff cases with MCO, BH-ASO, DSNP or other relevant partners to create a transition team. ➤ Coordinate with the Managed Care Systems Consultants (MCSC) for your region as necessary to ensure appropriate escalation.
Clients at 30 days from date of referral	➤ These cases should be staffed with a supervisor. ➤ Complex cases must be staffed with cross system partners
Clients 60 days from date of referral	➤ These cases should be staffed at regional level by designated staff. ○ Case staffing must be documented to include options explored and outcomes. ○ From the regional level, cases may be escalated to HCLA Headquarters (HQ) if there continue to be barriers. ○ Use the case staffing referral form (appendix V) to document cases referred to HQ.
Clients at 90+ days from date of referral or after regional/ cross system partner staffing	➤ These cases will be staffed at HQ in collaboration with designated regional managers. In addition, HQ will staff: ○ Special referrals from regions and hospitals ○ Cases brought to the attention of the administration from external interest groups. ➤ If all recommendations have been explored and there is continuous communication with cross system partners but without a clear path to transition, such cases may be restaffed at HCLA Headquarters (HQ).

Acute hospital: Guardianship and Conservatorship Assistance Program (GCAP)

The staff resources and detailed information outlined below are intended to provide support to regional staff with relevant program resources when handling GCAP cases.

What is the Guardianship and Conservatorship Assistance Program (GCAP)

Some individuals referred to HCS for long-term care services deal with multi-faceted barriers including the lack of a decision maker for consent to services making the assessment and transition more complicated and time intensive. To reduce some of the pressure on an already strained healthcare system, DSHS, in partnership with acute care hospitals, implemented a guardianship pilot project in July 2022 aimed at targeting this small sub-group of individuals for assistance with identifying Certified Public Guardians and/or Conservators for the purposes of accessing access LTC services which would allow for client transitions from Acute Care Hospitals.

Effective September 1, 2024, given the successful outcomes, DSHS has transitioned the guardianship pilot project to a program. The program is called the HCS Guardianship and Conservatorship Assistance Program (GCAP).

GCAP is a state-funded program with limited slot availability for clients meeting specific criteria. GCAP is designed to assist Acute Care Hospitals (ACH) in the identification of proposed guardians and/or conservators for a small subset of eligible and presumed eligible clients needing a decision maker to access LTC services. GCAP is designed as a collaborative process wherein DSHS HCS works in tandem with acute care hospitals to assist with the identification of proposed guardians and/or conservators while the hospital remains the petitioning party to a motion filed with the court under RCW 11.130. Only in limited situations does HCS serve as the petitioning party in such cases.

Additional information pertaining to GCAP may be found in Chapter 388-106-2100 WAC and on the Inpatient Hospital Assessments and Transitions stakeholder site: [GCAP Information and Resources](#)

Services that GCAP Provides

GCAP provides professional guardianship and/or conservatorship services to eligible clients for the purposes of establishing a legal decision-maker required to facilitate care transitions for eligible clients no longer able to consent to their own care. GCAP offers limited financial support to certified contracted professional guardians (CPG) and conservators as a way of removing barriers for Medicaid clients accessing professional decision-making services to support their long-term care needs. To support such work, service rates were mirrored from service rates for similar services offered through the Office of Public Guardians, to incentivize professional guardians and conservators to accept legal appointments for Medicaid recipient cases that would have otherwise posed financial obstacles in accessing decision-making services.

1. Each GCAP case receives:
 - a. A monthly guardianship and/or conservatorship service fee at the following denominations as calculated from the date of court appointment:
 - i. Months 1-3 at a monthly rate of \$710.00



- ii. Months 4-12 at monthly rate of \$440.00
 - iii. Months 13+ (Tier 2 clients only) at a monthly rate of \$235.00 or allowable Medicaid rate.
 - b. A one-time case establishment fee in the amount of \$1,500.00
 - i. This fee is a one-time fee, per GCAP case, paid to contractor to assist in the offset of legal filing fees and court costs which were identified as causing significant financial barriers to professional guardians and conservators willing to accept appointment of Medicaid cases.
- 2. Each GCAP case filed and appointed in King County receives:
 - a. A one-time King County Filing Stipend in the amount of \$2,500.00
 - i. This fee is a one-time fee, per GCAP case, paid to contractor to assist in the offset of legal filing fees and court costs which were identified as disproportionately higher in King County causing significant financial barriers to professional guardians and conservators willing to accept appointment of Medicaid cases in said county.
- 3. Each GCAP case that is terminated after contractor court appointment prior to the identified term completion date receives:
 - a. A one-time case closure fee in the amount of \$300.00
 - i. This fee is a one-time fee, per GCAP case, paid to contractor to assist in the offset of legal filing fees and court costs associated with final notices or court reports required to close an established guardianship or conservatorship legal case under RCW 11.130.
 - ii. This fee is not authorized for services completing the designated tier term.
- 4. Each new GCAP contractor receives:
 - a. A one-time only, operational expense stipend in the amount of \$4,000.00
 - i. This fee is paid upon the court appointment of a new contractor's first GCAP case following the execution of their initial DSHS GCAP contract.
 - This fee is not paid upon court appointment of first GCAP case following contract renewal or extension.
 - ii. This fee is paid to assist new contractors with offsetting the financial burden of operational expenses imposed on small businesses to meet initial contracting requirements, such as insurance requirements.
 - The contractor is responsible for maintaining ongoing compliance with contractor requirements after this one-time fee is issued.

What is a GCAP Program Slot, Tier Term, or Tier Designation

As outlined in WAC 388-106-2105, a GCAP program slot means a GCAP program vacancy based on timeframe of needed resources as designated by either a "Tier 1" and "Tier 2" designation when the following definitions are applied:

- 1. **Tier 1:** A program slot with a maximum service benefit of up to 12 months duration from the time of court appointment of a contractor.
- 2. **Tier 2:** A program slot with continuous service benefits for individuals not required to pay participation towards their cost of care based on financial thresholds per WAC 182-513-1315(1)-(3) or individuals who are not United States citizens.

A tier term is the corresponding amount of time a client will receive benefits based on the designated tier approved.

Who are GCAP Contractors

GCAP contractor eligibility criteria are outlined in [WAC 388-106-2110](#).

What are the client eligibility criteria for GCAP

GCAP eligibility criteria are outlined in chapter 388-106-2110 WAC. To be initially determined eligible for GCAP services, an individual must:

1. Meet LTC services Medicaid functional eligibility requirements in chapter 388-106 WAC and financial eligibility requirements in WAC 182-513-1315(1)-(3) or be determined provisionally approved;
2. Not have financial resources to pay for guardianship services, fees, or costs from their estate;
3. Have a qualifying neuro-cognitive diagnosis as defined in WAC 388-106-2105;
4. At the time of referral and acceptance into the program, be occupying an acute care hospital bed, and not be in a restricted sub-group, including but not limited to:
 - a. Occupancy in a bed readiness program bed
 - b. Occupancy in a skilled nursing facility bed
 - c. Occupancy in inpatient rehabilitation bed
 - d. Occupancy in an inpatient mental health bed
 - e. Occupancy in an emergency department bed
 - f. Occupancy in a long-term acute care hospital (LTACH) bed
 - g. Occupancy in an acute care hospital bed under observation status
 - h. Occupancy in an acute care hospital bed under a single bed certification pursuant to chapter 71.05 RCW
5. At the time of referral and acceptance into the program, no longer require an inpatient level of care at an acute care hospital;
6. Likely require the appointment of a guardian and/or conservator to be able to access and maintain long-term services and supports; and
7. Not have a professional or lay guardian or conservator willing to accept nomination.

To remain eligible for GCAP services for the duration of the designated term, an individual must:

1. Remain functionally and financially eligible for DSHS LTC benefits; and
2. Receive a DSHS LTC service.

How to make a GCAP referral

When it is determined that a client no longer has the ability to consent to LTC services and did not consent to authorizing a representative, a guardianship and/or conservatorship may be needed to support the client's transition and ongoing care. A hospital, directly or through assistance of an assigned case manager or public benefits specialist, may refer such a client for consideration for GCAP services by following the practice outlined in WAC 388-106-2115 and 388-106-2120.

1. If the hospital is unable to identify a proposed guardian or conservator for court nomination, the hospital may submit a referral for GCAP services to the Guardianship Program Manager (GPFM) for eligibility determination. The hospital must:



- a. Submit and complete the ListServ process to meet their due diligence in attempts to identify a less restrictive guardian or conservator willing to serve the client.
 - b. Submit the GCAP Referral Form which may be found on the Inpatient Hospital Assessments and Transitions Stakeholder website: [GCAP Information and Resources](#).
 - c. Submit all supplemental documentation and/or clinical packet as requested
 - d. Submit LTC application on behalf of client if one has not previously been submitted
 - i. The Guardianship Program Manager will provide eligibility determination within 3 business days from the date referral form and complete packet are received or completion date of statewide ListServ process, whichever occurs later.
 - ii. The Guardianship Program Manager will send a Notice of Department Decision (NDD) regarding program eligibility determination to the client and hospital referent.
 - o NDD 27-254: Notice of Department Decision- Approved
 - o NDD 27-255: Notice of Department Decision- Denied
2. If a client is determined to be eligible for GCAP services, the case will be:
- a. Assigned to the Case Manager per regional process and
 - b. The Guardianship Program Manager and/or GCAP SHPC will be listed on the overview screen in CARE to provide oversight of legal case progression and ongoing liaison services to contracted guardians and conservators for the duration of a client's GCAP tier term.:
 - i. Confirm hospital petitioner status.
 - a. When hospitals serve as petitioning party to the UGA motion, the hospital discharge planner collaborates with their legal counsel to execute petition, declaration statements, and legal pleading for filing with the court. Hospital discharge planner must supply contact information of hospital legal counsel to the Guardianship Program Manager for ongoing GCAP coordination.
 - b. When hospitals are unable to serve as petitioning party to the UGA motion, the hospital discharge planner must request for Petition Exemption ETR from the Guardianship Program Manager.
 - Petitioner Exemption ETRs will be processed within seventy-two hours (72) of receipt by the Guardianship Program Manager.
 - If approved for Petitioner Exemption ETR, HCS will serve as petitioning party through the Office of the Attorney General (OAG) and the acute care hospital discharge planner will be required to submit a supplemental declaration of support for HCS petition.
 - ii. Schedule client visits with identified proposed contractor(s).
 - a. Visits may occur in person, telephonically, or electronically based on client needs and contractor preference.
 - iii. Assist court visitor with obtaining required clinical documentation, including a Medical Report from a hospital provider.

3. If a client is appointed a guardian and/or conservator through GCAP services, the hospital acknowledges:
 - a. That transition may not occur until such time that DSHS receives copies of both orders appointing guardian and/or conservator and letters of office.

When is a GCAP record created

Effective September 1, 2024, all GCAP referrals will generate a GCAP record in CARE Web.

1. GCAP records can only be created by a member of Guardianship Management security group.
2. GCAP records are view only for HCS staff with CARE Web access.

When and how are GCAP records finalized

A GCAP record is finalized when either of the following occur:

1. A GCAP referral is received and eligibility determination results in denial; or
2. GCAP services are terminated.
 - a. The most common reasons for GCAP service termination include but are not limited to a client leaving hospital against medical advice prior to appointment of a GCAP Contractor, identification of a less restrictive guardian/conservator, no identified GCAP Contractor, client death, completion of GCAP service term, client no longer eligible for LTC services, alternative funding identified, etc.
 - b. When GCAP services are terminated:
 - i. the GCAP record is finalized in the CARE Web screen after noting the termination reason in the GCAP notes section;
 - ii. the case may be inactivated in CARE using the “No Current Discharge Plan” code or be reassigned as applicable;
 - iii. A Notice of Department Decision (NDD) regarding program termination is sent to the client, hospital referent, and GCAP contractor for all termination reasons other than termination for client death or completion of original GCAP tier term.
 - o NDD 27-256: Notice of Department Decision- Regarding Termination of Services

❖ A GCAP record remains “active” or “open” for the duration of the client’s designated GCAP service term, regardless of the client’s residence.

How are Medicaid LTC applications processed for GCAP clients

Financial eligibility determination for GCAP approved cases are processed by the same procedures outlined in [Chapter 7a](#) with the following exceptions:

1. If an individual is pending appointment of a contracted guardian or conservator through GCAP services, the referral is not to be withdrawn due to pending guardianship.
2. GCAP cases are eligible to remain open or in pending status under ‘good cause justification’ for up to 120 calendar days from the date of court appointment to ensure guardian/conservator receives necessary court documents sufficient to marshal pre-existing



client accounts and access financial documentation required for financial eligibility determination.

What are the responsibilities of the Guardianship Program Manager and GCAP SHPC

For GCAP Cases:

- Processes referrals, petitioner exemption requests, and issues corresponding Notice of Department Decisions (NDDs).
- Creates and manages the Guardianship/Conservatorship Screen in CARE Web to reflect legal case status updates pertaining to a petition filed under RCW 11.130
- Manages GCAP RAC and Authorizations

RAC	SERVICE CODE	MODIFIERS
3315- GCAP	SA111	• UA: Months 1-3 at monthly rate of \$710 • UB: Months 4-12 at monthly rate of \$440 • UC: Months 13+ (Tier 2 clients only) at monthly rate of \$235 or allowable Medicaid rate. • U1: Operational Expense Stipend \$4,000 • U2: King County Filing Stipend \$2,500 • U3: Case Establishment Fee \$1,500 • U4: Case Closure Fee \$300

- Coordinates with Public Benefits Specialist
- Communicate with legal teams and the Administrative Offices of the Courts (AOC)
- Monitors cases for the duration of specified GCAP term
- Serves as liaison for GCAP contractors
- Manage and monitor GCAP Contracts

Additional Decision Maker Resource Tools

<u>HCLA How to Identify a Guardian</u>	This is a resource tool designed to outline the process of identifying a person to serve as guardian and/or conservator for individuals who no longer have capacity to consent to services and have no legal decision-maker identified. A person must be identified for nomination as proposed guardian and/or conservator in order to file a legal motion with the court. This resource tool also serves to explain the process of identifying a proposed nominee utilizing alternative programs such as GCAP and Office of Public Guardians (OPG) as both are distinct and separate programs with their own eligibility criteria and governing laws.
<u>Power of Attorney vs Uniform Guardianship Act</u>	This is a resource tool designed to overview available court processes to explore identification of an alternative decision maker for individuals who no longer have capacity to consent to services themselves. This resource tool explains the differences between the Power of Attorney Act and the Uniform Guardianship, Conservatorship, and Other Protective Arrangements acts and the legal remedies that can be provided under each motion type.
<u>Document Review Checklist for Alternative Decision Maker Authority</u>	This is a resource tool designed to provide HCS staff with a checklist to evaluate a potentially identified alternative decision maker's legal authority to consent to LTSS on behalf of a client.
<u>HCLA Training Page</u>	This is a resource training designed to provide HCLA staff with instructions on how to use the <i>Document Review Checklist for Alternative Decision Maker Authority</i> form.



Appendix I: [HCS Hospital and Nursing Facility Escalation Contacts](#)

Appendix II: [DSHS Intake and Referral Form 10-570](#)

Available on the Acute Care Hospitals webpage

Appendix III: [Expedited Acute Hospital Application Coversheet](#)

Available on the Acute Care Hospitals webpage

Appendix IV: HCS Screening Tool: A Guide for Escalation

All cases that meet criteria outlined in the HCS Screening Tool: A Guide For Escalation should be escalated for a regional case staffing. See instructions on How to make a referral to the Regional Complex Case Staffing.

Appendix V: COMPLEX Regional/HQ Case Staffing Referral Template

Unless your regional leadership recommends the case to be brought to the Headquarters Case Staffing, start with the regional complex staffing. Once all recommendations from the regional staffing have been completed and there is still no clear path to a transition, alert your regional contact to bring the case to HQ for staffing. Please update the regional staffing form with any new information and send to your regional lead requesting a staffing with HQ.

[Complex Case Staffing form](#)

Appendix VII: Complex Case Staffing Escalation Pathway

The staff resources and detailed information outlined below is intended to provide support to regional staff with relevant program resources when handling complex cases.

- [Complex Case Staffing: About](#)
- [How to make a referral to the Regional Complex case staffing](#)
- [How to make a referral to the Headquarters Complex Case Staffing?](#)
- [How do I request assistance on a capacity or consent related concerns?](#)
- [Where do I send Guardianship and Conservatorship Assistance Program \(GCAP\) case referrals or questions?](#)
- [Managed Care Organization \(MCO\) and Dual Eligible Special Needs Plan \(DSNP\) escalation support: Including BHWS and CBHS/1915\(i\)](#)
- [Resources and Trainings](#)

COMPLEX CASE STAFFING

Complex case staffing is a collaborative venue where subject matter experts come together to problem-solve and generate ideas to address challenging situations. It serves as a platform for interdisciplinary teams to discuss barriers, explore various perspectives, and develop innovative strategies to propel the case forward effectively. The process involves active engagement, shared expertise, and a focus on achieving positive outcomes for the client.

There are regional and headquarters pathways available for complex cases. These venues are open to all HCS and AAA teams and occurs virtually.

How to determine which venue to staff my case?

Staff should start at the Regional Complex Case Staffing unless your regional leadership recommends the case to be brought to the Headquarters Case Staffing.

How to make a referral to the Regional Complex Case Staffing

Each region has their own process for staffing complex cases. Please contact your region's MCSC for information on how to refer your case to be staffed and/or escalated.

Region 1	Megan McCue, Complex Case Staffing Specialist	megan.mccue@dshs.wa.gov
Region 2	Laura Botero, Managed Care Systems Consultant (MCSC)	r2ccs@dshs.wa.gov
Region 3	Social Services SHPC Helpdesk	altsar3shpchelpdesk@dshs.wa.gov

What are the next steps after I send an email to my regional MCSC?

The MCSC will respond to your inquiry within 2 business days and partner with you on the staffing date and time.

How to make a referral to the Headquarters (HQ) Complex Case Staffing

1) Staff with your supervisor	2) Fill out the <i>Complex Case Regional & HQ Case Staffing Referral*</i>	3) Email form to the Complex Case Staffing Specialist, Megan McCue Megan.McCue@dshs.wa.gov
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* You can find the referral form [Complex Case Staffing Form](#)

What to expect when referring to the Headquarters Complex Case Staffing?

Referrals will be added to the next HQ staffing date unless a different staffing date is requested. Staffing's occur weekly Fridays. The Complex Case Staffing specialist, the program manager or supervisor will send the assigned SSS3 an invite to the HQ Complex Case staffing which is held via teams. Each case



manager, supervisor, or Program Manager will have 3 to 5 minutes to present client's case and barriers. After completion of the case staffing, the Complex Case Staffing Specialist (CCSS) will email recommendations to the Program Manager and Supervisor for next steps, SER note staffing and follow up with hospital on collaboration and notification of case escalation. The CCSS will then track client's case until barriers have been resolved.

How do I request assistance on a capacity or consent related concerns?

The case manager should submit a request for escalation when any legal decision-making document(s) initially reviewed and determined to be insufficient should be staffed with supervisor **and** escalated to Headquarters for final review **prior to** communicating any decision. Headquarters staff will review, provide final determination, and assist with communication to involved parties. For escalation requests involving document reviews for alternative legal decision maker authority, the case manager should complete the [Document Review Checklist for Alternative Decision Maker Authority](#) form before submitting a request for assistance. For additional instructions on completing the form, refer to [Chapter 3](#) or the Additional Decision Maker Resource Tools and/or the [HCLA Training Page](#) at end of Chapter 9.

- 1) **For Hospital and/or GCAP cases involving document reviews**, send an email to the escalation pathway inbox at: HCSDecisionMakerEscalationPathway@dshs.wa.gov
 - a) When submitting a request, attach copies of **both** the completed *Document Review Checklist for Alternative Decision Maker Authority* form **and** the document(s) in question and provide the following information: Client first and last name
 - b) Client ACES ID
 - c) Region
 - d) Current Location of Client
 - e) Concern or Explanation of Inquiry Request
- 2) Allow up to 5 business day response time. **For All Other cases**, refer to [Chapter 3](#) **Getting Plan Approval**.

Where do I send Guardianship and Conservatorship Assistance Program (GCAP) referrals or questions?

Referral form and GCAP specific information may be found at: [GCAP Information and Resources](#). Regions may send their inquiries directly to the GCAP Team shared inbox at: GCAP@dshs.wa.gov

What are the next steps after I send an email?

For escalation pathway emails, HQ staff will respond to your inquiry within 5 business days and partner with you on recommendations, document review outcomes, and any next steps depending on the escalation request type. For GCAP case referrals or questions, the GPM will respond to your inquiry or referral within 2 business days and update referral status and eligibility determination in a SER note.



MANAGED CARE ORGANIZATION (MCO) AND DUAL ELIGIBLE SPECIAL NEEDS PLAN (DSNP) ESCALATION SUPPORT: INCLUDING BHWS, IBSS AND CBHS/1915(I)

Who are the Managed Care Systems Consultants (MCSC) and what do they do?

MCSCs are part of the HQ integration team, and each region has a MCSC assigned to assist with connecting staff to the Managed Care Organizations (MCOs) and Dual- Special Needs Plans (D-SNP). They play a key role in the coordination of Behavior Health Wraparound and Supports (BHWS), Intensive Behavioral Supportive Supervision (IBSS) and Community Behavioral Health Support (CBHS/1915i) escalation requests and assist on complex cases in the regions and with our AAA partners.

How do I request support?

- MCO and/or DSNP care coordination
- BHWS
- IBSS
- CBHS/1915i escalation or support

Send an email to your regional MCSC with your inquiry, client's name and Provider One number.

Region 1	Jennifer Torres- Salas	MCSCsupport@dshs.wa.gov
Region 2	Laura Botero	
Region 3	Genevieve Boyle	

What are the next steps after I send an email?

The MCSC will respond to your inquiry within 2 business days and partner with you on next steps depending on the escalation request.

RESOURCE AND TRAININGS

[Chapter 7f](#): Residential Support Waiver (RSW)

[Chapter 24](#): Nursing Services & Triggered Referrals

[Chapter 22a](#): Apple Health Managed Care and Apple Health Medicare Connect (D-SNP)

[Chapter 22d](#): Community Behavioral Health Supports (CBHS)

[Community Behavioral Health Support \(CBHS\) Services](#): 1915i SharePoint

[Chapter 29](#): Roads to Community Living (RCL)

[Transition Academy](#): SharePoint site for case manager transition resources

Who to reach out for additional training or questions?

The Integration Team is here to support regional staff. If you are interested in additional training reach out to the main contact person listed below.

Inpatient Hospital Assessments and Transition Policy	Jody Gasseling Erika Gustafson	Jody.Gasseling@dshs.wa.gov Erika.Gustafson@dshs.wa.gov
Community Behavioral Health Supports (CBHS)	Managed Care System Consultant (MCSC)	MCSCsupport@dshs.wa.gov
Uniform Guardianship Act DPOA, Consent, Capacity and Decision Making	Sarah Tremblay Joshua Glasgow	GCAP@dshs.wa.gov
Roads to Community Living (RCL)	Jody Gasseling	DSHSALTSARCLReferrals@dshs.wa.gov

Appendix VIII: Glossary

Word	Definition
Complex client escalation process	Established process that requires multi-systems supports in the community to establish and sustain transitions to community settings. Such cases present significant medical, psychiatric and/or criminal concerns that inhibit transitions to community settings.
Community settings	Long-term care service options where clients can reside such as the client's home, Adult Family Home, Assisted living facilities among others.
Conservator	A person appointed by the court to make decisions with respect to the property or financial affairs of an individual, adult or minor, subject to conservatorship.
Hospital assessment	A CARE assessment to determine functional eligibility for long-term care services in community-based settings.
Hospital discharge planners	Designated staff who work with the client to create and implement a discharge plan. Discharge functions are usually carried out by social workers and Registered Nurses in hospitals. Managed care organizations and other insurance carriers, including Medicare, participate in transition planning and play an important role.



Inpatient Rehabilitation (IPR)	Inpatient hospitalized for purposes of rehabilitation. When an individual transitions to IPR outside a hospital or Long-term acute care (LTAC), HCS considers that transition a hospital discharge.
Involuntary Treatment Act (ITA)	A court ordered mental health or substance use disorder treatment that is a civil legal process.
Guardian	A person appointed by the court to make decisions with respect to the personal affairs, support, care, health, and welfare of the adult subject to guardianship to the extent necessitated by the adult's limitations.
Length of Stay	For HCS, Length of stay in acute care hospitals refers to the period from the date a hospital patient is referred to access long-term care services through the duration of their hospitalization.
Medical necessity	A determination by the attending hospital physician that the patient needs to remain in the hospital to receive medical care. A client who meets this definition is admitted under private health insurance, Medicare, or Medicaid.
Medically stable or predictable	The patient at this point does not need acute medical intervention, is close to baseline functioning and their immediate needs, treatments, and therapies have been achieved. In most cases, the client can transition to a community setting.
Priority Cases	Cases that the hospital request to handle as priority upon referral and meet the priority criteria, outlined in this chapter. For such cases HCS staff are required to contact the client within 2 days and conduct an assessment within 7 days if conditions for conducting an assessment are met.
Provisional Approval	The process of allowing clients a conditional approval for accessing the State-Funded Guardianship and Conservatorship Assistance Program under Medicaid Long-Term Services and Supports (LTSS), without having to wait for the full functional and financial Medicaid eligibility determination.
Psychiatrically stable	The patient has been determined by a psychiatric provider, usually a psychiatrist or psychiatric nurse in a hospital or psychiatric inpatient facility to no longer need in-patient hospitalization. The individual at this point is close to baseline functioning and their immediate medical psychiatric needs, treatments, and therapies have been achieved, evidenced by no use of physical or chemical restraints in the past 3 days prior to discharge.
Referral	A referral is any request for service that is accompanied by a Medicaid application or for a client with current Medicaid eligibility. A referral generates an intake. HCS is expected to assist individuals who may need assistance in completing an application.



Special Agent	The person appointed by the court for temporary authority over a specific purpose or task pursuant to RCW 11.130.375 or RCW 11.130.635. The special agent differs from court visitor, who acts as the court investigator. Special Agents are granted specific authority that are time limited, typically 60 days or up to 120 days maximum.
State Hospital Discharge	An individual discharging from a state psychiatric hospital onto HCS LTC services.
Swing Bed	A hospital bed that can be utilized as a skilled nurse facility bed. This is considered a discharge from an acute hospital and is transferred to an NFCM worker.
Transition plan	A care plan developed for a client indicating where the client will transition to include the type of support/ services the client will need. This plan is created by the client, family, hospital discharge planner, and HCS or AAA staff. The client may seek to transition in different Long-term care service options including nursing homes.

REFERENCES & PROGRAM RESOURCES

Related WACs, RCWs & Federal Regulations

WAC 388-106-0015	What long-term care services does the department provide?
RCW 70.41.310	Long-term care—Program information to be provided to hospitals—Information on options to be provided to patients.
RCW.74.39A.040	Department assessment of and assistance to hospital patients in need of long-term care.
RCW 74.34.020	Definitions
Code of Federal Regulations 482.13 (e): Condition of participation: Patient’s rights—Restraint or seclusion Code of Federal Regulations .	
Centers for Medicare and Medicaid (CMS) State Operations Manual SOM Appendix A .	

Transition Resources

Adult Medicaid Behavioral Health Treatment Services	This document is intended to be used to help identify the services available for someone with behavioral health challenges. The term “behavioral health” refers to mental health, substance use, or co-occurring mental health and substance use disorders. Adult Medicaid Behavioral Health Treatment Services
Behavioral Health Wrap Around Support, previously Behavioral Health Personal Care	Beginning July 1st, 2024, a Managed Care Organization (MCO) will only fund the following Behavioral Health Wraparound Support (BHWS) formerly, Behavioral Health Personal Care (BHPC) for additional personal care hours reflected in an increase beyond the CARE generated hours. To review eligibility, see LTC Chapter 22a .
Community Behavioral Health Support (CBHS) Services/1951i	Supportive Supervision and Oversight (WAC 182-561-0400). <u>Supportive Supervision and Oversight</u> is direct monitoring, redirection, and cueing of the client to prevent at risk behavior that may result in harm to the client or to others. These interventions are not related to the provision of personal care.
Behavioral Support Services	Services are available to inpatient clients under WA Roads. Client training is available through COPEs and should be accessed through that program for all COPEs eligible individuals. Individuals who are not eligible for COPEs should receive this service through WA Roads. S
State Funded Guardianship and Conservatorship Assistance Program (GCAP)	For hospitalized individuals determined to not have decisional capacity and who lack a legal decision maker necessary to access LTSS. The program contracts with certified professional guardians and conservators statewide to accept court appointment for these challenging cases in order to facilitate transitions of these individuals out of acute care hospitals. WAC 388-106-2100. Refer to Appendix VIII of this chapter.
HCS Complex Cases & MCO Coordination contacts list	HCS HQ contacts list for assistance on Complex Case Staffing provided by the SHDD team and MCSCs. Refer to Appendix VII of this chapter.
Housing Maintenance Allowance (HMA)	The HMA is income, up to 100% of the Federal Poverty Level, that the client can keep maintaining his/her residence during a NF or institutional stay. WAC 182-513-1380 . For program detail see Chapter 10 of the Long-term care Manual
Individuals with Complex Behaviors	Individuals with challenging behaviors (i.e., assaultive, property destruction, self-injurious, challenging sexualized behaviors, history of arson, and/or history or criminal activity), the assigned case manager or assessor may complete DSHS 10-234a to include in the residential provider referral packet.

CHAPTER 9: Inpatient Hospital Assessments and Transitions

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State Funded Community Transition or Sustainability Services (CTSS or WA Roads)	CTSS are non-recurring setup items or services necessary to assist individuals establish, resume, or stabilize a home or community-based setting. WAC 388-106-0950 , WAC 388-106-0955 , WAC 388-106-0960 . Refer to Chapter 5a of the Long-term Care Manual for details.
Discharge Options-Desk Aid for Citizens vs. Non-citizens	This is a desk tool used by Home and Community Living Administration (HCLA) field staff that has all the medical coverage groups/programs in Washington and what Home and Community Service can be authorized under that medical program if functionally eligible. Discharge Options Desk Aid Citizens vs. Non Citizens
Specialized Behavior Support Services in Residential Settings	This is a compiled list of specialized behavior support services available in residential settings. These services are available to eligible LTC individuals with personal care and complex behavioral needs related to a mental health, neurocognitive or dementia diagnosis. The settings are not intended to replace the need for behavioral health treatment or supports accessed through the behavioral health care system. HCS Specialized Behavioral Support Services
Supportive Housing	Service that supports individuals with complex needs secure community-based, affordable housing of their choice along with individualized support to assist the person with stabilization and self-identified goals. For -HCLA recipients, this service is available in two ways: Foundational Community Supports (FCS), or the Governor's Opportunity for Supportive Housing (GOSH). Refer to Chapter 6a of the Long-term Care Manual for details.
The Medicaid & Long-term care services for Adults Brochure	22-619 Medicaid and LTSS for Adults : This brochure is distributed to individuals interested in services. In addition, HCS hospital Supervisors and Case Managers coordinate with their local Area Agency on Aging who maintain a list of contracted service providers.
Transition Care Center of Seattle (TCCS)	A specialized Nursing Facility serving complex populations of dually eligible (Medicaid-Medicare) beneficiaries transitioning out of acute care hospitals. Refer to Admission Process Flow and the Specialized Referral Form attached below for details. Transitional Care Center of Seattle
Workflow	Workflow was created to assist case managers with understanding workflow processes from referral to transition. Acute Hospital and Local Psych Workflow State Hospital Referral Workflow

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/12/2020	Grace Kiboneka	Version incorporates draft MB review comments from the field and subsequent responses for policy	
April, 2021	Grace Kiboneka	Version: - Incorporates clarifying language and technical corrections to several sections in the chapter and adds a new section concerning the role of HCS hospital case manager in confirming decision making capacity. Added a link where hospital staff can be referred to access a brief training on HCS process for transitioning clients out of hospitals.	
Dec, 2021 & Jan, 2022	Grace Kiboneka	Added new language under role of CM in determining capacity. Removed requirement for updating notes weekly in acute care screen. Reduced waiting period from 6 to 4 month for a case to be inactivated. Added new language for Hospital withdrawal of a referral, updated section about escalation of complex cases, Appendix IV, V , escalation of complex cases	
May 2022	Grace Kiboneka	Updated HCS Regional escalation contact chat. Appendix I	
October 2022	Grace Kiboneka	This version includes the following major modifications to: - the role of Case managers in determining decision making capacity - Coordination with hospital discharge planners - Hospital withdrawals of client referred to HCS - Escalation of a complex client case - Escalation to the HCS Region Escalation Contact Chart	
August 2023	Grace Kiboneka	This version has no new policy. It clarifies policy for: - Individuals in isolation rooms, and one on precaution - Updates table for cross systems complex case contacts, managed care coordination and adds SHDD a new resource—Transition Specialists - Added SHDD and CBHC contact list as an attachment in the Resource table. - Provides a compiled list of Specialized Behavior Support Services for Residential settings. - Updated referral form for SDCCP and TCCS services.	
March 2024	Grace Kiboneka	- Added detailed policy guidance on Restraint. - Clarified language for clients using IM frequently. - Updated Complex Staff resources. - Updated HCS escalation contact list.	

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		Created appendix VII for escalation pathway resources and removed previous escalation contact matrix from the main body of the chapter and corresponding program information.	
October 2024	Jody Gasseling and Erika Gustafson	- Updated chapter title to reflect transition work - Updated contact information for chapter owners - Removed BHPC language and added CHBS, BHWS, IBSS (1915i) - Fixed grammatical errors - Updated Referral and Admission Process form for TCCS. - Updated Specialized Setting Referral Template - Updated Appendix I HCS Escalation Regional Contact Chart - Added section on Electronic Health Records - Created appendix VIII for Guardianship and Conservatorship Assistance Program (GCAP) policy	
March 2025	Jody Gasseling and Erika Gustafson	- Move and create new section for RCCM to Hospital Transfers - Updated Appendix I HCS Region Escalation Contact Chart - Additional Decision Maker Resource Tools - Edited, When Would A Hospital Referral for Transition be Inactivated? - Added: legal issues, to What Info Is Needed by HCS Hospital Case Managers to Conduct an Assessment - Edited: What Conditions Must Be Met for HCS to Conduct a Hospital Assessment - Updated escalation pathway contacts and emails - Added additional SER documentation when transferring Residential, NFCM, and In Home cases - Linked Transition Academy under “What are some examples of frequent barriers to acute care hospital clients assessments or transition planning” as well as “what additional transition strategies should be applied to complex client referrals”.	
July 2025	Erika Gustafson and Jody Gasseling	- Change ALTSA to HCLA - Change DDA to DDCS - Removal of regional guardianship case manager duties - Moved Consent, Decision making and Capacity to Chapter 3 - Removal of Complex Transition Pilot - Updated escalation pathway - Revised: What Are the Responsibilities of the Guardianship Program Manager - Added “Document Review Check List for Alternative Decision-Making Authority” under Additional Decision Maker Resource Tools	

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October 2025	Jody Gasseling, Erika Gustafson, Latia Townsend	• Alignment of acute hospital and state hospital policy • Added LaTia Townsend as SHDD Point of Contact • Clarified when a client is not ready for a hospital assessment. • Added Special Considerations for State Hospital Transitions • Added ITA definition and case manager responsibilities • Added IRT referral process • Added Pre-Discharge Checklist • Added case manager responsibilities for RSO clients • 6358 State Hospital Discharge Review for SHDD clients	
April 2026	Jody Gasseling, Erika Gustafson, Sarah Tremblay	• Added: What is the Role of Case Managers When Assessing a Client with a Known Legal History? • Simplified language in section “When is an individual not ready for an Inpatient Assessment?” • Alignment clarified language in EHR policy • Updated GCAP Escalation path • Updated new links to forms, added form 20-340 with CM instructions • Added definition of inpatient hospital • Added NGMA process for SH and AH • Removed RSO guidance and sent to Chapter 3 • Added definition to “HCS Guidance about use of restraints” • Added TDPS, Early Engagement, OPD, Forensic patients, Early engagement and NGRI • Linked to Chapter 3 on “What is the Role of HCS When Receiving an Inpatient Hospital Referral”	
July 2026	Jody Gasseling, Erika Gustafson, Sarah Tremblay	• Updated Titles to Inpatient Policy Systems Change Manager • Added Joshua Glasgow as a Chapter owner • ALTSAAcuteHospitalGuardianshipCaseStaffing@dshs.wa.gov inbox to HCSDecisionMakerEscalationPathway@dshs.wa.gov • Added GCAP@dshs.wa.gov inbox for all GCAP referrals • Moved TDPS under EHR section • Added Chapter 24 under Resources and Trainings • Updated existing links • Removed appendix VI: specialized setting referral template	

Nursing Facility Case Management and Relocation

The purpose of this chapter is to ensure that:

- Nursing facility residents who have the desire to move to another setting are assisted by the Nursing Facility Case Manager (NFCM) in assessing barriers to relocation. This may include:
 - Ensuring residents and their informal supports have information about community long-term care options.
 - Ensuring the desire for community transition and any barriers to relocation are identified early.
 - Working with the client, their formal decision maker, their family, NF staff, and others to remove or address any barriers to discharge (transition planning).
 - Assessing, care planning, authorizing services, and making referrals and coordinating care with other community and informal resources.
 - In coordination with the nursing facility, authorizing and arranging transition resources.
- Individuals (Medicaid and Non-Medicaid), who have an intellectual disability or related condition and/or serious mental illness, are assessed for their need for specialized services per the Pre-Admission Screening and Resident Review (PASRR) process (see [PASRR section](#) for more information).
- Medicaid clients are determined/ confirmed to meet nursing facility eligibility.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Julie Cope RCL/NFCM Policy Unit Manager
360.725.2529 julie.cope@dshs.wa.gov

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NURSING FACILITY CASE MANAGEMENT AND RELOCATION PURPOSE, HISTORY AND PHILOSOPHY

Philosophy of Nursing Facility Case Management

The State of Washington is among the nation's leaders in rebalancing institutional and community-based long-term care services. The Washington State legislature recognized the desire of most people to maintain as much independence as possible in lesser cost settings and as a result passed legislation directing the department to expand the options available to long-term care clients beyond nursing facility care ([Chapter 74.39 RCW](#), [Chapter 74.39A RCW](#), and [Chapter 70.41 RCW](#)). This legislation also directed that the department provide transition planning for individuals to assist them in moving to the least restrictive setting of their choice.

The Home and Community Living Administration (HCLA) continues to work actively with individuals from the point of admission to a nursing facility to achieve the client's community transition goals and potential. This includes meeting face-to-face with clients early in their admission and working with families and staff at the facility to advocate that therapies, treatments and training is provided in a timely fashion. The goal is for clients to receive services in the least restrictive, most appropriate setting that meets the client's care needs while honoring client choice and preference.

HCLA embraces the belief that individuals with very high care needs can be cared for and supported in a variety of settings through the implementation of waivers and state plan services which provide alternatives to nursing facility long term care. HCLA's mission has been, and continues to be, to provide an array of long-term services and supports options from which clients and their families can choose.

The Role of the Nursing Facility Social Worker

The discharge planning responsibilities of nursing facility staff are governed by WAC [388-97-0080](#), [WAC 388-97-0120](#), [42 Code of Federal Regulations \(CFR\) 483.15](#), and [42 CFR 483.20](#), and [42 CFR 483.25](#):

- [42 CFR 483.15](#) requires that when a resident's health improves sufficiently, the resident can be discharged with appropriate notice. Facilities are required to provide sufficient preparation to the resident to ensure safe and orderly transfer.
- [42 CFR 483.20](#) requires that the facility conduct initial and periodic comprehensive assessments (there are timeframes established in federal rule).
- [42 CFR 483.25](#) requires the assessment include the services needed to attain the resident's highest physical, mental and psychosocial well-being possible.

The care plan must include a summary of the resident's stay and final status, and a post discharge plan of care. The nursing facility staff should work collaboratively with the Nursing Facility Case Manager (NFCM) to provide and ensure a smooth transition from institutional long-term services and supports to community long term services and supports.



Providing Nursing Facility Case Management and Relocation Activities

Home and Community Services (HCS) provides nursing facility case management by working with HCS/Area Agency on Aging (AAA)/Developmental Disability Administration (DDA) staff, the client, family members/informal supports, formal decision makers, nursing facility staff, the client's physician, and community providers to assist clients in accessing services in the community.

NFCMs are responsible for transition planning and case management for:

1. Dual eligible clients (Medicare clients who also have Medicaid as a secondary payment source).
2. Medicaid applicants/recipients who need nursing facility payment to cover the cost of their care.
3. Private pay clients, when requested and as time allows.

NFCMs are **not** responsible for transition planning and case management for:

1. Program of All-Inclusive Care for the Elderly (PACE) enrolled clients. These cases should not be transferred/worked by NFCMs because the PACE organization is responsible for the transition planning and case management responsibility for these clients. HCS does not need to determine NFLOC for PACE enrolled clients as they already meet LOC, inherent to PACE enrollment and PACE organizations authorize NF admits prior to admit. These cases should remain assigned to their current HCS/AAA worker who coordinates with the PACE organization as needed. Please refer to Chapter 22c Program of All-Inclusive Care for the Elderly (PACE) for additional information.

A NFCM should not wait for communication from the nursing facility informing them that a client is ready for discharge. Instead, the NFCM should be actively involved with the resident at the earliest possible time to work with them, their formal decision maker, their family, the SNF, and community providers to remove/address barriers to a transition to a community setting.

Note: For more information on case transfer timeframes for when an in-home client enters an institutional setting, see the [Case Transfer section of LTC Manual Chapter 5: Case Management](#).

NFCMs:

1. Are familiar with the nursing facility administrator, the Director of Nursing, the social services worker(s), and the discharge planner(s) in their assigned facilities.
2. Conduct a face-to-face visit for each newly admitted **Medicaid and dual eligible** client within 30 calendar days to begin to dialog about community options and their steps/desire for community transition. This action may be combined with the Nursing Facility Level of Care determination for the Medicaid resident.
3. Meet with the client, monitor health conditions and physical status for stability and predictability and document all work and progress towards the client's transition goals in CARE. Document your person-centered planning discussions with the client in a SER at a minimum of every 60 days.



4. Give information to nursing facility staff and residents on the services and supports provided by HCLA. This includes meeting with residents, their formal decision maker, and families to revisit LTSS options and reconsider community transition on a regular basis.

What is the NFCM's Role with Hospital Swing Beds?

The Social Security Act allows certain small, rural hospitals and critical access hospitals to use their beds for both acute care and post-acute skilled nursing facility care with Department of Health approval. These swing bed residents' conversions require physician orders from acute care to swing bed status and ongoing progress notes in the hospital's medical record system.

Rural Hospitals with approved swing beds must comply with SNF participation requirements under [42 CFR 482.58\(b\)\(1-7\)](#):

1. Resident rights
2. Admission, transfer, and discharge rights
3. Freedom of abuse, neglect, and exploitation
4. Social Services
5. Discharge Summary
6. Specialized rehabilitation services
7. Dental Services.

Critical Access Hospitals must comply with SNF participation requirements under [42 CFR 485.645\(d\)\(1-8\)](#):

1. Residents' rights
2. Admission, transfer, and discharge rights
3. Freedom from abuse, neglect, and exploitation
4. Social Services
5. Comprehensive care plan and discharge planning requirements
6. Specialized rehabilitative services
7. Dental Services
8. Nutrition Services

NFCMs are assigned to swing bed residents after admission for [nursing facility case management activities](#) and to support relocation activities to community settings. Any NFCM tasks performed on behalf of a Hospital Swing Bed resident should be captured in the NFCM's performance standards.

As Hospital Swing Beds are licensed and approved by the Department of Health, mandatory reporting requirements related to quality of care or transition planning practices will be filed with the [Department of Health as a complaint by email or online](#).



For more detailed Swing Bed information, review the [CMS Fact Sheet on Swing Bed Services](#).

Note about the use of Restraints in the Hospital: The use of restraints for the prevention of falls should not be considered a routine part of falls prevention. The use of restraints for staff convenience is prohibited and should be reported to the Department of Health. For additional information on restraint use in Hospitals, see the Resource section in [Chapter 9: Inpatient Hospital Assessments and Transitions](#)

What is the NFCM's role with a Hospital's Bed Readiness arrangement with their assigned Nursing Facility?

Many Hospitals have strong relationships with local nursing facilities in their communities and will invest in efficiencies with transferring patients from their acute care hospitals to these nursing facilities. The NFCM's role in these nursing facilities remains consistent with what is outlined in the [Nursing Facility Case Management and Relocation activities](#) section. The assigned NFCM to these facilities will likely see a larger volume of interdisciplinary meetings and resident care conferences to discuss transition barriers and planning progress. NFCMs should review the tips box above to maximize efficiency and meet with their supervisors to discuss workload volume when the number of care assessments required for these facilities exceeds 12 per month.

NFCM Tips:

- Obtain a copy of the nursing facility census on a weekly basis to confirm the number of newly admitted/discharged Medicaid only and dual eligible (Medicaid/Medicare) clients.
- Ask the Facility Administrator for read only permissions/access to their electronic medical record.
- Bring HCLA informational pamphlets to nursing facilities as resource materials for residents and families.
- Attend client care conferences with nursing facility staff to keep apprised of progress towards transition goals.
- Organize your schedule to ensure completion of 2-3 full CARE assessments a week.

NFCM WORK PERFORMANCE & RELOCATION STANDARDS

HCS Nursing Facility Case Managers perform a wide variety of activities relating to NF admission, Medicaid resident case management and NF transitions. One measurement of work performance standards relates specifically to actively assisting a client to relocate to a community setting. "Relocation" for this purpose is defined as a transition to a community setting in which all the following is true:

1. The individual is an active HCS client and is assigned to an HCS RU in CARE
2. There is a discharge date on the NFCM screen in CARE (and the RCL screen if utilizing RCL)

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3. The case manager has completed a full face to face CARE assessment with the client, that was created after the date of admission (during the nursing facility stay) and was:
 - a. Moved to Current (either before or after transition); OR
 - b. Completed and moved to History (indicated by all green progress bars in CARE Web)
4. Has a program chosen in the Care Plan screen that is not Nursing Home Services ([for clients that do not meet NFLOC this field may be blank](#)).
5. Has a planned setting chosen in the Care Plan screen that is not Nursing Facility, including when the client is not functionally eligible
6. Has an address in the Contact Details Screen that is not designated as a Nursing Facility, but instead is an HCBS Setting with a start date to correlate with the discharge date on the NFCM screen.
7. Is not discharging to jail, hospital, or another institution. (see [Case Transfer Protocol for Institutional \(Hospital, Nursing Facility, or ICF-MR\) Settings](#))
8. Has not died while in the nursing facility.

The expectation is that NFCMs will complete an average of five relocations per month which meet these criteria. The Regional Administrator or designee may identify circumstances beyond the control of an employee that could affect his or her ability to meet this minimum standard. As it is understood that not all full CARE assessments result with a community transition, NFCMs are expected to create a minimum of eight face to face full CARE assessments each month. This may be accomplished by setting up your weekly calendar as described in the [appendix section](#) of this chapter.

NFCM Tips:

- Meet with nursing facility staff and residents on a regular basis to assist with prioritizing and reprioritizing weekly scheduled CARE assessments. Weekly in person visits at the Nursing Facility is an efficient practice which ensures all NFLOC determinations are met timely and supports person-centered transition goal monitoring.
- Use the MDS Acuity Report to identify Medicaid residents with low acuity who should be approached/reapproached with community LTSS options.
- Consider using RCL or WA Roads services to authorize a Community Choice Guide &/or Client Training Services to support a resident's transition planning.
- Request a resident care conference with the nursing facility staff, the resident, formal decision makers, and family members to keep apprised of progress towards transition goals, and to discuss barriers to transition planning.
- Discuss all services or supports available to a resident which may be helpful for community living, such as affordable housing, PERS, Assistive Technology, Durable Medical Equipment, and Community Transition Goods and Services. Not all clients want personal care.

NFCMs are **not** responsible for transition planning and case management for:

- Program of All-Inclusive Care for the Elderly (PACE) enrolled clients. These cases should not be transferred/worked by NFCMs because the PACE organization is responsible for the transition planning and case management responsibility for these clients. The NFLOC determination will be completed by the PACE Case Manager. These cases should remain assigned to their current HCS/AAA worker who coordinates with the PACE organization as needed. Please refer to Chapter 22c Program of All-Inclusive Care for the Elderly (PACE) for additional information.

NURSING FACILITY ADMISSION: FROM THE COMMUNITY SETTING (HCS/AAA/DDA RESPONSIBILITIES)

***Note:** for individuals admitting from the community and whose PASRR Level I screening indicates that a Level 2 assessment is required, DDA PASRR Assessors will determine the client is appropriate for nursing facility care as defined in PASRR prior to admission to the nursing facility (see *PASRR Section* for more information.) DDA PASRR Assessors who identify that there is no HCS Case Manager assigned to a Medicaid Nursing Facility resident will escalate this to their DDA PASRR Program Manager for resolution.

Before a client admits to a nursing facility from a community setting the AAA/HCS/DDA case worker must:



1. Make sure the client meets nursing facility level of care (NFLOC) per the NFLOC assessment in CARE:
 - a. NFLOC eligibility questions are located in the Pre-Transition & Sustainability folder on the NF Case Management screen. The questions are accessed by clicking on the “+” button when a record doesn’t exist for the Nursing Facility stay or the “Edit/View” button if a record does exist for the NF stay on the Nursing Facility Case Management History table. A new window will be displayed which will enable access to the NFLOC questions. Click on the NFLOC tab at the top of the screen. For each new NFLOC generated, six (6) EBS questions will be displayed in the lower half of the screen. CMs cannot exit the Nursing Facility (NF) Case Management screen unless all questions are answered. Click on the save icon at the top left of the screen once the questions are complete before exiting.
 - i. All clients who are eligible for a LTC waiver or state plan, such as CFC or CFC+ COPES, are eligible for admission to a nursing facility and do not need to be re-assessed prior to completing the NFLOC questions on the NFLOC tab (a NFCM can use a DDA assessment to complete the NFLOC assessment in CARE, when needed).
 - ii. Client’s medical chart, nursing assistant notes, and staff interviews and other records can be used to supplement interviews with the client to assess activities of daily living, cognition, etc. to perform the NFLOC assessment for clients on state plan services such as Medicaid Personal Care (MPC), as well as for Medicaid recipients/applicants (clients who are receiving Medicaid, but not home and community program services and supports).
 - iii. For clients who are case managed by DDA, the DDA Case Resource Manager (CRM) completes this NFLOC determination process based on the current DDA assessment. For cases that are co-assigned to a HCS NFCM, the DDA CRM or co-assigned NFCM completes this NFLOC determination process, in consultation with the DDA CRM.

See the recorded training [Documenting NFLOC in CARE](#) for instructions on updating the NFCM screen.

2. Notify HCS management of admission, per local policy, and assist the client with the admission process as needed.
3. Document in the SER note:
 - a. The reason for admission to the nursing facility.
 - b. A discussion with the client/representative of attempts to explore other setting and support service options.
 - c. Notification of admission to regional HCS management, following local policy.

***Note:** If eligible, clients may choose nursing facility care regardless of the alternatives available, but the case manager must explain and offer all options and document the discussion in the SER note. Because the Nursing Facility is a medical setting, the facility will likely request support with obtaining a History & Physical, Physician Orders with Medication List and the PASRR as part of their admission consideration.

4. Assist the client in finding a Medicaid-certified nursing facility by using [NF Compare or Nursing Home Locator](#), if necessary.



- a. Medicaid-certified nursing facilities may not discriminate against Medicaid clients per [WAC 388-97-0040](#).
 - b. A nursing facility may request a full CARE assessment and CARE Assessment Details for Admission consideration.
 - c. Do not facilitate client admission to a facility that has a "Stop Placement". Residential Care Services (RCS) Division may issue a "Stop Placement" when a nursing facility is in violation of its contract. Do not admit new clients until the "Stop Placement" has been rescinded by RCS. The RCS district manager may approve readmission for clients on a case-by-case basis while a stop placement is in effect.
5. Verify that a [PASRR Level I Screening Form](#) was completed prior to admit. For more information, read the [PASRR section or visit the PASRR Program Website](#).
 - a. If the PASRR Level I was not performed prior to admission, the case manager should complete the form, including making referrals for a Level 2 if indicated.
 - i. Inform the nursing facility Admission Coordinator that the admission should not have occurred without the PASRR process being followed.
 - ii. Make a report to the Complaint Resolution Unit (CRU) regarding the admission without the PASRR being completed.
 - b. If a Level 2 PASRR evaluation was indicated on the Level 1 PASRR form, verify the PASRR Level 2 was completed, and the NF has a copy of the results. Make a note in the SER note to indicate the evaluation was performed.
6. For clients with Classic Medicaid: To begin payment and document nursing facility eligibility, submit the electronic [DSHS 14-443 form](#) to the Public Benefits Specialist (PBS) in Barcode, and include the following:
 - a. The date of the request for NFLOC determination or CARE assessment.
 - b. If the client is functionally eligible or if the level of impairment does not meet nursing facility eligibility.
 - c. Date of admission.
 - d. Name of the facility.
 - e. If the client is likely to meet/exceed 30 days. *(This indicates the NFCM's good faith belief that the client will be residing in the facility for less or more than 30 days based on the information they have available. The PBS uses this information to determine which program rules to apply for the facility stay and to create an award letter which allows the facility to claim and be paid.)*
 - f. Date of discharge, if applicable. Complete this box if the client has already been discharged from the facility at the time that you determine NFLOC. Also include the setting to which the client discharged, and which program was used, if services were authorized. The nursing facility also has a responsibility to submit a Notice of Action with this information, which the NFCM may retrieve or corroborate.
 - g. [Click here](#) for more information on how the "payment begin date" is determined.
7. For MAGI or State Funded Medical Care Services (MCS) clients: Communicate the NFLOC determination directly in ProviderOne under the NFLOC Screen to include the following:
 - a. The date of the request for assessment (this is the date the SNF submitted the Intake and Referral form to determine NFLOC).
 - b. The date of admission.



- c. The date NFLOC was determined (this is the date of the NFLOC assessment; it should match the date on the NFLOC tab in CARE).
- d. [See the section on Clients with Managed Medicaid for payment information regarding clients on an Apple Health managed care plan.](#)

Note: Did you know there is an NFCM automated tickler in CARE that will generate 30 days after a client is determined “Yes” for NFLOC and “Yes” for Expected Discharge within 30 days?

8. Send a copy of the CARE Assessment Details to the nursing facility upon request. The service summary does not need to be signed for admission purposes.
9. End date all open authorizations effective the day prior to the admission. **Do not send a termination Planned Action Notice (PAN).** The client continues to be eligible for LTSS, they will be receiving services in another setting. Functional and Financial eligible for services remains in effect.
10. Transfer/assign the case to the NFCM per local transfer policy, when applicable (see [Case Transfer Protocol for Institutional \(Hospital, Nursing Facility, or ICF-MR\) Settings](#) for more information).
11. **Do not inactivate the client in CARE;** the NFCM will confirm NFLOC and monitor the case to facilitate transition planning.
12. The NFCM should conduct a face-to-face visit for each newly admitted **Medicaid** and dual eligible client within **30 calendar days** to begin to dialog about community options and the steps/desire to return to a community setting.

Note: For more information on case transfer timeframes for when an in-home client enters an institutional setting, see the [Case Transfer section of LTC Manual Chapter 5: Case Management](#).

Note: The Veterans Affairs Registered Nurses (VARN) determines NFLOC eligibility for all state Veteran’s home admissions.

NURSING FACILITY ADMISSION: FROM THE HOSPITAL (NFCM/ DDA CRM RESPONSIBILITIES)

Note: For individuals discharging from a hospital setting and whose PASRR Level 1 screening indicates that a Level 2 assessment is required, DDA PASRR Coordinators will determine the client is appropriate for nursing facility care as defined in PASRR prior to admission to the nursing facility (see *PASRR Section* for more information).

In the absence of delegated authority, for home and community-based clients who are admitted from the hospital, Medicaid-funded clients, or for residents who apply for Medicaid, within the first 10 calendar days of assignment, the NFCM or DDA Case Manager, must:

1. Ensure the client meets nursing facility level of care (NFLOC) per the NFLOC assessment in CARE:



- a. NFLOC eligibility questions are located in the Pre-Transition & Sustainability folder on the NF Case Management screen. The questions are accessed by clicking on the “+” button when a record doesn’t exist for the Nursing Facility stay or the “Edit/View” button if a record does exist for the NF stay on the Nursing Facility Case Management History table. A new window will be displayed which enables access to the NFLOC questions, click on the NFLOC tab at the top of the screen. For each new NFLOC generated, six (6) EBS questions will be displayed in the lower half of the screen. CMs cannot exit the Nursing Facility (NF) Case Management screen unless all questions are answered. Click on the save icon at the top left of the screen once the questions are complete before exiting.
 - i. All clients who are eligible for a LTC waiver such as CFC + COPES are eligible for admission to a nursing facility and do not need to be re-assessed prior to completing the NFLOC questions on the NFLOC tab (a case manager can use a DDA assessment to complete the NFLOC assessment in CARE, when needed).
 - ii. A client’s medical chart, nursing assistant notes, and staff interviews and other records may be used to supplement interviews with the client to assess activities of daily living, cognition, etc. to perform the NFLOC assessment for clients on state plan services such as MPC, as well as for Medicaid recipients/applicants (clients who are receiving Medicaid, but not long-term services and supports). Consider including the date of admission and name of the hospital, in the comment field of the NFCM screen in CARE.
 - iii. Explain and consider authorizing [Home Maintenance Allowance \(HMA\)](#) for clients likely to return home within 6 months of a physician’s certification.
 - iv. If the NFLOC determination assessment was not completed face-to-face, conduct a face-to-face visit for each newly admitted **Medicaid** and dual eligible client within 30 calendar days to begin to dialog about community options and the steps/desire for discharge.
 - v. If the client was in a SNF resident prior to the hospitalization and is returning to the same facility where they resided prior to the hospital stay, a new NFLOC determination is not required.
 - vi. If the client was a SNF resident prior to the hospitalization and is returning to a different facility than the one they resided in prior to the hospital stay, **a new NFLOC must be performed and documented in the NFCM screen in CARE.**
 - vii. For clients who are case managed by DDA, consider including HCS assigned NFCM for transition support or consultation on the current DDA assessment. HCS cannot enter in the NFLOC or complete the NFCM screen if the case is not assigned to an HCS RU.
 - viii. Tutorials on this process can also be accessed by NFCMs on the [NFCM Workspace - Home](#)

See the recorded training [Documenting NFLOC in CARE](#) for instructions on updating the NFCM screen.

2. Verify that a [PASRR Level I Screening Form](#) is completed. For more information, read the [PASRR section](#).
 - a. If the PASRR Level 1 was not performed prior to admission:



- Inform the nursing facility Admission Coordinator that the admission should not have occurred without the PASRR process being followed.
 - Make a report to CRU regarding the admission without the PASRR being completed.
- b. Level 2The facility must ensure that when a Level I PASRR screening identifies the need for a Level 2 evaluation, the PASRR Level 2 evaluation is obtained and uploaded into PCC. The Level 2 evaluation must clearly identify all specialized services and recommendations. The nursing facility is responsible for reviewing these recommendations and incorporating all required specialized services into the resident's individualized care plan.

Note: Unless other agreements have been made, if the case is being retained by the AAA, the NFLOC assessment may be completed by the AAA case manager, coordinating with the NFCM as necessary. All required steps regarding the NFLOC process must be followed, including completion of the necessary documentation.

3. For Classic Medicaid clients, complete and submit the electronic DSHS [14-443](#) form in Barcode to the PBS (unless already sent by Residential Care Case Manager (RCCM)/AAA/DDA) and complete the Nursing Facility Admission section by checking/filling in the appropriate boxes, including each of the following:
- a. The date of the request for assessment. This is the date the Nursing Facility requested the Intake and Referral from HCS. This is not the date of assignment in CARE.
 - b. If the client is functionally eligible or whether the resident does not meet nursing facility eligibility.
 - c. Date of admit.
 - d. Name of the facility.
 - e. If the client is likely to meet/exceed 30 days. This is the case manager's good faith belief regarding the anticipated length of time the client will be residing in the facility (indicating either less or more than 30 days). The Public Benefits Specialist uses this information to determine which program rules to apply for the facility stay and to complete the award letter which allows the facility to be paid.
 - o If it was initially anticipated the client's stay would not exceed 30 days, however the client's stay ends up exceeding 30 days, the NFCM must inform the PBS using the electronic DSHS [14-443](#) form.
 - f. Date of discharge, if applicable. Complete this box if the client has already been discharged from the facility at the time you determine NFLOC. Also, include the setting the client discharged to and which program was used if services were authorized.
4. [Click here](#) for more information on how the "payment begin date" is determined for Classic Medicaid clients.
5. For MAGI clients: Communicate the NFLOC determination directly in ProviderOne under the NFLOC Screen to include the following:
- a. The date of the request for assessment (this is the date the SNF submitted the Intake and Referral form to determine NFLOC).



- b. The date of admission.
- c. The date NFLOC was determined (this should match the date reflected on the NFLOC tab in CARE).
- d. [See the section on Clients with MAGI for payment information regarding clients on an Apple Health managed care plan.](#)
- e. Documenting this NFLOC determination directly in Provider One requires permissions awarded to your ProviderOne profile. For AAA/DDA and HCS Case Managers who are not primarily assigned to Nursing Facilities, you can reach out to NFLOCResolution@dshs.wa.gov for support in this process.

Monitor and document each client's transition-planning progress in SER within CARE. SER face-to-face conversations with each active client at least every 60 days. These conversations should capture the client's current preferences for care planning, behaviors, and any progress toward transition goals. When any changes in ADLs are identified, update the NFLOC and EBS eligibility determination.

6. Coordinate with nursing facility staff and other case managers. Do not rely on nursing facility staff to call when the client is ready to discharge. The work of an NFCM begins when the client is admitted to the nursing facility.
7. Attend care conferences as needed or requested. The NFCM may request a Care Conference at any time.
8. Work with the AAA, DDA and/or other HCS staff regarding clients who are returning home within 30 days.

Note: Did you know there is an NFCM automated tickler in CARE that will generate 30 days after a client is determined "Yes" for NFLOC and "Yes" for Expected Discharge within 30 days?

Note: If a client on a LTC waiver was admitted into the nursing home from the hospital, there is no need to have them sign an Acknowledgment of Services form.

NURSING FACILITY ADMISSION OR APPROVAL OF EXPANDED BEHAVIOR SUPPORT SERVICES IN A NURSING FACILITY (HCS COORDINATION OF BEHAVIOR SUPPORT CASE MANAGEMENT AND NFCM)

Before a client admits to a nursing facility with Expanded Behavior Supports (EBS) or receives approval for Expanded Behavior Support (EBS) services in this setting:

1. Ensure the client meets nursing facility level of care (NFLOC) per the NFLOC assessment in CARE:
 - a. NFLOC eligibility questions are in the Pre-Transition & Sustainability folder on the NF Case Management screen. The questions are accessed by clicking on the "+" button if a record doesn't exist for the Nursing Facility stay or the "Edit/View" button if a record does exist



for the NF stay on the Nursing Facility Case Management History table. A new window will be displayed which enables access to the NFLOC questions; click on the NFLOC tab at the top of the screen.

- i. All clients who are eligible for a LTC waiver such as the Residential Support Waiver are eligible for admission to a nursing facility and do not need to be re-assessed prior to completing the NFLOC questions on the NFLOC tab (when cases are co-assigned a case manager can use a DDA assessment to complete the NFLOC assessment in CARE, when needed).
- ii. Client's medical chart, nursing assistant notes, staff interviews and other records can be used *to supplement interviews with the client* to assess activities of daily living, cognition, etc. to perform the NFLOC assessment for clients on state plan services such as MPC or Chore, as well as for Medicaid recipients/applications (clients who are receiving Medicaid, but not home and community programs).
- iii. For clients who are case managed by DDA, the NFCM completes this NFLOC determination process based on the current DDA assessment or in consultation with the DDA CRM.

See the recorded training [Documenting NFLOC in CARE](#) for instructions on updating the NFCM screen.

2. For acute hospital clients seeking EBS please refer to [Chapter 7f: Residential Support Waiver](#) referral process.

Expanded Behavior Supports referrals will be reviewed by the RSW Committee, the Case Manager sends the CARE Assessment and the 11-130 documenting the EBS Eligibility approval to the prospective SNF for EBS admission or EBS conversion consideration. A full CARE assessment is not a requirement for admission into a SNF, however, if one is completed, include this information as part of an admission packet.

- a. The Case Manager coordinates admit date/EBS Start date with the SNF and regional delegate.
 - b. The regional delegate will notify HCLA HQ, NFCM Supervisor and the NFCM assigned to the facility.
 - i. This communication allows HCLA HQ to generate a letter to the Nursing Facility outlining billing claim codes, the exceptional care rate, and provides a start date for these specialized nursing facility services.
 - ii. This communication alerts the NFCM of this new Medicaid resident's admission or start date in their assigned facility.
3. **Communication to HQ must occur within 60 days of approval start or end date to ensure timely claims.**
 4. For each new NFLOC generated, six (6) EBS questions will be displayed in the lower half of the screen. CMs cannot exit the Nursing Facility (NF) Case Management screen unless all questions are answered. Click on the save icon at the top left of the screen once the questions are complete before exiting.
 - a. For existing admission records generated prior to October 1, 2025, EBS questions will not generate. EBS eligibility should be reviewed throughout the SNF stay.
 - b. To enter a new EBS record, click on the "+" button in the EBS history table. After completing all the questions, the client's EBS eligibility level (EBS, EBS Plus, EBS Plus

Specialized Services, ECS Respite) will appear to the right of the questions, along with a determination date displayed to the right and in the EBS history table.

EBS details

Has a history of frequent and repeated episodes of destabilization resulting in loss of services, homelessness, hospitalization or incarceration?

Yes

No

Does the client have a history of an inability to remain medically or behaviorally stable for a period of longer than six months?

Yes

No

Has exhibited behaviors or uncontrolled symptoms and has an unmet need for supportive interventions?

Yes

No

Has demonstrated difficulty managing medications which has affected their ability to live in the community?

Yes

No

Requires daily 1:1 support &/or a daily structured activity program to minimize behavioral symptoms?

Yes

No

Is receiving ongoing PT/OT evaluation, assessment to use a less restrictive device?

Yes

No

Note: See the Nursing Facility [Expanded Behavior Support Service Level Descriptions](#) for detailed information.

5. When a client is determined Expanded Behavior Supports eligible and resides in a contracted Skilled Nursing Facility (SNF):
 - a. The determination date becomes the start date for EBS services.
 - b. Within 2 working days of EBS eligibility determination the case manager must:
 - i. Notify the SNF of the eligibility determination.
 - ii. [Send an email](#) to ebbsreferrals@dshs.wa.gov including:
 1. Client's full name
 2. ACES ID or ProviderOne ID
 3. Date of determination
 4. Facility name and location
 5. EBS eligibility level
 6. Cc supervisor, NFCM PM, or regional EBS delegate, and SNF staff contact information.
 - c. Upon receiving the email, HQ will:
 - i. Forward the information to the [NF Rates Coordinator](#)
 - d. The [NF Rates Coordinator](#) will:
 - i. Load the new EBS add-on rate into ProviderOne for reimbursement
 - ii. Generate an approval letter with claiming instructions
 - iii. "Reply all" to the original notification email with the approval letter attached



- e. HQ will retain copies of all EBS approval letters in case the original communication is not received by the case manager or SNF contact.
- 6. When a client is determined eligible for Expanded Behavior Supports and the SNF is *not* contracted for EBS:
 - a. The case manager may share a list of contracted EBS SNFs with the client, client representative, formal or informal decision maker, and SNF staff.
 - i. The list can be found in the [appendix](#).
 - b. If the client chooses to transition to an EBS contracted SNF, the NFCM will provide the client and the SNF the EBS contracted Facilities list to assist the SNF with facilitating a SNF to SNF transition, if preferred.

Note: A list of facilities contracted for Expanded Behavior Supports is provided in the [appendix](#). It includes each facility's contracted scope, region, and county.

- 7. When a client does not meet Expanded Behavior Supports eligibility:
 - a. Once all questions are complete and the client is determined not to be eligible for EBS services:
 - b. No further action is required.
 - c. Save and Exit
- 8. When a client initially eligible for Expanded Behavior Supports is no longer eligible:
 - a. If a client is determined eligible for EBS upon admission but later becomes ineligible during their Skilled Nursing Facility (SNF) stay, follow these steps:
 - b. Update the EBS determination
 - i. Navigate to the NF Case Management screen.
 - ii. Click the "+" icon in the EBS History table to create a new EBS Determination.
 - iii. Answer all questions.
 - iv. The system will automatically:
 - 1. Generate an End Date for the previous EBS determination.
 - 2. Create a new entry indicating the client is "Not eligible."
 - c. Within 2 working days of EBS eligibility determination the case manager must:
 - i. Inform the SNF of the updated EBS determination.
 - ii. [Send an email](#) to ebbsreferrals@dshs.wa.gov including:
 - 1. Client's full name
 - 2. ACES ID or ProviderOne ID
 - 3. End date of EBS eligibility
 - 4. Facility name and location
 - 5. Cc supervisor, NFCM PM, or regional EBS delegate, and SNF staff contact information.
 - d. Next Steps by HQ
 - i. HQ will forward the information to the [NF Rates Coordinator](#).
 - ii. The EBS add-on rate will be end dated in ProviderOne prohibiting future SNF claims for this service.
- 9. When a client eligible for Expanded Behavior Supports on admission has a change in condition requiring a new determination:



- a. If a client was initially determined eligible for EBS upon admission and later experiences a change in condition during their Skilled Nursing Facility (SNF) stay that requires redetermination and a change in EBS service level:
 - b. Update the EBS Determination in CARE
 - i. Go to the NF Case Management screen.
 - ii. Click the "+" icon in the EBS History table to create a new EBS Determination.
 - iii. Answer all questions based on the client's current condition.
 - iv. The system will:
 - 1. Automatically generate an End Date for the previous determination.
 - 2. Create a new entry with a Start Date and updated EBS service level.
 - c. Within 2 working days of EBS eligibility determination the case manager must:
 - i. Inform the SNF of the updated EBS determination.
 - ii. [Send an email to eb referrals@dshs.wa.gov](mailto:eb referrals@dshs.wa.gov) including:
 - 1. Client's full name
 - 2. ACES ID or ProviderOne ID
 - 3. Date of new determination
 - 4. Facility name and location
 - 5. Updated EBS eligibility level
 - 6. Cc supervisor, NFCM PM, or regional EBS delegate, and SNF staff contact information.
 - d. Next Steps by HQ
 - i. HQ will forward the updated information to the NF Rates Coordinator.
 - ii. The NF Rates Coordinator will:
 - 1. Load the new EBS add-on rate into ProviderOne for reimbursement.
 - 2. Generate an approval letter with claiming instructions.
 - 3. "Reply all" to the original notification email with the approval letter attached.
 - 4. Cc the case manager and SNF contact.
 - e. Recordkeeping
 - i. HQ will maintain copies of all EBS approval letters in case the original communication is not received.
10. When a client receiving EBS services no longer meets NFLOC, transfers to other nursing homes, chooses to receive Hospice services, passes away, or is discharged from the SNF:
- a. Client no longer meets NFLOC criteria
 - i. The case manager should update the NFLOC questions as needed to accurately reflect the client's functional status.
 - ii. This action will automatically generate an EBS end date in the EBS History details table.
 - b. Client transfers to other nursing homes
 - i. The case manager should update the current NFLOC with a discharge date and location.
 - ii. This action will automatically generate an EBS end date in the EBS History details table.
 - iii. Generate an NFLOC for the new SNF stay and answer the EBS eligibility questions.



- c. Client elects to receive Hospice services
 - i. A client may remain eligible for EBS services.
 - ii. The SNF may not claim for both Hospice and EBS services during the same period.
 - iii. EBS services may be paused or discontinued for the duration of Hospice billing.
 - d. Client passes away or discharges from the SNF
 - i. When a discharge date is entered in the NFLOC section, the system will automatically generate an EBS end date in the EBS History details table.
 - e. Within 2 working days of EBS eligibility determination the case manager must:
 - i. Inform the SNF of the updated EBS determination.
 - ii. [Send an email to eb referrals@dshs.wa.gov](mailto:eb referrals@dshs.wa.gov) including:
 - 1. Client's full name
 - 2. ACES ID or ProviderOne ID
 - 3. End date of EBS eligibility
 - 4. For Transitions, indicate which setting the EBS recipient transitioned
 - 5. Facility name and location
 - 6. Cc supervisor, NFCM PM, or regional EBS delegate, and SNF staff contact information.
 - f. Next Steps by HQ
 - i. HQ will forward the information to the [NF Rates Coordinator](#).
 - ii. The EBS add-on rate will be end dated in ProviderOne prohibiting future SNF claims for this service.
11. EBS History Table Overview
- a. The EBS History Table displays the client's current EBS eligibility level, including associated start and end dates.
 - i. The top section allows users to delete the current determination if it was entered in error.
 - ii. The lower section lists past EBS determinations in descending order. These entries are view-only and cannot be modified or deleted.

EBS History Table – Additional Information

- 1. EBS history is linked to each individual NFLOC.
- 2. A comprehensive history across all NFLOCs is not shown.
- 3. To view EBS determinations from a specific SNF stay, users must click into each NFLOC entry individually.

Expanded behavior support (EBS)

EBS history

Current EBS eligibility level		Start date	End date
EBS Plus		09/15/2025	09/15/2025
+ Past EBS eligibility level		Start date	End date
EBS		09/15/2025	09/14/2025
Not eligible		09/15/2025	09/15/2025
EBS		09/15/2025	09/14/2025

12. EBS Referrals Inbox

- The eb referrals@dshs.wa.gov inbox will continue to serve as a resource for case managers and Skilled Nursing Facilities (SNFs).
- When a referral for EBS eligibility determination is received in the inbox from the SNF, the information will be forwarded to the assigned case manager with a Cc to their supervisor.

- The assigned case manager will be responsible for reviewing the referral and entering the determination into the NF Case Management screen. The case manager should verify that a [PASRR Level I Screening Form](#) was completed prior to admit. For more information, read the [PASRR section](#).

- When a Level 2 PASRR evaluation is indicated on the Level 1 PASRR form, verify the PASRR Level 2 was completed, and the NF has a copy of the results. Make a note in the SER to indicate the evaluation was performed.

It is anticipated that most of the recipients of Expanded Behavior Support services in nursing facilities will have PASRR Level 2 recommendations. Consider including these approaches in the client's care plan.

- If the PASRR Level 2 was not performed prior to admission, the case manager should Inform the nursing facility Admission Coordinator that the admission should not have occurred without the PASRR process being followed.
- Make a report to CRU regarding the admission without the PASRR being completed.

14. Coordinated Case Management:

- The assigned case manager will complete the NFLOC and EBS determination and document this in the NF Case Management Screen in CARE (if not already completed) and then transfer primary case management in CARE to the regional delegate.
 - For clients with Classic Medicaid: To begin payment and document nursing facility eligibility, submit the electronic [DSHS 14-443 form](#) to the Public Benefits Specialist (PBS), and include the following:
 - The date of the request for assessment.
 - If the client is functionally eligible or if the level of impairment does not meet nursing facility eligibility.
 - Date of admit.
 - Name of the facility.
 - If the client is likely to meet/exceed 30 days. *(This indicates the CM's good faith belief that the client will be residing in the facility for less or more than 30 days based on the information they have available. The Public Benefits Specialist uses*



this information to determine which program rules to apply for the facility stay and to complete the award letter which allows the facility to be paid.)

- Date of discharge, if applicable. Complete this box if the client has already been discharged from the facility at the time you determine NFLOC. Also include the setting to which the client discharged, and which program was used, if Home and Community Based Services (HCBS) were authorized.
- ii. [Click here](#) for more information on how the “payment begin date” is determined.
- iii. For MAGI or State Funded Medical Care Services (MCS) clients: Communicate the NFLOC determination directly in ProviderOne under the NFLOC Screen, including the following:
 - The date of the request for assessment (this is the date the SNF submitted the Intake and Referral form to determine NFLOC).
 - The date of admission.
 - The date NFLOC was determined (this is the date of the NFLOC assessment; it should match the date on the NFLOC tab in CARE)
 - [See the section on Clients with MAGI for payment information regarding clients on an Apple Health managed care plan.](#)

The assigned case manager will provide ongoing EBS case management for the client.

- Complete SERs in CARE to document continued eligibility every three (3) months..
- Documentation of continued eligibility must include confirmation of the client’s status through one of the following:
 - Review of the client’s nursing facility medical record, or
 - Communication with the nursing facility social work team, or
 - Attend an EBS or interdisciplinary team meeting with the SNF.
- b. The case remains active and co-assigned to the EBS CM and NFCM for the duration of EBS eligibility.
- c. When the EBS participant is ready for transition planning to a lesser level of care, the EBS CM coordinates with the NFCM and transfers primary case management to the NFCM in CARE.



- d. The NFCM completes the CARE assessment and works on transition planning. When intensive behavior support services are needed in the community, the CM will make an RSW referral per [Chapter 7f: Residential Support Waiver](#).

Note: Expanded Behavior Support services in a Nursing Facility is considered a Specialized Nursing Facility Program. There are other Specialized Nursing Facility Programs: Exceptional Care Rate, Community Home Project, Ventilator/Tracheotomy Weaning Program, and the Non-Citizen's Long Term Care Program. More information is available in the [HCA Nursing Facility Billing](#) Guide. There is also a Specialized Nursing Facility named the Transitional Care Center of Seattle. Information on how to make a referral for admission into Transitional Care Center of Seattle & Nursing Facilities which hold an Expanded Behavior Supports contract can be found in the [Appendix](#).

Exceptional Care Rate requests per [WAC 388-96-781](#) should be forwarded to Jevahly.Wark@dshs.wa.gov.

Many of these Specialized Nursing Facility Programs will require coordination &/or a prior authorization before utilization. Please direct questions regarding this process to: TCCSAdmissionRequest@dshs.wa.gov

How is the Payment Begin Date Determined?

For Medicaid Recipients: To ensure timely hospital discharge of Medicaid-eligible individuals, Medicaid payment begins on the date of the request for a NFLOC assessment or the date of admission to the NF, whichever is later (including swing beds). The nursing facility requests a NFLOC through the intake process for clients on Classic Medicaid and MAGI. Nursing facilities must request NFLOC assessments before or on the same day of admit to be guaranteed payment (this includes weekends).

For Medicaid Applicants: NFs must request assessments for Medicare/private-pay NF residents converting to Medicaid as soon as it is determined that the resident will likely need Medicaid funding. Medicaid payment will begin on the date:

- a. The financial application for NF care was received; or
- b. Nursing facility admission; or
- c. When the client is functionally and financially eligible.

Payment can begin no more than three months prior to the first day of the month in which the financial application is received.

NURSING FACILITY ADMITS FOR APPLE HEALTH (AH) MANAGED CARE CLIENTS (CLASSIC AND MAGI)

The Apple Health (AH) managed care program is a managed medical care program that serves over 1 million Medicaid clients statewide. This program is administered by the Health Care Authority (HCA)

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which contracts with managed care health plans to provide comprehensive medical care including preventative, primary, specialty and ancillary health services to all eligible clients in the state.

The AH contract with the managed care organizations (MCOs) includes a rehabilitative and skilled nursing facility benefit as part of the medical benefits covered by HCA. The MCO is responsible for paying for rehabilitative or skilled nursing days in a nursing facility if the MCO authorized the stay. The contract requires the MCO to provide a written authorization approval or denial to the nursing facility for any stay. The facility will use this authorization to bill the MCO for services or use a denial to bill fee for service. HCA's [Nursing Facility Billing Guide](#) provides detailed instructions regarding the responsibilities of the nursing facility.

How do I know if the resident is enrolled in an AH MCO?

Staff can verify real time enrollment in an AH MCO in ACES Online. From the client summary screen select 'Medical Information' under the Details tab. You will see the ProviderOne ID for the client and AH MCO the client is enrolled in.

Client >> Medical Information

New Search: Client ID:

Benefit Month: December 2021

Client

Client ID: Name:

Primary Language: English (EN) Extra Help Needed: Yes (Y) [Equal Access](#)

Client Medical Information

ProviderOne ID: NA Hospice Indicator: No (N)

Medicare: Restriction Indicator: No (N)

TPL Insurance: DDD Client Indicator: No (N)

Placement Code:

Managed Care Information

Health Plan	Program	Start Date	End Date
Amerigroup Washington Inc	Fully Integrated Managed Care	10/01/2021	12/31/2999

AU Medical Information

AU ID	Coverage Group	Eligibility Start Date	Retro Medical	Delayed Certification
	SSI Long Term Care (L01)	06/01/2020	No (N)	No (N)

Can an AH MCO enrollee transfer to another facility?

Yes, but the transfer must be coordinated with the MCO responsible for payment of the stay. The facility needs to contact the MCO to authorize and coordinate services.

When does a NFLOC need to be completed for an AH MCO enrolled resident?

1. If the client is covered by the AH MCO rehab or skilled nursing benefit, then no NFLOC is required. Always refer the nursing facility to the AH MCO if there are questions regarding the client's MCO benefit.
2. The facility must notify HCS of a need for NFLOC assessment by requesting a social service intake and the NFCM must determine NFLOC when any of the following occurs:
 - a. The client is not admitting to the nursing facility under a benefit covered by the MCO;
 - b. The client enrolls in an AH MCO after date of admit; or
 - c. The client's rehab or skilled nursing benefit is ending (or has ended) with the AH MCO.



3. The NFCM must notify HCA whether or not the client meets NFLOC by communicating the NFLOC determination directly in ProviderOne under the NFLOC Screen. The record is available for HCA and the NF to review in the ProviderOne system. Include the following in your communication:
 - a. The date of the request for assessment (this is the date the SNF submitted the Intake and Referral form to determine NFLOC);
 - b. The date of admission;
 - c. The date NFLOC was determined (this is the date of the NFLOC assessment; it should match the date on the NFLOC screen in CARE); and
 - d. Whether or not the client meets NFLOC.

It is important the NFCM completes the form with accurate dates. Based on the dates provided, HCA's NH Payment Unit will determine SNF payment date discrepancies and forward these to HCS HQ. Payment dates are managed directly by HCS HQ and HCA.

If the client meets NFLOC, the payment begin date for the NF is based on the following:

For Medicaid Recipients:

To be guaranteed payment, nursing facilities must request a NFLOC assessment for a client not admitting with coverage from an MCO, enrolls in an AH MCO after date of admit or as soon as it is determined the client's skilled nursing or rehab benefit will be ending to be guaranteed payment (this includes weekends). **Medicaid payment begins on whichever is later:** the date of the request for a NFLOC assessment or the date of admission to the NF.

For Medicaid Applicants:

For applicants, the department may back date the institutional date up to three months prior to the date of application as long as the client is otherwise eligible. To determine financial and functional eligibility, NFs must request a NFLOC assessment and assist the client in applying for Medicaid on [Washington HealthPlanFinder](#) as soon as it is determined a resident will likely need Medicaid funding.

See [Clients that Do Not Meet Nursing Facility Level of Care](#) for more information regarding a client who does not meet NFLOC.

Do we need to send a 14-443 on MAGI or MCS clients?

If the client is MAGI or State Funded Medical Care Services (A01, A05, A24), do not send a 14-443 to the PBS unless the client can only be served under an HCBS Waiver and not MPC or CFC upon discharge. Public Benefit Specialists will not make eligibility changes for individuals eligible for MAGI even if the client is in a NF for 30 days or more. For [Managed Medicaid recipients, NFLOC](#) is communicated to the Health Care Authority directly via ProviderOne. This ability to enter/edit the NFLOC screen in ProviderOne requires a profile update via a Non-HCA Employee Access Request form to be submitted to hcaitsecurity@hca.wa.gov. For AAA/DDA and HCS Case Managers who are not primarily assigned to Nursing Facilities, you can reach out to NFLOCResolution@dshs.wa.gov for support in this process.



Do we update the NFLOC Communication in ProviderOne at the time of discharge?

The NFLOC determination in ProviderOne is completed at the time of admit, application or conversion and is updated when a MAGI or MCS client discharges. Refer to [NFLOC Communication in ProviderOne](#) section for additional P1 documentation instructions for this scenario.

A screenshot of the "Update NFLOC Information" form in the ProviderOne system. The form has a light gray header with the title "Update NFLOC Information" and a small icon on the left. Below the header, there are several input fields: "Provider ID:" with a blacked-out value, "NFLOC Request Date:" with a date of 08/13/2024 and a calendar icon, "Admit Date:" with a date of 08/13/2024 and a calendar icon, "Discharge Date:" with a date of 10/01/2024 and a calendar icon, "NFLOC Determination Date:" with a date of 08/13/2024 and a calendar icon, "NFLOC End Date:" with a date of 12/31/2999 and a calendar icon, and "Meets NFLOC:" with a dropdown menu set to "Yes". There is also a "Note:" field with a text area. The form has a small upward arrow icon in the top right corner.

Will Managed Care Assist with Care Coordination and Transition Planning?

When a client enrolled in managed care needs assistance to coordinate their health care services and access to appropriate treatment, the NFCM must assist the client and their guardian, if applicable, to request “[care coordination](#)” from the client’s Apple Health MCO (including clients who have managed care only for behavioral health services).

The Medicaid and Medicare Managed Care Coordination Contact information can be found on the [HCS/AAA intranet website](#) on the right side of the webpage, under Contractors. Alternatively, this contact information and other resources are available on the [Cross System Care Coordination | DSHS](#) website. To request care coordination, the CM may send a [secure email](#)* to the client’s MCO to request

Note: Requests for Exceptional Care Rate requests from SNFs for clients enrolled in MCOs must be submitted directly to the assigned MCO. HCS cannot process these requests on behalf of an MCO.

care coordination and assistance to address barriers the client is experiencing to access medically necessary care covered by Apple Health.

*Emails from the DSHS URL (@dshs.wa.gov) identifies the requestor as a DSHS employee and meets HIPAA requirements to request care coordination on behalf of a HCS/AAA client.

1. When making a care coordination request include the following in your email:
 - a. In the Email “Subject” line, provide the reason for care coordination request. For example:
 - i. Mental health treatment
 - ii. Durable medical equipment
 - iii. Needs Primary Care Provider
 - b. In the body of the email, provide the following information:
 - i. Client Name
 - ii. Client ProviderOne ID: (9-digit number ending in WA)
 - iii. Date of Birth
 - iv. Residence Type
 - v. CM Name and Contact Information



vi. Summary of client barrier/issue/need

2. If you do not receive a response or assistance with your request timely, the CM should discuss the case with their supervisor to determine if escalation is needed. Sent a second email to the MCO with 'escalation' in the title of the email.
3. If the CM and supervisor do not receive a response, they may determine escalation to HCS HQ is needed when issues are not resolved.
 - a. If the CM supervisor determines that escalation to HQ is appropriate, the CM supervisor will submit the original email communication and escalation with the MCO to Ethan.Leon@dshs.wa.gov

Once the request for escalation is received, HCS HQ will outreach with HCA to discuss the identified barrier to access. Based upon the type of request, the case manager and supervisor will be notified regarding next steps. You can find more detailed information on [Managed Care](#) in Chapter 22 of the LTC Manual.

PRE-ADMISSION SCREENING & RESIDENT REVIEW (PASRR)

What is PASRR?

Federal regulations (42 CFR §483.100 – 138) require that **all** individuals applying for or residing in a Medicaid-certified nursing facility be screened to determine whether they:

1. Have serious mental illness or an intellectual disability or related condition; and if so,
2. Require the level of services provided by a nursing facility; and if so
3. Require specialized services beyond what the nursing facility may provide.

The [Level I Pre-Admission Screening and Resident Review Form](#) documents the first level of screening. If serious mental illness or intellectual disability or a related condition is identified or credibly suspected, a Level 2 evaluation is required to confirm or exclude identification, determine whether the individual requires nursing facility level of care, and determine whether specialized services are required.

Who should be screened under PASRR?

Anyone seeking nursing facility admission to a Medicaid-certified nursing facility, whether funded by Medicaid or a non-Medicaid source, must be screened **prior** to admission.

Who completes the Level I pre-admission screening for people coming from a hospital?

Any professional who is referring an individual for admission to a nursing facility may complete the [Level 1 PASRR form](#). The form may also be completed by designated HCS or DDA staff who are facilitating the referral.



The nursing facility is responsible for ensuring that the form is complete and accurate **before** admission. After admission, the NF must retain the Level 1 form (and the Level 2, if applicable) as part of the resident record. In the event the resident experiences a significant change in condition, or if an inaccuracy in the current Level 1 is discovered, the NF must complete a new PASRR Level 1 and make referrals to the appropriate entities if a serious mental illness and/or intellectual disability or related condition is identified or suspected.

Who completes the Level 1 pre-admission screening for individuals coming from their own homes or from a residential setting?

- The referring physician or ARNP should complete the form.
- For Medicaid funded clients, the HCS, AAA, or DDA worker should verify that the screenings are complete for current clients being admitted in a NF.
 - DDA may complete the Level I screening for DDA clients who are being admitted to a nursing facility directly from home.

Are there exceptions to a Level I being completed?

Level I screens are not required for individuals who are:

- Transferring from one NF to another NF; or
- Being readmitted to the same NF following hospitalization (applies only if a Level I PASRR screen had previously been completed and is still applicable to the individual's status).

What happens if someone meets the PASRR criteria for PASRR Level 2?

The referral source will contact DDA and/or the Behavioral health (BH) contractor for an evaluation. (See [DDA PASRR](#) and the [BH PASRR](#) Internet sites for a list of evaluators.)

1. Unless the individual meets criteria for an exempted hospital discharge or Categorical Determination, a DDA assessor or MH contractor must perform a Level 2 evaluation to verify the diagnosis prior to admission to the nursing facility, determine whether nursing facility admission is appropriate, and determine whether the person needs specialized services. If the person has both a serious mental illness and an intellectual disability or related condition, the individual must receive a Level 2 evaluation from both DDA and Behavioral Health.
2. It is the nursing facility's responsibility to ensure that a potential resident has a completed PASRR Level 1 screening and, if necessary, a Level 2 evaluation **prior** to admission into the facility.

Are there exceptions to a Level 2 evaluation being completed?

Per 42 CFR §483.104, a person may be admitted to a NF without a PASRR Level 2 when:

1. The person is readmitted to the NF directly from a hospital after receiving acute inpatient care at the hospital;
2. The NF admission is to treat the condition for which the person was hospitalized; and



3. The person's attending physician, ARNP, or physician's assistant certifies that the person requires fewer than 30 days of nursing facility services (*Level 2 required by Day 31 if stay unexpectedly exceeds 30 days*).

Is an NFLOC needed for a client who meets the PASRR level 1 screen?

Yes, NFLOC is a requirement for Medicaid recipients in nursing facility settings. For individuals who have a positive Level 1 screening and require a Level 2 evaluation, the assigned DDA or HCS CM completes the [NFLOC](#) assessment following all regular policies. DDA PASRR Assessors will determine the client is appropriate for nursing facility care as defined in the PASRR determination process prior to admission to the nursing facility. DDA PASRR Assessors document this information within their PASRR Data System (PDS). In the event a DDA PASRR Assessor identifies that an HCS Case Manager is not assigned to the DDA Client in CARE, this will be escalated to the DDA PASRR Program Manager for resolution.

What are "specialized services"?

"Specialized services" is a term used in federal PASRR regulations (42 CFR §483.120) to describe any services or equipment that are (1) recommended in a Level 2 evaluation to meet the needs of individuals with serious mental illness or an intellectual disability or related condition, and (2) exceed the scope of services normally provided by the nursing facility.

What if a Nursing Facility finds that a person's condition has changed after admission?

The NF must complete a new PASRR Level 1 and make referrals to the appropriate entities if a serious mental illness and/or intellectual disability or related condition is identified or suspected. The NF should promptly refer residents to [DDA PASRR](#) or the local [BH PASRR](#) evaluator when either of the following occur:

- Already have a mental illness or developmental disability and show a significant change in condition (improving or declining).
- Develop a serious mental illness and may need a Level 2 evaluation.
- If the resident has had a significant improvement, the facility must request a new NFLOC from HCS to verify functional eligibility.

What if there is not a PASRR contracted evaluator in my area or if I have questions about a PASRR contracted evaluator?

HCA is responsible for contracting with all Level 2 PASRR contractors who conduct evaluations related to mental illness. For questions about HCA contracted PASRR evaluators, please contact Elizabeth Loska beth.loska@hca.wa.gov or call 360-725-1478 and review the website: [PASRR Program Contacts by County](#).

DDA is responsible for conducting Level 2 evaluations related to intellectual disability or related conditions. For questions about the DDA Assessors, please contact your local [DDA PASRR](#) Coordinator.



How should I document case activities when the client is receiving PASRR services (For DDA PASRR Assessors only)?

Complete SERs for activities related to community transition for clients in PASRR RUs using the SER subject lines in **bold type** below:

- **PASRR Client – Case Manager Assigned:** Enter a SER with this Purpose code when a current NF resident desiring community transition is assigned a DDA or HCS case manager (see example below).

A screenshot of the SER (Subject Event Report) form. At the top, there are two buttons: "Add SER" and "Search SER". Below them is a blue reminder box that says: "Reminder: Please add 'COVID-19' to the Subject Line if the SER is related to a COVID-19 related business purpose." The form has several fields: "Contact method" (a dropdown menu currently showing "NFCM (HCS)"), "Subject" (a text input field), "Entry" (a large text area), "Purpose" (a dropdown menu with a list of options), and "Contact date" (a date input field with a calendar icon). The "Purpose" dropdown menu is open, showing a list of options. The option "PASRR Client - Case Manager Assigned" is highlighted in blue. Other options in the list include "CCG", "TCM (HCS/AAA)", "Plan Amendment (DDA)", "Complaints", "NPS Assessment Priority (DDA)", "Admin Hearing", "QA File Review", "Judicial", "NCC Review (DDA)", "Housing", "PASRR Client - Community Setting Declined", "PASRR Client - Potential Provider Identified", "PASRR Client - Residential Referral", "PASRR Follow-Up Packet and PAN Sent", "DDA Residential Resource Management", and "AFH Sig Change Request".

- **PASRR Client – Community Setting Declined:** Enter a SER with this Purpose code when a PASRR client is offered a viable community setting that meets their needs, but the individual or guardian does not accept the setting.
- **PASRR Client – Potential Provider Identified:** Enter a SER with this Purpose code when a potential community-based provider is identified.
- **PASRR Client – Residential Referral:** Enter a SER with this subject when referral information is shared with a potential provider for community transition (adult family home, supported living agency, assisted living, etc.).

For DDA and HCS Case Managers: Contact the DDA Regional PASRR Team prior to inactivating a case in CARE when the client is assigned to a PASRR RU. When transferring a shared PASRR case:

1. On the Transfer Form, note that the case is shared with a DDA PASRR worker; document the office and name of the worker on the form.
2. Contact the regional PASRR Team (see below) to let them know the case is being transferred.
3. In the SER documenting the transfer, the transferring worker should note that the client has a DDA PASRR case worker that should be notified once the case is assigned.
4. The assigned worker in the receiving RU should email the Regional PASRR Team to let them know the case has been transferred and is now assigned.
5. Upon notification, the Regional DDA PASRR Team can add the PASRR information back into the CARE Overview screen.

DDA PASRR distribution lists:

- DSHS DL DDA R1 PASRR Team: ddar1pasrrteam@dshs.wa.gov



- DSHS DL DDA R2 PASRR Team: ddar2pasrrteam@dshs.wa.gov
- DSHS DL DDA R3 PASRR Team: ddar3pasrrteam@dshs.wa.gov

What if I have other questions about this process?

For other questions about PASRR, please refer to your regional HCS or DDA office or your local RCS field manager.

CLIENTS THAT DO NOT MEET NURSING FACILITY LEVEL OF CARE (NFLOC)

The nursing facility should submit a Intake and Referral Form ([DSHS Form 10-570](#)) when:

1. A new Medicaid client has been admitted from the hospital.
2. A current resident is converting from Medicare to Medicaid.
3. A current resident's rehab or skilled nursing benefit has ended with the AH MCO.
4. A resident is applying for Medicaid.
 - Financial eligibility may be retroactively determined for up to 3 months.
 - Functional eligibility must be requested at the time the Medicaid application is submitted.
5. A client has expressed interest in transitioning to the community.
6. The resident's health has improved to the extent that they may no longer meet nursing facility level of care. .

If the client does not meet nursing facility eligibility 1) at time of admission to the nursing facility or 2) at any time during their nursing facility stay, a full CARE assessment should be completed as soon as possible to verify functional eligibility. Follow steps as outlined in the CARE Web Help file when a client does not meet functional eligibility for HCBS programs. Document any changes in NFLOC status by completing the following:

1. A new line will need to be created on the Nursing Facility Case Management Screen in the NFCM history table in CARE to document the change in determination.
 - a. Create a new line on the NFCM Main screen by clicking on the "+" sign on the NF Case Management screen history table.
 - b. Select the SNF where the client resides (it will likely be the same as the previous line).
 - c. On the NFLOC tab, answer questions 1 through 5. If the client does not meet NFLOC (All "no" answers to questions 1-5), the system will auto-populate "Does the client meet NFLOC?" with "No".
 - d. Select "Yes" from the drop-down for "Expected to discharge within 30 days?"
 - e. Expanded Behavior Supports (EBS) eligibility questions (6) will generate on the lower half of the screen.
 - These questions must be completed prior to exiting the screen.
 - If the client *is not* determined to be eligible for EBS, no further action is required.
 - If the client *is* determined to be eligible for EBS, once a CARE assessment is complete:



- Discuss Residential Support Waiver (RSW) services and settings with the client.
- Consider submitting Form 11-130 RSW and EBS Eligibility to RSW Committee for eligibility determination.

Nursing Facility Case Management

Nursing facility case management history

	Current nursing facility	Admit date	Meet NFLOC	Discharge date	
	Transitional Care Center of Seattle	09/21/2022	No		
+	Past nursing facility	Admit date	Meet NFLOC	Discharge date	
	Transitional Care Center of Seattle	09/21/2022	Yes		
	MANOR CARE HEALTH SERVICES (LYNNWOOD)	11/01/2020	Yes	11/27/2020	
	RAILARD CENTER	01/29/2019	Yes	11/11/2019	

- The NFCM will send written notice to the nursing facility that the client no longer meets NFLOC and that payment will end in 30 days (*see sample letter in [Resources](#)*).
 - A copy of the letter saying payment to the facility will end must be provided to the client.
- The facility must initiate discharge of a resident who does not require nursing facility care ([WAC 388-97-0100](#)).
 - The facility must send a 30-day notice to the client, the client's surrogate decision maker and, if appropriate, a family member or the client's representative.
 - Notice of a resident-initiated discharge must also be provided to the LTC Ombudsman office.
 - The notice to the client and representative(s) must include the reason for denial and their right to a fair hearing, per [RCW 74.42.450](#).
 - If the client requests a fair hearing and prevails based on the NFCM re-determining NFLOC, send a letter to the client and SNF describing continuous eligibility (see sample letter in [Resources](#)).
 - For Classic Medicaid only:** When an NFCM is aware that a fair hearing has been requested, they must notify the public benefits specialist of this via a 14-443 communication.
- HCLA's policy is to authorize payment for up to 30 days or until the client is discharged, whichever is earlier:
 - For Classic Medicaid only:** Notify Financial via a 14-443 communication that the client no longer meets NFLOC.
 - Client must meet financial eligibility in order for the facility to be paid.
 - Payment will be made from state funds to the nursing facility.
- Continue to work with the client on transition planning options and document all efforts in CARE.
- If the case manager observes that a facility has a pattern of admitting clients who do not meet NFLOC or that does not initiate determination of level of care for residents whose health has improved, notify your supervisor, and call the Complaint Resolution Unit (CRU) hotline with specific concerns.



Note: When a Medicaid resident declines to participate in a full CARE assessment to verify NFLOC, indicate this in the Reason for Assessment field. Keep in mind that the client should always be the primary source of information, so notify the resident that an assessment will be completed without their participation. To receive services funded by Medicaid in a nursing facility setting, the client must remain Nursing Facility Level of Care. A video tutorial on this process can be found on the NFCM Workspace.

To facilitate payment to the NF using state funds:

1. Upon completing the NFLOC assessment and determining NF level of care is not met:
 - a. The case worker indicates on the NFLOC tab that the client does not meet NFLOC with the date of the determination.
 - b. If the client has been a resident and this is a change in status, follow the instructions above to create a new line on the NFCM history table.
 - c. The case worker assigns RAC 3301 in CARE, but no authorization is created.
2. **After the client discharges from the SNF**, the case worker completes Barcode form 14-443 (Financial/Social Services Communication) or Updates the NFLOC Communication in ProviderOne (NFLOC for MAGI or MCS) indicating that NFLOC is not met and includes the following statements in the Comment box of the 14-443 or NFLOC Screen in P1 (see sample below):
 - a. The client has been assigned RAC 3301
 - b. The RAC was added in CARE by the case manager and sent to P1.
 - c. The dates of service to be paid using state only funds.
 - d. The date of discharge (date of discharge is not paid, per the NH billing guide).

A screenshot of the "Update NFLOC Information" form in the ProviderOne system. The form contains several date fields: "Provider ID:" (redacted), "NFLOC Request Date:" (08/13/2024), "Admit Date:" (08/13/2024), "Discharge Date:" (10/01/2024), "NFLOC Determination Date:" (08/13/2024), and "NFLOC End Date:" (10/01/2024). There is a "Meets NFLOC:" dropdown menu set to "Yes". A "Note" box is highlighted with a blue border, containing the text: "This client has been assigned RAC 3301 in CARE. The dates of service to be paid using state only funds are 8/13/2024 - 09/30/2024. Client discharged on 10/01/2024."

3. The SNF bills as usual:
 - a. HCA's NH Payment unit will look for the 14-443 in Barcode or NFLOC Screen in P1 and process claims when NFLOC is not met, and the RAC and discharge information is provided.
 - b. If NFLOC is not met per the 14-443 or NFLOC screen in P1, but RAC and discharge information is not provided, payment is "on-hold" until clarification is received (not denied, but not paid).
 - c. If there is no 14-443 or NFLOC Determination in P1, the claim is denied per usual procedure and facility must contact their assigned NFCM to get it completed.



DETERMINING AND DOCUMENTING TRANSITION GOALS

The NFCM will:

1. Visit the client and inform the client and/or family/representative, as appropriate, of case management services and inquire about the resident's transition goals. Informed consent is always obtained directly from the person unless he/she/they is legally not competent to consent. In that event, State statute ([RCW 7.70.065](#)) allows the following in order of priority to give informed consent for adults: legal guardian, Durable Power of Attorney, spouse or State registered domestic partner, adult children, parents and adult siblings. Additional resources can be found at: [Consent, Capacity, Legal Decision Makers, and Guardianship Topics](#)
2. When appropriate, work with the client, nursing facility staff, and family to help the client relocate to a community-based setting.
3. Offer support to the client, the family and/or representative by addressing concerns regarding care in the nursing facility or other quality of life issues.
4. Monitor progress towards transition goals and encourage progress towards the highest level of functioning possible. **All cases must remain active for a minimum of 6 months to monitor progress and address transition barriers.** There is no maximum length of time a case may remain active while a Medicaid funded resident is residing in a nursing facility.
5. If it is not feasible for the client to return to their own home, talk to the client, their family/representative, and/or their case manager about other living situations such as adult family homes or assisted living facilities. In coordination with the nursing facility staff, contact AFHs and ALFs to determine if they have openings and discuss the client's care needs to learn if they would be interested in meeting the client.
6. Encourage the education of clients so that they may address their own care needs, such as self-medication programs, nutritional programs, or home evaluations.
7. Document progress towards community transition in the SER and update applicable screens in CARE.

The client's preferences should be the primary influence regarding transition planning; family desires should be considered in transition planning but should not be the sole source. See [HCS Decision Making for Transition Planning](#) in the Appendix Section of this Chapter.

Ready for Relocation

When the client chooses to live in a less restrictive setting, the NFCM will:

1. Perform a CARE assessment (initial, significant change, or reapply) with the client.
 - a. For clients on DDA services, contact the DDA CRM/PASRR Coordinator to initiate the completion of a DDA assessment and to coordinate any discharge resources that may be needed.



- b. The assessment to prepare a client for community transition while they are in a SNF or hospital setting does not require the assessor to assess the community setting prior to moving the assessment to current (see [Chapter 3](#) regarding if an assessment is in a setting other than the client's home or residence where services are being provided). The 30 day face-to-face visit required by the receiving case worker meets the requirement to identify any safety or other concerns regarding the living environment (See [Chapter 5](#) for details).

Note: CARE assessments may be initiated or completed at any point of the client's nursing facility stay. It may be necessary to complete more than one CARE assessment to accurately reflect the client's long-term service and support needs in the community. To ensure accuracy and reduce unnecessary administrative work, CARE assessments may be moved to current as close as possible to the anticipated date of discharge. Finalizing the assessment near the discharge date minimizes the likelihood that multiple Interim Assessments will be required.

2. Develop an individualized plan that reflects client choice and the person's specific care needs. Document in a SER the client's informed decision regarding setting and care.
3. If appropriate, authorize [Transition Resources](#) and request [care coordination](#) with the resident's managed care organization.
4. Create an approval Planned Action Notice (PAN) for all services the client is authorized to receive as outlined in CARE (With the exception of any services provided through [WA Roads](#).)
5. Within 7 days of discharge, update the following in CARE (whether or not the assessment is ready to move to Current or History):
 - a. Discharge date on the NFCM main tab by highlighting the line in the table and clicking on the "Edit/View" button (if the client discharged on RCL after a reinstitutionalization, update the Discharge Date on both the NFCM **and** the RCL screens.)
 - b. Update information in CARE on the Contact Details screen in CARE Web.
 - c. Choose the appropriate Residence Type in addition to updating other residence information. The dropdown options under Residence Type include Correctional Facility, Homeless, Medical Hospital, Psychiatric Hospital, as well as every residential and in-home setting, including if the individual is living with a relative; use "Other" only when there is no appropriate option.
 - d. The residence Start Date should be the same as the Discharge Date (the Start Date field can be manually corrected on the Contact Details screen in CARE.)
6. On the CARE Plan:
 - a. Indicate Program (only choose RCL if the client has been enrolled on the RCL Enrollment Screen). If the program choices do not reflect CFC, then refer to [Client does not meet NFLOC](#) section of this chapter.
 - b. Client chosen/planned living Situation.
7. For the relocation to be included on the monthly NFCM Transition report, move the assessment to Current/ History:
 - a. Do not delay assisting a client with their transition while waiting for the assessment to be moved to current. **If the client is making an informed decision to decline personal care or**

Note to CM: A video tutorial detailing how to make your discharges count with relocation standards can be found on the [NFCM Workspace](#).



other long-term services and supports, the assessment can be moved to History but must have all “Green progress bars” and Care Plan Screen completed to be included in the report.

No Current Transition Plan/Goal

Some individuals or designated decision maker may not be interested in discussing a return to the community immediately upon admission. For clients who do not have a current discharge plan or do not currently expect to return to a community setting, offer ongoing support to the client, family and/or representative by addressing concerns regarding care in the nursing facility or other quality of life issues and continue to support all efforts towards reducing or eliminating transition barriers to a less restrictive setting. If, **after a minimum of 6 months**, the client has not made any progress towards their transition goals, you *may* Inactivate the client in CARE using the “No Current Discharge Plan” code. Case inactivation *is not* required if there is no transition plan, cases may remain active if no transitions goals are identified. **For those residents receiving [specialized nursing facility services](#) or Guardianship & Conservatorship Assistance Program (GCAP), these clients must remain active with nursing facility case management.** Please see Chapter 9 for specific actions related to GCAP Cases.

Follow up with clients at least annually to determine if interest/motivation to return to the community has changed, or whether the client’s informal supports have changed. Document these discussions of offering alternative setting choice and sharing information on community resources and services in a SER.

Note: For DDA co-assigned clients, move the LTC assessment to history and remove yourself from the CARE team on the Overview screen. **Do not inactivate the client in CARE.** If the client is receiving PASRR services, follow all protocols in the [PASRR section](#).

CASE TRANSFER PROTOCOL FOR INSTITUTIONAL SETTINGS (HOSPITAL, NURSING FACILITY, OR ICF-ID)

The intent of this case transfer policy is to encourage coordinated transition/treatment planning in the best interest of the client. The AAA CM, RCCM or DDA CRM/ PASRR Coordinator should collaborate with the facility’s assigned NFCM to determine when a case transfer is appropriate for a client who intends to return to a community setting. For those nursing facility residents who are already on an HCS NFCM’s active caseload the following also applies when a client transitions to another institutional setting:

In that regard, AAA, DDA and/or HCS staff may:

- Assess client in the NF or hospital.
- Determine NFLOC in the NFCM tab of CARE.
- Attend care conferences at the hospital, NF, or ICF-IDs
- Access transition resources for clients
- Review medical records and/or files.
- Request Housing Maintenance Allowance (HMA)



Timeline Benchmarks

The client may remain with the RCCM or AAA CM for 30 days from initial admission to Nursing Facility regardless of subsequent changes in institutional setting (hospital, SNF, ICF-ID). The client case may be kept longer than 30 days if a return to community setting is imminent. If the client does not intend to return to their previous setting, the NFCM/RCCM/CM/AAA may transfer client to the NFCM unit immediately (earlier than 30 days). DDA CRMs/PASRR Coordinators will co-carry the case with the NFCM assigned to the nursing facility where the client resides.

When a hospital stay goes beyond 30 days, the NFCM/RCCM/CM/AAA may coordinate with the Hospital unit regarding the transfer of the case. When an NFCM is unclear whether the client will return to the nursing facility, retain case management of the client until the 30-day timeline, or until the client transitions to another nursing facility. Upon admission into another nursing facility, the NFCM will transfer the case to the assigned NFCM of that center. NFCMs are required, to staff the client case with the ongoing Hospital Case Manager/RCCM/AAA/DDA case manager at transfer.

The NF case manager Supervisor will:

1. Immediately staff the case with the hospital supervisor unit,
2. Create a hospitalization transfer SER with the following information
 1. Hospital Name
 2. Admission date
 3. Current hospital social worker
 4. Barriers to returning to SNF setting.
 5. Date of staffing with Hospital Supervisor
 6. Is the client decisional? (If not, who is the guardian/conservator or DPOA)?
 7. What steps have been taken to maintain or allow the client to return to previous setting?
3. Transfer the case to an HCS hospital case manager supervisor for case assignment.

[See Chapter 5 Case Management of the Long-Term Care Manual.](#)

TRANSITION RESOURCES

Home Maintenance Allowance (HMA)

Home Maintenance Allowance: The HMA is income, up to 100% of the Federal Poverty Level, which the client can keep maintaining their community home during a NF or institutional stay. [WAC 182-513-1380](#)



Who is eligible?	A single client applying for HMA must be: 1. A Medicaid recipient; and 2. Certified by a physician that the client will likely be institutionalized in a NF or Medical Institution for no more than six months. A married client may be eligible if: 1. Both members of the couple are residing in a NF or receiving Housing Maintenance Allowance; and 2. One of them is likely to return to their place of residence within six (6) consecutive months. A married client whose spouse is not institutionalized is not eligible for the HMA.
What is covered under the HMA?	The client is allowed to keep 100% of the federal poverty level of their income to maintain their community home.
How do I authorize HMA?	1. Consult with the client or Public Benefits Specialist to determine the first month that an HMA may be authorized. 2. Request written verification from the client's physician that the client is likely to return home within six consecutive months. This may be in the physician's orders at the Nursing Facility, or you may use the HMA DSHS Form 14-456 3. Document the verification of the written Physician's Certification in a SER or place the completed HMA in the client's electronic client record. 4. If the physician certifies the client is likely to return home within six months: a. In Barcode, indicate the home maintenance allowance exemption on DSHS form 14-443 (HCS/AAA staff) or on DSHS Form 15-345 (DDADDA staff) and provide the start date. 5. If the physician will not certify the individual is likely to return home within six months: a. Indicate on DSHS form 14-443 (HCS/AAA staff) or on DSHS Form 15-345 (DDADDA staff) there is no HMA and leave the HMA Start Date blank. b. List details of the HMA actions in the CARE SER using Contact Code "NFCM" 6. Send the client a letter indicating the HMA Action if denied. Note: If the AAA CM retains case management of the case, the completion of the HMA is their responsibility. For clients shared by HCS and DDADDA, the DDADDA CRM/PASRR Coordinator completes the HMA. Additional HMA completion resources can be found on the NFCM Workspace.
When do I authorize this service and for how long?	The HMA begins on the first of the start month (as stated on the) and ends when the client is discharged from the facility or at the end of six months, whichever comes first. HMA should not be requested for a month in which the client does not have participation (i.e. the first month of admission or when Medicare is the



	primary payment source). For non-SSI clients, circumstances must be reviewed after 90 days, and the Public Benefits Specialist must be informed of the need for an extension of an additional 90 days or termination of HMA. If a client transitions to their community home and is later re-admitted, you may reauthorize the HMA with a Physician's certification indicating the client will likely return to their community home within six months. If a client has HMA approved but does not owe participation during the approved allowance benefit period (for example, the client's stay is covered by a medical benefit or is private pay for an interrupting period of time such as after an acute hospitalization), the six consecutive month limit may be adjusted by notifying the Public Benefits Specialist via DSHS form 14-443. No new verification from the physician is required if the break is covered during the original verification period.
What if it is a Temporarily Institutionalized SSI Recipient?	• SSI only income: Upon NF admission, the client's SSI income is exempted; therefore, these clients are not eligible for a HMA. • SSI/SSA (or some other income): Authorize the HMA taking into consideration the client's SSI income for the first 3 months. • SSI income would need to be subtracted from the total need, since this income is available to the client for the first 3 months. If the client continues to need NF care following the first 3 months and has additional income such as SSA, pension, retirement, etc., authorize an income exemption for 3 additional months.
Are ETRs allowed for HMA?	• If the client has only SSI income and requires NF care following the first three months of institutional care, Emergency Rental Assistance may be authorized to maintain the client's residence see LTC Manual, Chapter 6B: Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance). • No ETRs are allowed for HMAs longer than six months in duration. • No ETRs are allowed for amounts over the federal poverty level per month.

Community Transition Services (CTS) & Transition Support Services

Community Transition Services (CTS): CTS are used to purchase one-time, set-up expenses necessary to help relocate clients discharging from an institutional setting to a less restrictive setting (see [WAC 388-106-0270](#)). The Appendix includes a [Supporting Client Transitions to the Community - YouTube](#) video which describes some of these services. **See *Which Program to Use: Transition and Sustainability Goods and Services* in the [Appendix](#) as a reference guide.**



Who is eligible for Community Transition Services (CTS)?	HCS/AAA clients who are receiving Medicaid long-term services who: • Are discharging from a nursing facility, institution for mental disease (IMD) or intermediate care facility for individuals with intellectual disabilities (ICF-ID) to a home and community-based setting; and • Will be receiving Roads to Community Living (RCL), Community First Choice (CFC) or Residential Support Waiver (RSW) services upon discharge. CTS funds must be considered before you use CTSS state funds. For those on the Address Confidentiality Program, refer to Chapter 3: Assessment and Care Planning for additional information on service coordination. To ensure accuracy and reduce unnecessary administrative work, CARE assessments may be moved to current as close as possible to the anticipated date of discharge. Finalizing the assessment near the discharge date minimizes the likelihood that multiple Interim Assessments will be required.
What is covered under Community Transition Services SA297? CTS: Goods SA296? HCS Only: You may utilize Amazon for purchasing Goods. See Amazon Authorization Desk Aid in Appendix section.	Services may include: 1. First month's rent, security deposits, safety deposits 2. Utility set-up fees or deposits 3. Health and safety assurances, such as pest eradication, allergen control, or non-recurring cleaning fees prior or upon return to the home. 4. Moving fees 5. Non-recurring rental insurance required for lease up. Goods may include: 1. Furniture, essential furnishings, and basic items essential for basic living outside the institution. For AFH Settings reference WAC 388-76-10685, and for Assisted Living Settings reference WAC 388-78A-3011 which outline resident unit furnishings in these settings. In the event a residential setting indicates they are unable to provide the required furnishings as outlined in WAC, notify the provider of their requirements as outlined in WAC, and also submit a referral to RCS to document the provider's inability to meet residential unit furnishings per WAC. 2. The provision of goods that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistances, such as purchasing a microwave. CTS cannot be used to authorize environmental modifications. If a client transitioning from a congregate setting needs an environmental modification completed prior to discharge, that service must be accessed via COPES or CTSS depending on eligibility.
What is not covered under CTS?	• Federal rules require that services do not include recreational or diversional items such as television, cable or DVD players. • CTS does not pay for items or services paid for by Medicaid or other programs and resources, through the state plan or waiver such as



	groceries available under the Food Assistance benefit. Roads to Community Living will allow a one-time pantry stocking for enrolled participants. Community Transition Services may not be used to furnish or set up living arrangements that are owned or leased by an AFH, ARC, EARC, ESF or AL facility. For eligible clients, state funded CTSS can be used in combination with federally matched CTS for items/services not covered under CTS.
How much can I spend?	The amount that can be used for CTS is \$2500. Note: If both CTS and CTSS funds are being authorized, the “combined” costs cannot exceed \$2500 without an approved ETR. CTSS ETRs are Local, CTS ETRs require a HQ approval by the CFC Program Manager.
Do I need to use a contracted provider?	If the DSHS payment system will pay directly for a service or item, a contract is required for all CTS providers. - Service providers such as pest eradicators, janitorial services and movers must be contracted with the CTSS contract and paid directly via ProviderOne. - Check to see if the provider has an existing contract for the service or goods that will be provided. - If there is not an existing contract, notify your local AAA Contracts Management team of the network capacity need. Providers must meet all other obligations associated with the contracting process such as background checks, Medicaid Provider Disclosure Statement and insurance requirements, when applicable. - For one-time payment for deposits or set up fees, the Special Considerations contract may be used. - NOTE: - A contract is not required if another payment mechanism is utilized. Options include: - Using a client services P-Card (state issued credit card available to HCS HQ staff); or - Authorizing a contracted provider to pay for rental deposits and community living set-up fees directly and be reimbursed. - Compensation to the contracted provider for issuing payment does not count towards the CTS \$2500 limit.
How do I authorize CTS?	- Perform a CARE assessment to determine/document the need and plan of care for the CTS. CTS needs are often captured in the Treatment table as “Community Transition Goods or Items” or “Community Transition Services” Program and/or Client Safety. - The Sustainability Goals screen in CARE may be used as part of transition planning and as a communication tool with contracted providers.



	- For CFC and COPES, move the assessment to <i>Current</i>. The CTS provider will be assigned the “Community Transition Goods or Items” or “Community Transition Services” Program treatment on the Supports screen as the paid provider. For RCL enrolled recipients, services may be initially authorized without a current assessment, though will need to be included and documented in a completed assessment. - Document the extent of services provided and the cost in the SER; for Nursing Facility discharges use Contact Code “NFCM.” - Assign the applicable Program RAC and authorize the items or services using the appropriate code(s). For CFC recipients, the total cannot exceed \$2500 without an HQ approved ETR. For RSW clients, add RAC 3056 “RSW-CFC ancillary services.” - Submit a DSHS form 02-615 Invoice Coversheet to DMS with all invoices, receipts, etc. Include verification that the client received the goods or services. - Send the client a Planned Action Notice reflecting CTS.
When do I authorize this service?	This is solely for one-time payments to help a client establish a residence (no ongoing services/items). Only if the client has needs beyond what is covered under CTS may state funded CTSS also be used. Under CFC and RSW programs, CTS funds can be accessed up to 30 days after discharge if the item/service is needed for a successful transition and no other resource is available. When Community Transition Services are furnished to individuals returning to the community from an institutional setting, the service is not considered complete and may not be billed until the participant leaves the institution and is enrolled in the CFC or RSW program. You may use CTS each time the eligible client is discharged from a Nursing Facility or State Hospital. Additional information can be found in CFC Chapter 7b.
Are ETRs allowed for CTS?	All CFC CTS funds that exceed \$2500 must have an ETR approval from the Community First Choice (CFC) Program Manager. Send CFC ETR requests by choosing “Pending HQ Approval” in processing status and Victoria Nuesca as the “Worker”. Send a notification email to victoria.nuesca@dshs.wa.gov with CTS ETR in the subject line.
Community Choice Guiding: SA263 Issuing Payment for AT Good present: SA266	- Community Choice Guiding (when leaving a Nursing Facility or State Hospital.) to include non-medical transportation services. - This service includes coordinating, educating, and linking the client to resources which will establish or return an individual to 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 the care plan. 3. Most clients receiving Community Choice Guiding services will benefit from concurrent authorization of both SA263 and SA266 service codes. See more information on Community Choice Guiding in Chapter 7b: COPES
Non-Medical Transportation T2003	Non-Medical Transportation can be used to support a client's non-medical transportation needs. Examples include supporting a client's reinstatement of benefits with Social Security or to visit Adult Family Homes for admission consideration. Non-Medical Transportation could also be used for other one-time transportation needs which will support a client's community living. For those AAAs which are not contracted with a local non-medical transportation provider, staff may utilize MedStar Transportation. The referral process for this Statewide contracted provider can be found in the appendix. To capture non-medical transportation in CARE, ensure that "Non-Medical Transportation" is reflected in the Treatment Screen and assigned to the paid provider in the Supports Screen. See more information on Transportation Services in Chapter 7b: COPES.

See *Which Program to Use: Transition and Sustainability Goods and Services* in the [Appendix](#) as a reference guide.

Community Transition or Sustainability Services (CTSS)

Community Transition or Sustainability Services (CTSS): CTSS are state funded non-recurring setup items or services necessary to assist individuals establish, resume or stabilize a home or community-based setting. WAC 388-106-0950 ; 388-106-0955 ; 388-106-0960 .	
Who is eligible for CTSS?	A client is eligible for community transition or stabilization services if they: 1. Meet eligibility criteria to receive long-term services and supports from home and community services; 2. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own home, or are living in the community and need stabilization services to remain there; and 3. Do not have other programs, services, or resources to assist them with these costs; and 4. Have needs beyond what is covered under the Community Transition Services (under CFC or RSW); or 5. Are not eligible for Community Transition Services (under CFC or RSW). 6. DDA clients who are being discharged from Nursing Facilities only.
What is covered under CTSS?	CTSS Goods may include:



CTSS Goods SA290 CTSS Services SA291 HCS ONLY: Amazon Desk Aid located in Appendix section.	1. Furniture, essential furnishings, and basic items essential for basic living outside the institution. For AFH Settings reference WAC 388-76-10685, and for Assisted Living Settings reference WAC 388-78A-3011 which outline resident unit furnishings in these settings. In the event a residential setting indicates they are unable to provide the required furnishings as outlined in WAC, notify the provider of their requirements as outlined in WAC, and also submit a referral to RCS to document the provider's inability to meet residential unit furnishings per WAC. 2. The provision of goods that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistances, such as purchasing a microwave. CTSS Services may include, but are not limited to: 1. Security deposits that are required to lease an apartment or home, including first month's rent. 2. Activities to assess need, arrange for, and procure necessary household furnishings. 3. Setup fees or deposits for utilities, including telephone, electricity, heating, water, and garbage. 4. Services necessary for your health and safety such as pest eradication and nonrecurring extreme cleaning.
What is not covered under CTSS?	CTSS does not pay for items or services paid for by other state programs or Community Transition Services. CTSS does not include recreational or diversional items such as television, cable, or gaming systems.
When do I need a provider contract?	If the DSHS payment system will pay directly for a service or item, a contract is required for all CTSS providers. • Check to see if the provider has an existing contract for the service or goods that will be provided. • If there is not an existing contract, notify your local AAA Contracts Management team of the network capacity need. Providers must also meet all other obligations associated with the contracting process such as background checks, Medicaid Provider Disclosure Statement, and insurance requirements, when applicable. • For one-time only payment for deposits or set up fees, the Special Considerations contract can be used. • NOTE: 1. A contract is not required if another payment mechanism is utilized. Options include: a. Using a client services P-Card (HCS Only State issued credit card); or b. Authorizing a contracted individual transition services provider to pay for deposits and set-up fees directly and be reimbursed. i. Compensation to the contracted provider for issuing payment does not count towards the CTSS \$850 limit.



How do I authorize CTSS?	You must: 1. Perform a CARE assessment to determine/document the need and plan of care for the CTSS. CTSS needs are captured in the Treatment screen in CARE as “Community Transition Goods or Items” or “Community Transition Services” with a comment indicating the nature of the service in the comment box. Assign the “Community Transition Goods or Items” or “Community Transition Services” Treatment to the paid provider in the Care Plan Screen. 2. If the client will <u>not</u> be discharging with long-term care services, document the client’s need and reason for the allowance in the SER. 3. The Sustainability Goals screen in the Client Details section of CARE may be used as part of transition planning and as a communication tool with contracted providers. 4. Complete the Housing Modification Property Release Statement (DSHS Form 27-147) for all environmental modification authorizations if the client has a rental agreement or does not own the residence. 5. Document all costs in the SER under Contact Code “NFCM”, for non NFCM transitions, use “Admin” Activity Code. 6. Authorize services and/or items using the appropriate code(s). The total cannot exceed \$850 without local ETR. 7. Submit a DSHS form 02-615 Social Services Invoice/Receipt Packet Cover Sheet to DMS with all invoices, receipts, housing modification property release statement, etc. Include verification that the client received the goods or services. 8. Send the client a Planned Action Notice for any CTSS. Note: To ensure accuracy and reduce unnecessary administrative work, CARE assessments may be moved to current as close as possible to the anticipated date of discharge. Finalizing the assessment near the discharge date minimizes the likelihood that multiple Interim Assessments will be required.
When do I authorize this service?	This is solely for one-time payments to help a client establish, resume, or stabilize a residence (no ongoing services/items). CTSS funds can be accessed if the item/service is needed for community living and no other resource is available. You may use the CTSS each time the eligible client transitions from an institution or for each occurrence of instability that threatens the loss of the client’s continued living in the community.
Are ETRs allowed for the CTSS?	Yes, all CTSS requests that exceed \$850 must have a local office ETR approval.

See *Which Program to Use: Transition and Sustainability Goods and Services* in the [Appendix](#) as a reference guide.



Assistive Technology (AT)

Assistive Technology (AT): These services should be considered for those clients who are eligible for assistive technology through RCL, RSW (known as CFC Ancillary Services) or CFC ([see chapters for additional information](#)). Assistive Technology funds may be used to purchase adaptive/assistive items and devices. Assistive technology is designed to:

1. Increase a person's functional independence &/or substitute for caregiver assistance with an ADL, IADL or health related task;
2. Maximize a person's health and safety;
3. Increase the likelihood that adults in institutional settings will transition to their own homes and communities.

For RCL Participants only:

Smart Care Device is an assistive technology option for in home clients on Roads to Community Living. The Smart Care Device is an AI device that interacts and engages with a client to provide support through proactive suggestions, cuing and reminders for ADL &/or IADL tasks or health-related activities, and accessing their community. This service would be captured as Technology Support Services in the Treatment screen and assigned to a paid provider in the Supports Screen. See [Chapter 29: Roads to Community Living](#) for additional details. For additional resources please see the [Assistive Technology SharePoint](#), HCS SharePoint site.

Technology Support Consultation and Technical Assistance is available. This option provides individualized AT recommendations by an assistive technology professional as well as technical assistance to ensure the client can incorporate AT into their daily life. This service would be captured as Technology Support Services in the Treatment screen and assigned to a paid provider in the Supports Screen. See [Chapter 29: Roads to Community Living](#) for additional details. For additional resources please see the Assistive Technology SharePoint HCS SharePoint sites.

Please see [Chapter 7b: Community First Choice](#) from the LTC Manual for more information on CFC Ancillary services that are offered to CFC and RSW recipients.

Social/ Therapeutic Leave

Social/ Therapeutic Leave: The Department will pay the nursing facility for a Medicaid resident's social/therapeutic leave up to 18 days per calendar year. See [WAC 388-97-0160](#).

What is covered under Social/ Therapeutic Leave?

Social/ Therapeutic leave gives NF residents an opportunity to participate in:

- Social/ Therapeutic activities outside the NF and beyond the care of the NF staff.
- Trial visits to less restrictive settings-more information below.

Social/ Therapeutic leave **must not** be used for medical care leave in another medical institution.



How is the NF paid?	The department pays for up to 18 days (24 hr. periods) per calendar year for each Medicaid resident's social/ therapeutic leave. The nursing facility must track the number of days spent per year. NFs are required to notify the department of social/therapeutic leave in excess of 18 days per year through a Notice of Action (DSHS form 15-031).
How do I know if an ETR is needed?	NFs and/or the resident can request additional Social/ Therapeutic leave from the department in excess of 18 days per year.
Are ETRs allowed for Social/ Therapeutic Leave?	1. Requests for ETRs for social/ therapeutic leave exceeding 18 days per calendar year may be approved with a local ETR. ETR should be submitted via the electronic ETR process in CARE. ETRs that promote resident independence are appropriate. 2. Any requests for over 18 days of leave must be approved prior to the client taking the leave. 3. If an ETR for leave exceeding 18 days per calendar year is approved or denied you must: • Notify the HCS Financial Worker using a Social Service/Financial Services DSHS 14-443 form, making a note in the Comments section; • Document approval/denial in the SER; and • Send a letter notifying the client of the approval or denial Note: Frequent or excessive social/therapeutic leave may indicate the resident has potential for NF discharge.
Trial Visits	Many nursing facility residents may choose to consider moving to a new living arrangement or an Adult Family Home or Assisted Living Facility as their preferred community services setting and may wish to have a trial overnight period before finalizing their decision. The client may use their social/therapeutic leave for this purpose. A trial visit is often paired with CCG services to support the coordination of the visit. The CCG may pay for the trial residential services with state funded Community Transition and Sustainability Services (RAC 3105) at the daily rate as outlined in CARE. Any trial visit would be reimbursed to the CCG under SA291 or SA295 for RCL enrolled participants.

Roads to Community Living (RCL)

Roads to Community Living is a statewide, demonstration project funded by the “Money Follows the Person” grant. The purpose of the RCL demonstration project is to investigate what services and supports will successfully help people with complex, long-term care needs transition from institutional to community settings. For clients meeting eligibility criteria, additional transition services are available while the client is in the nursing facility and for one year after they have moved to the community. See the [RCL chapter of the LTC Manual](#) for more information regarding eligibility and services offered. Send any inquiries or referral requests directly to: dshsaltsarclreferrals@dshs.wa.gov.



HCS Housing Resources

Home and Community Services has resources to increase access to permanent and affordable housing for its clients and continuously strives to expand the availability and utilization of services that support tenancy in independent housing centering on the following beliefs and values:

- Affordable housing is the foundation for stability and growth.
- Housing improves health.
- Income, age, ability, lack of family and friends, or past or current conduct should not prevent anyone from having a home.
- Each tenant holds their lease or mortgage and is responsible for maintaining tenancy.

There are affordable housing vouchers and subsidies the HCS Housing Team can help you access, and Supportive Housing available to HCLA clients to support their tenancy.

See the [Housing Resources for HCS Clients](#), Chapters 6a and 6b₂ of the LTC Manual for more information regarding eligibility and services offered.

State Funded Community Transition and Sustainability Services & Washington Roads

Community Transition and Sustainability Services (RAC 3105) and Washington Roads are additional state funded service packages created from the lessons learned and cost savings seen through the first year of the RCL project. In 2009, the Washington State legislature approved this additional funding to relocate adults from institutions and are available to assist with transition planning for clients who are not eligible through RCL and also as a resource for challenging or complex cases involving individuals who are currently living in the community, but who are at risk of losing their community setting.

See the CTSS/WA Roads, [Chapter 5a](#), of the LTC Manual for more information regarding eligibility and services offered.

RESIDENT RIGHTS

NFCMs should be familiar with resident rights and report any significant or repeated resident rights violation to the RCS Complaint Resolution unit (CRU) for review and investigation.

Single incidents, not classified as abuse, neglect, abandonment, or financial exploitation, may be handled through consultation and education with the provider or by involving the Long-Term Care Ombudsman Program. The Ombudsman program is responsible for protecting the rights of all residents and handling complaints from facility residents. The Long-Term Care Ombudsman can be contacted at 1-800-422-1384.



Residents of nursing facilities have the same civil and legal rights of all US citizens, plus additional resident rights. These rights can be found in [Chapter 70.129 RCW](#). Resident rights include, but are not limited to:

- Right to a dignified existence
- Right to self-determination
- Right to be fully informed
- Right to raise grievances
- Rights of access
- Rights regarding financial affairs
- Right to privacy
- Rights during discharge/transfer:
 - A facility cannot use the following reasons to transfer/discharge a resident*:
 - o Resident is disruptive, argumentative, and/or obnoxious.
 - o Resident doesn't follow facility policies or their care plan.
 - o Caring for the resident is too hard or costs too much.
 - o The resident refuses treatment.
 - o The resident's Medicare eligibility ended.
 - o The resident's savings is gone and they are now Medicaid-eligible, as described in the facility's policy for accepting Medicaid

*Unless the actions jeopardize the health and safety of themselves and/or other resident(s).

Facility Initiated Discharges

The Centers for Medicare and Medicaid Services (CMS) began an initiative to examine and mitigate nursing facility-initiated discharges in violation of federal regulations. Per CMS, a facility-initiated transfer or discharge is one that the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.

Before a long-term care facility transfers or discharges a resident, the facility must first attempt through reasonable accommodations to avoid transfer or discharge, unless agreed to by the resident.

Discharge Criteria for Nursing Facilities

There are very specific and limited criteria under which a nursing facility can initiate the discharge of a resident without the resident's consent:

- The resident no longer requires nursing facility level of care (see [NFLOC section](#))*
- The facility can no longer meet the resident's level of care needs**
- Resident poses a health or safety risk to themselves or others*
- The resident has failed to pay.
- The facility ceases to operate/closes.

*Documentation by a full CARE assessment is required.

**Documentation by a medical doctor is required.



Residents who are sent to the emergency room or hospital must be permitted to return to the facility unless the resident meets one of the above criteria. The facility may not evaluate the resident's behavior based on the behavior at the time of the transfer to the hospital.

Notification

The facility must provide written notification to the resident, resident's representative and state LTC Ombuds 30 days in advance of the date of discharge*. DSHS Form 10-237 can be used by the SNF to provide notice, but the SNF can develop and use their own notice as long as it includes the following:

- The reason for transfer or discharge;
- The effective date of transfer or discharge;
- The location to which the resident is transferred or discharged;
- A statement of the resident's appeal rights,
- LTC Ombuds information
- For residents with intellectual disability or mental health disorder, information regarding Disability Rights WA

*Exceptions: Other residents' health or safety would be in danger, the resident has urgent medical needs requiring a transfer or discharge, or the resident has not lived in the facility for 30 days.

Appeals

The resident has up to 90 days to appeal the facility-initiated notice of transfer or discharge. If the individual appeals notice, the facility cannot discharge the resident during the appeal process and by law, must assist the person in helping the resident prepare and file an appeal request.

As a case manager/social worker, you may need to intervene by having a conversation(s) with a provider to determine if a provider is trying to discharge a client in conflict with Chapter 70.129 RCW.

As an employee of DSHS, you are a mandated reporter:

Call and report any issues of abuse, neglect, exploitation, and abandonment of any nursing facility resident. This report will remain confidential within the limits provided by law. For additional information regarding abuse, neglect, self-neglect, exploitation or abandonment, see the [Adult](#)

[Protective Services web page](#). **1-800-562-6078**



OUT OF STATE NURSING FACILITY ADMISSIONS

WA State Clients Admitted in Recognized Bordering City Nursing Facilities

Medicaid clients admitted in recognized bordering city nursing facilities for stays of 30 days or less, who intend to return to Washington, may receive coverage, if eligible. [WAC 182-501-0175](#) lists the bordering cities as:

- Idaho: Coeur d'Alene, Moscow, Sandpoint, Priest River and Lewiston
- Oregon: Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater and Astoria
- Per WAC 182-502-0120, stays of greater than 30 days may be approved by HCLA HQ when the resident's needs cannot be met within the state.

The bordering city nursing facility must be contracted with WA State to receive payment. Prior to admission, the assigned CM should:

- Ask the out of state facility if they have a nursing facility contract with Washington State; and
- Verify a fully executed contract is in the ACD.
- Notify the HCLA's NH Payment Coordinator of out of state admission by emailing: NFRPaymentCoord@dshs.wa.gov
- Information regarding the rate for the bordering city SNF is determined by the NH Rates unit (if there are questions, the contracted SNF can contact them using the same email as above).

Follow the procedures listed in the "[DDA Nursing Facility Admission: From the Community Setting \(HCS/AAA/DDA Responsibilities\)](#)" section of this chapter. If the stay extends beyond 30 days, the client must do one of the following:

1. Move to a Washington State nursing facility;
2. Apply for benefits from the bordering state; or
3. Supply the NFCM with information to demonstrate that there is a definite discharge date planned within the subsequent 30 days (e.g. a statement from the client's physician stating that the client needs an additional 20 days of rehabilitation after the first 30 days expires.)

If a Washington State client applies for Medicaid from the bordering state and is determined not to be eligible, the NFCM must assist the bordering city Nursing Facility and the client in moving back to Washington within 30 days. Continue payment authorization until the move is complete. Document your efforts in a SER and notify NFRPaymentCoord@dshs.wa.gov if the client's stay exceeds 60 days.

Clients who are placed in out-of-state nursing facilities for emergency purposes may also receive coverage for their short stay per [WAC 182-502-0120](#). The NFCM must determine if the client meets nursing facility eligibility based on information available and notify financial.

Note: Children residing in the Providence Child Center are exempt from these requirements. Providence Child Center must comply with all PASRR requirements.



Clients Seeking Nursing Facility Care in Washington from Out of State

If a NFCM receives an inquiry regarding an individual seeking NF care in Washington and the individual is a resident of another state, encourage the individual or their representative to contact the facility to which the individual is interested in admitting. Individuals may not receive services in two states at the same time. If the individual is currently a resident of a NF in another state, staff at the discharging facility and staff at the admitting facility typically work together to arrange the transfer. If the individual is moving from another state and is not currently receiving nursing facility care out of state, the family and/or representative can work with the receiving NF to arrange the admission. If an admission date is known, the application process can be started on the [Washington HealthPlanFinder](#) website or through the local Home and Community Services office. However, the application for services cannot be finalized until the individual has made the move to the state.

ADMISSION OF DDA CLIENTS

From home/residential settings

The Case Manager must:

1. Work with the DDA to determine if nursing facility care is the most appropriate service for the client (see [DDA Admission: From the Community Setting \(HCS/AAA/DDA\) Responsibilities](#) for more information).
2. All clients entering the nursing facility must have a PASRR Level I screening completed prior to admission to the facility. If a PASRR Level 2 Assessment is required as a result of the PASRR Level I, verify that the Level 2 Assessment was performed prior to admission (see [PASRR FAQs](#) for more information). As part of the PASRR process, the DDA PASRR coordinator will determine if the client is appropriate for NF admission. This is not the functional eligibility determination. For those clients who only have a DDA PASRR RU assigned, the DDA PASRR coordinator will notify HCS for NFCM assignment. The assigned HCS NFCM will complete the [NFLOC determination](#).
3. If a DDA assessment in CARE has been completed and moved to current, either the DDA assigned case manager or the NFCM may use this information to complete the NFLOC and EBS eligibility determination questions on the NFLOC Tab. See the [section regarding NFLOC](#) for more information). The NFCM should consult with the DDA for co-assigned cases when necessary to determine NFLOC.
4. Review and authorize the admission, if appropriate.
5. Follow all other protocols found in the section on [Admission from Community](#) settings.
6. If requested, participate in inter-disciplinary team staffing or provide consultation to the DDA or other case managers involved with the resident.
7. DDA retains case management responsibility for transition planning in coordination with the NFCM.

From the hospital

The assigned Case Manager must:

1. Determine NFLOC within the first 10 calendar days of assignment and inform the public benefits specialist per the [DSHS 14-443](#) form.



- a. For each new NFLOC generated, six (6) EBS questions will be displayed in the lower half of the screen. CMs cannot exit the Nursing Facility (NF) Case Management screen unless all questions are answered.
 - b. Click on the save icon at the top left of the screen once the questions are complete before exiting.
2. Follow all other protocols found in the section on [Admission from the Hospital](#)
3. If requested, participate in inter-disciplinary team staffing or provide consultation to the DDA or other case managers involved with the client.
4. DDA retains case management responsibility for reassessment and transition planning in coordination with the NFCM.

Note: Children residing in the Providence Child Center or Bridges to Home are exempt from these requirements. Providence Child Center and Bridges to Home must comply with all PASRR requirements. DDADDA will coordinate with the Department of Children, Youth and Families (DCYF) case manager for these residents admitted to Nursing Facilities for children as necessary.

STATE FUNDED LONG-TERM CARE FOR NON-CITIZENS

The Home and Community Living Administration has limited state funding available for non-citizens in need of long-term care services outside of a hospital, but who are not eligible for federally matched Medicaid, Aged, Blind and Disabled (ABD) cash or Medical Care Services (MCS). New admissions into nursing facilities or residential settings under the state-funded long-term care program must be pre-approved by Emily Watts, Home and Community Services HQ, via email at: emily.watts1@dshs.wa.gov. For these state funded long term care recipients, any transition planning and transition services are paid for with state funded service packages. Use of these funds must receive prior approval by Emily Watts or her delegate. For more information reference [Chapter 5a: CTSS/WA Roads](#).

Further detail may be found at the [Social Service Authorization Manual](#).

HOME & COMMUNITY SERVICES PRIVATE HEALTH INSURANCE AND GOOD CAUSE DETERMINATIONS

Medicaid clients are required to cooperate in the identification and use of third party liability (insurance carriers) that may be responsible for paying for nursing facility care and other long-term care services. Clients may object to the options offered by their private insurance for a variety of reasons, including the location of the facility. The Department is allowed to exempt the client from cooperation if we have determined that there is “good cause” for the exemption.

If a client has third party liability (TPL) and resides in a facility that is a non-participating/non-network/non-contracted provider of the plan, the following process will occur:



1. The nursing facility will contact the insurance carrier to determine if they will pay a non-participating/non-network/non-contracted provider, or can decide to become a participating/network/contracted provider, if possible.
2. If the TPL has denied coverage and the nursing facility believes good cause exists, the nursing home must contact the client's case manager (NFCM) through the local HCS office.
3. The local NFCM determines if a client should be exempted from using their TPL if there is no DSHS participating/network/contracted nursing facility within 25 miles or 45 minutes from the client's current residence.
4. If there is a DSHS participating/network/contracted nursing facility within 25 miles or 45 minutes of the client's current residence, the NFCM will talk with the client and/or the client's representative about the possibility of moving to a facility that is within the insurance carrier's network.
5. The local NFCM, in coordination with their supervisor, will determine if good cause exists.

The final decision regarding good cause is made by the local HCS office:

1. To determine good cause, the local NFCM will evaluate the reasons why the client does not want to transfer to a participating network provider. Good cause can include a variety of reasons such as location, physical or emotional harm, or that a move to a different NF will cause transfer trauma.
2. The NFCM will document in the SER if good cause is approved or denied.
3. If approved, the NFCM must inform the HCA-Coordination of Benefits at 1-800-562-3022
4. If the client is deceased, no longer a resident at the facility, or no longer has the insurance, a local exception to policy to [WAC 182-501-0200](#) may be submitted by the nursing facility directly to Home and Community Services headquarters to the NFCM Program Manager.

Note: The Veterans Affairs Registered Nurses (VARN) or other designee of the Washington Department of Veterans Affairs shall complete all good cause determinations for all state Veteran's home admissions.

RULES AND POLICY

RCW 74.42.055	Discrimination against Medicaid recipients prohibited.
RCW 74.42.056	Department assessment of Medicaid eligible individuals – Requirements.
RCW 74.39.041	Community residential options—Nursing facility eligible clients
RCW 7.70.065	Informed consent-Persons authorized to provide for patients who do not have capacity while the person is in a hospital or skilled nursing facility setting

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WAC 388-96-781	Exceptional care rate add-on – Covered Medicaid residents; please submit requests to Jevahly.Wark@dshs.wa.gov
WAC 388-97	Nursing Homes; Resident Rights, Care and Related Services
WAC 388-106-0355	Am I eligible for nursing facility care services?
WAC 388-106-0360	How do I pay for nursing facility care services?

REVISION HISTORY

<i>Date</i>	<i>Made By</i>	<i>Change(s)</i>	<i>MB #</i>
7/2026	Jevahly Wark Desiree Vallejo Rebecca Kaiser	- Removed monthly and twice monthly EBS eligibility review. - Removed reference for Kroger Authorization Process - Updated all references from DDCCS to DDA	
4/2026	Julie Cope Jevahly Wark	- Clarified that nursing facilities residents who are receiving GCAP services must remain active. - Expanded Behavior Supports updated to remove the case management attendance at EBS meetings with SNFs. - Text box added to indicate Expanded Behavior Supports process for dual assigned DDCCS clients - Language added to include contact for SNF exceptional rate requests - List of contracted EBS facilities added to appendix - CARE assessment moved to current guidelines	
11/2025	Jevahly Wark Cassie Pizano	- Expanded Behavior Supports eligibility updated throughout the chapter. - EBS Supports in SNF (Roles and Responsibilities) Document updated in Attachment Library - Medstar forms added - Included Guardian & Conservatorship Assistance Program as part of the Specialized Nursing Facility programs which must remain active for case management.	
7/2025	Julie Cope	Updated ALTSA references to reflect Administration name change to Home and Community Living Administration (HCLA)	

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	Rebecca Kaiser Cassie Pizano	• Updated all DDA references to reflect their new divisional name of Developmental Disabilities Community Services (DDCS) • Added references to the SharePoint Site: NFCM Workspace for assigned Nursing Facility Case Managers. • Included a 60-day face-to-face discussion SER requirement for active NFCM cases. • Updated DSHS Form 14-456 Home Maintenance Allowance to include client ACES # • Updated Desk Aid for Amazon Business	
3/2025	Julie Cope Jevahly Wark Cassie Pizano	• Added clarification when a client no longer meets NFLOC, the chosen program in the Care Plan screen may remain blank. • Added additional clarification for DDA case manager's roles and responsibilities throughout the chapter. • Added clarification that HCS cannot enter an NFLOC in CARE if the case is not assigned to an HCS RU. • Removed the requirement for the case manager to complete PASRR Level 1 screening form. • Added link to NFCM Workspace within Client No Longer Meets NFLOC section. • Clarified transfer protocols for cases transferring from nursing facility settings to hospital case management. • Updated treatment name for CTS from "other" to "Community Transition Goods or Items" and "Community Transition Services" • Removed Bathroom Equipment from the transition resources table as this is a covered service under the Apple Health benefit. • Update to Expanded Behavior Supports referral, approval, and notification process. • Updated TCCS Referral Flow Document in Appendix and added TCCS Referral Email Template. • Updated Assistive Technology to include Smart Care Companion and Technology Support	H25-010

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		Consultation and Technical Assistance service descriptions.	
10/2024	Julie Cope	- Added a Note Box with Expanded Behavioral Supports referral considerations - Provided the TCCSAdmissionRequest@dshs.wa.gov mailbox for coordination support related to Specialized Nursing Facilities. - Clarified that residents receiving specialized nursing facility services must remain active with nursing facility case management. - Added MedStar statewide non-medical transportation referral process to appendix. - Included Chapter 3 hyperlink for additional information on the Address confidentiality Program.	H24-062
7/2024	Julie Cope	- Updated hyperlinks and formatting. - Provided instruction that the discharge date is to be entered in ProviderOne for MAGI and MCS participants. Previous P1 procedure only documented the discharge date when a client no longer met NFLOC.	H24-044
4/2024	Julie Cope	- Provided minor clarifications surrounding Transitional Care Center of Seattle and Expanded Behavior Supports. - ProviderOne requires a profile change to enter/edit this functional eligibility directly into the system. The date of discharge will now be communicated in ProviderOne directly for MAGI and MCS recipients. - Included additional transfer clarification for NFCMs whose clients become hospitalized. - Updated EBS Support Level Eligibility & Description and EBS/RSW Referral Flow chart in Appendix to reflect updated RSW Committee language.	H24-018
12/2023	Julie Cope	- Amended EBS in SNF HCS Coordination instructions to be consistent with MB H23-076 - Added updated EBS Service Level Description to Appendix. - Clarified PASRR Level 2 evaluation information. - Clarified length of time a case may remain active with NFCM.	H23-090

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		- Amended the Home Maintenance Allowance client letter. - Added Non-Medical Transportation (T2003) to the Community Transition & Transition Support Services section. - Included Trial Visit information under Social/Therapeutic Leave section.	
8/2023	Amanda Speck Julie Cope	- Added HCS Purchasing Card Process to Appendix - Added Hospital Swing Bed and Hospital Bed Readiness information. - Removed APS Funded Client Intervention Services from Transition Resources Section - Revised EBS approval and notification instructions to incorporate Eligibility form 11-130 & EBS Descriptions in the Appendix. - Clarified instruction for out-of-state Nursing Facility admissions in neighboring cities. - Clarified case coordination instruction for those cases shared with DDA.	H23-071
6/2023	Julie Cope	- NFLOC determination exclusion for PACE participants - Updated TCCS Referral Flow Chart to include Specialty Settings referral form	H23-039
11/2022	Julie Cope	- Updated NFLOC Documentation screen - HCS Decision Making for Transitions resources - Included RCL Referral mailbox - Updated TCCS Referral Form	H22-064
5/2022	Julie Cope	Included face to face assessments into NFCM Work Performance and Relocation Standards. Updated CTS Funding Limits. Incorporated DSHS Form 11-159 into EBS Eligibility, Added ALTA Housing Resources to the Transition Resource section, updated hyperlinks and screenshots, added Transitional Care Center of Seattle Admission Referral Flow & Supporting Client Transitions to the Community YouTube video to Chapter Appendix	H22-028
12/2021	Julie Cope	Added additional information on coordinating with MCOs. Refined Specialty Nursing Facility Program Note to include the TCCS Referral Flow hyperlink added in the Appendix.	H22-005
05/2021	Julie Cope	Amended HMA instructions, added Sample Letter for Home Maintenance Allowance replacing PAN, added Residential Furnishings WACs	H21-050

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2/2020	Julie Cope	Updated HMA PAN instructions in Transition Resources	H20-056
12/2019	Julie Cope	Updated MAGI Communication procedures with HCA to include direct entry of NFLOC determination in ProviderOne Added Kroger Authorization Process to Appendix	H19-066
9/2019	Julie Cope	Added Sample Letter for Social/Therapeutic Leave to Appendix	H19-048
7/2019	Julie Cope	Added Policy Regarding Case Management of SNF residents approved for Expanded Behavior Supports	H19-039

APPENDIX

Example of NFCM Weekly Tasks Schedule

NFCM Tasks	Monday	Tuesday	Wednesday	Thursday	Friday
Facility On Site Visits-2x a week		10a-4p		10a-4p	
NFLOC Determination/ Redetermination		During Visit		During Visit	
Weekly Transition Coordination Meetings (SNF & NFCM)		10a-12:00p			
PointClickCare Review -New Admissions/Transitions	9-10:00a		9-10:00a		
Face to Face CARE Assessment		During Visit		During Visit	
Supervisor on Site Visits each Quarter		10-12:00			
MCO Transition Coordination meetings <i>Every Other Week</i> (CCW, UHC, Molina, CHPW, Wellpoint, Humana)				1-3:00p	
DME Specialist referrals for Transition Coordination		11:30-12p			
Office/Desk Day for SERs, Referrals, Authorizations, Emails, Phone calls &					8-5:00pm

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NFCM Tasks	Monday	Tuesday	Wednesday	Thursday	Friday
Paperwork to DMS for imaging, case transfers.					
MDS Acuity Report and compare to SNF Census	Monthly				

Every On-Site Visit should include:

1. Meeting with SNF staff to prioritize CARE assessment of the day, debrief after CARE Assessment is completed identifying SNF Roles and NFCM next steps, and prioritize next three scheduled CARE assessments. Share Pending CARE assessment with SSD, Obtain Plan approval with Resident, SER Actions
2. Introduce self to each new admit (Intake) where NFLOC is needed and document NFLOC in NFCM Screen, SER and enter 14-443/P1. Work with SNF staff and client to ensure HMA is requested, when eligible.
3. Complete required documentation with clients to include 14-225, Rights and Responsibilities, Release of Information, Signature on Service Summary etc.
4. Confirm that LTSS Brochures, RCL Brochures, and NFCM Brochures are available for the Social Services Department, Admissions and the Business Office.

HCS Decision Making for Transitions/Authorized Representative

[ALTSA- How to Identify a Guardian](#)

[ALTSA Power of Attorney vs. Uniform Guardianship](#)

[HCS Decision Making for Transitions.pdf](#)

Amazon Authorization Process (NFCM Only)

[Desk Aid for Amazon Business](#)

Client Services Purchasing Card Process-HCS Only

HCS Purchasing Card

[02-615 Social Services Packet Coversheet](#)

Documenting NFLOC in CARE - YouTube



Nursing Facility Expanded Behavior Supports Service Eligibility & Description

[Expanded Behavior Supports Contracted Facilities](#)

[Expanded Behavior Supports in SNF-Support](#)

Transitional Care Center of Seattle

[TCCS Referral for \(Client Initials\).msg](#)

[TCCS Admission Request Flow Chart](#)

What Program to Use: Transition and Sustainability Goods and Services

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

Supporting Client Transitions to the Community - YouTube

MedStar Non-Medical Transportation Referral Process

[Non-Medical Transportation Request Process](#)

[Medstar Trip Request Form](#)

[Medstar Stretcher Transport Form](#)

CHAPTER 10: Nursing Facility Case Management and Relocation

Long-Term Care Manual



Sample Letters:

SAMPLE LETTER

(Print on HCS letterhead)

Date:

To: <<Nursing Facility>>

Subject: Nursing Facility Level of Care Determination

This notification is to inform you that I recently performed a review of the nursing facility level of care for <<Resident's Name>>, a resident of your facility, and determined that <<he/she>> does not meet nursing facility level of care and therefore is not eligible for Medicaid payment. Nursing facility level of care criteria is determined in WAC 388-106-0355.

You are required per RCW 74.42.450 to send the client a 30 day discharge notice following all notification requirements. Medicaid payment through ProviderOne will end 30 days from the date of this letter.

If you have any questions or assistance with discharge planning, please feel free to contact me directly.

Sincerely,

<<CM Name>>

Home and Community Services

CHAPTER 10: Nursing Facility Case Management and Relocation

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SAMPLE LETTER

(Print on HCS letterhead)

Date:

To: <<Nursing Facility>>

Subject: Nursing Facility Level of Care Re-Determination

This notification is to inform you that, based on a request for a Fair Hearing, I recently performed another assessment of the nursing facility level of care for <<Resident's Name>>, a resident of your facility, and determined that with additional information regarding care, <<he/she>> <<does>> meet nursing facility level of care and continues to be eligible for Medicaid coverage in the facility. Nursing facility level of care criteria is determined in WAC 388-106-0355. Medicaid payment through ProviderOne will continue.

All notices can be rescinded and the LTC Ombuds office should be notified of this change in determination.

If you have any questions or assistance with discharge planning, please feel free to contact me directly.

Sincerely,

<<CM Name>>

Home and Community Services

cc: <<Nursing Facility Resident>>

SAMPLE LETTER

(Print on DSHS Letterhead)

Date:

CHAPTER 10: Nursing Facility Case Management and Relocation

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To: <<NF Resident Name>>

Subject: Social and Therapeutic Leave

We received your request for an Exception to Rule, WAC 388-97-0160. You have requested additional social and therapeutic leave days.

The exception to rule (ETR) has been <<approved/denied>> for <<amount>> of days.

If you do not agree with the ETR decision, you may call your case manager with your concern. You also have the right to present your complaint in writing to your case manager's supervisor.

- Address your written complaint to "NFCM Supervisor of (Case Manager's Name)", or
- Ask your Nursing Facility Case Manager for the name of their supervisor.

Upon receipt of your written complaint, the Supervisor will review the ETR decision on your complaint and notify you in writing within ten (10) days of their decision.

If you are not satisfied with the Supervisor's decision, you have the right to send your written complaint to the Home and Community Services Regional Administrator for your region.

The Home and Community Services Regional Administrator or designee will review your written complaint and send you a written notice of his/her decision within ten (10) working days of receipt of the complaint. This notice terminates the complaint procedure.

If you have any questions or would like assistance with transition planning to another setting, please feel free to contact me directly.

Sincerely,

<<CM Name>>

Home and Community Services

cc: <<Nursing Facility>>

CHAPTER 10: Nursing Facility Case Management and Relocation

Long-Term Care Manual



SAMPLE LETTER

(Print on DSHS Letterhead)

Date:

To: <<NF Resident Name>>

Subject: Home Maintenance Allowance Income Exemption

This notification is to inform you that you have not been approved the Home Maintenance Allowance income exemption. Home Maintenance Allowance (HMA) eligibility criteria is outlined in [WAC 182-513-1380](#). You are not eligible for HMA due to:

- ☐ The HMA income exemption is allowed for a single institutionalized client or institutionalized couple. A married client whose spouse is not institutionalized is not eligible for the HMA.
- ☐ HMA is limited to a maximum six-month period; and requires a physician certification that the client or couple is likely to return to their community home within the six-month period. The physician will not certify the likelihood of your return to a community home.
- ☐ SSI only income. Upon Nursing Facility admission, your SSI income is exempted for three months; therefore, you are not eligible for a HMA.

If you have any questions and would like assistance with transition planning to another setting, please feel free to contact me directly.

Sincerely,

<<CM Name>>

Home and Community Services

cc: <<Nursing Facility>>



Working with the Consumer Directed Employer (CDE)

The purpose of this chapter is to describe the policy and procedure for social services staff when care planning and coordination with the Consumer Direct of Washington (CDE).

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Natalie Lehl Care Management Program Manager
Natalie.Lehl@dshs.wa.gov

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BACKGROUND

Consumer Direct Care Network Washington (CDWA) is the contracted vendor of the Consumer Directed Employer (CDE). CDWA serves as the administrative employer for all Individual Providers (IPs) of in-home personal care, respite services, and participants who receive personal or respite care. CDWA manages credentialing, payroll, and other administrative employer responsibilities. Clients select, schedule, supervise, and dismiss Individual Providers as their managing employer.

CDWA also manages Carina, a service that helps with matching clients and caregivers.

WORKING WITH CARINA THROUGH CDWA

CDWA can assist a client who needs help creating a job posting in Carina to find an Individual Provider. Carina posts are active for 60 days. If an Individual Provider is not found during the 60 days, CDWA will attempt to contact the client/authorized representative to confirm that an Individual Provider is still needed. If so, CDWA will re-post the job in Carina. If CDWA is unable to reach the client/authorized representative, they may follow-up with the Case Manager for care planning assistance or information.

Case managers may provide flyers to clients requesting additional information about Carina's services and how to sign up:

- [Carina, English Consumer-Case Manager One-Pager](#)
- [Carina, Spanish-Espanol Consumer-Case Manager One-Pager](#)

Additional resources are available in Carina for clients and Individual Providers that have a preferred language other than English:

- To update language preferences, click [here](#).
- To add language preferences to a Job Post, click [here](#).
- Downloadable flyer about Carina for INDIVIDUAL PROVIDERS in multiple languages: [Dropbox Folder](#)

AUTHORIZING TO CDWA

The CDE is considered the Medicaid provider for clients who receive personal care from an Individual Provider. When a client chooses to receive care from CDWA, the Case Manager (CM) will need to do the following:

- Add CDWA to the CARE plan and move the assessment to current. Case Managers should not wait until the Individual Provider is fully hired to move the assessment to current.
- Assign all tasks the Individual Provider(s) will complete to CDWA's ProviderOne ID #2148685-01. The ProviderOne name will appear as Consumer Direct Care Network (CDCN).



- Open an authorization using service code: T1019, U6.
 - Do not authorize using service code T1019 [no modifier].
 - For new clients, the start date of the CDWA authorization will be no earlier than the same day as the client's financial and functional eligibility start date.
- For initial service setup, complete electronic form DSHS 14-443 for HCS or DSHS 15-345 for DDA in Barcode Start date given should align with CDWA's authorization start date.
- If no Individual Provider has been identified, refer the client or Authorized Representative to Carina to pose an ad in search for an Individual Provider. If unable to use Carina, refer them to CDWA for additional assistance with this process.
- If an Individual Provider who is not already employed by CDWA has been identified by the client, the Individual Provider should be directed to CDWA's website to submit their online application.
- CARE notifications from CDWA will let a Case Manager know when an Individual Provider has been hired.

SENDING AND RECEIVING ASSESSMENT DOCUMENTS

Client Assessment Details and Service Summary must be sent to CDWA via CARE. For this to occur:

- Consumer Direct Care Network (CDCN) must be identified on the Support screen as a paid provider; and
- There must be an active authorization header to the Consumer Direct Care Network (CDCN) using ProviderOne ID #214868501
 - Service lines do not need to be created to send documents.

If staff try to send documents to CDWA prior to those two steps being completed, staff will receive an error message advising why the documents cannot be sent.

Staff will use CARE to select which assessment documents will be sent to the CDE. Upon review by the Individual Provider, the CDE will electronically sign the Service Summary/LTSS PE Care Plan/PCSP and return it electronically to DMS (Barcode) where it will be stored in the client's Electronic Record (ECR). A CARE Tickler will alert the Primary Case Manager when a CDWA signed Service Summary/LTSS PE Care Plan/PCSP is submitted to DMS. The Case Manager will enter an SER that the CDWA signed Service Summary/LTSS PE Care Plan/PCSP is visible in client's ECR.

For Development Disabilities Community Services, staff can send documents to CDWA through the CARE Web application by triggering the Slide Out from the Assessment History table. The necessary fields will be enabled if the assessment is in Current status.



Historical Service Summaries that need to be sent to CDWA will not be able to be sent via CARE. If a Service Summary for an assessment that is no longer in current must be submitted to CDWA:

- Secure email the Service Summary to InfoCDWA@consumerdirectcare.com
- Add in the subject line "Old Service Summary unable to send via CARE"

CDE NOTIFICATIONS & CARE

CARE functionality provides staff with important updates regarding client care with the CDE. CDWA has developed a [Notification Matrix](#). The notifications are sent to the primary Case Manager assigned to the client's case in CARE and are intended to provide staff advanced notice of changes that could impact client care. Supervisors can also view the notifications sent to staff; the functionality of CDE notifications screen mirrors that of the existing CARE Ticklers screen.

CDE Notifications include notices such as a client's Individual Provider(s) losing eligibility to work or a client at risk of losing CDE services due to nonpayment of client responsibility. These notifications are provided to give Case Managers the information needed to address potential gaps in care for clients.

Case Managers are NOT expected to address concerns with Individual Providers or make efforts to get them back in compliance.

For more information, review the CARE Help File/Assessors Manual.

CONTACTING CDWA

Client needs to contact CDWA:

Refer the client or their representative to CDWA's [Contact Us website](#) page:

- [CDWA's email address](#)
- Text: 877-532-8568
- Call: 866-214-9899

Case Manager needs to contact CDWA:

- Call the Case Manager ONLY line: 866-932-6468
- [CDWA's email address](#)
 - Please provide: Client name, ProviderOne ID, physical address, phone number, email, date of birth (DOB), preferred language, and gender.
 - Ensure outgoing emails are encrypted according to DDA, HCA and AAA local policy and ensure that NO personal health information (PHI) in the subject line.
 - For DDA, HCS, and AAAs within the DSHS firewall, you may include [DSHS Secure] within the email's subject line to encrypt.
 - [CDWA's email address](#) (can receive encrypted [Secure] emails).



Individual Provider needs to contact CDWA:

- All new Individual Providers should visit [CDWA's website](#) and click on the Careers tab.
- If an Individual Provider needs assistance, the Case Manager may refer them to:
 - [CDWA's email address](#)
 - Call: 866-214-9899
 - Text: 877-532-8568

NEW CLIENT AUTHORIZATION: NEW TO CDWA, NEW TO MEDICAID SERVICES

This process applies to all clients who are referred to CDE services, including clients:

- New to Medicaid services;
- New to CDE services who want to hire an Individual Provider as part of their care plan; or
- New clients utilizing both home care agency-based and CDE services simultaneously.

An Individual Provider match is **not** required for staff to issue an authorization and send the Client's Assessment Details and Service Summary to CDWA.

Instructions

Case Manager creates a CDWA authorization.

Case Manager will send the Assessment Details and Service Summary to CDWA using the "Send Documents to CDWA" menu option in CARE web.

If the Client knows who they would like to hire as an Individual Provider, they will contact CDWA with the Individual Provider's information. CDWA's Client Support Team will then verify if the Individual Provider is new to the hiring process or if they are an existing Individual Provider.

Note, the Case Manager can assist the Client with notifying CDWA if the Client requests. The following should be used when e-mailing this information to CDWA:

Case Manager will secure [email CDWA](#) with a the embedded subject line. CDWA applies email filters based on the subject and key words to direct the email internally to CDWA's Client/Individual Provider Support Team.

- **Subject Line of email:** "[CDWA new client / new to Medicaid services](#)"
- **Include in email if known, the Individual Provider's:**
 - Name
 - Phone number
 - Email, and
 - Mailing address



If an Individual Provider is **not** known, the CDWA Client/Individual Provider Support Team will use information from the client's Assessment Details and Service Summary to post the job in Carina, if the client needs assistance.

Case Manager will [email CDWA](#) with the Client/Authorized Representative (AR) contact information if it is not noted in the client's Assessment Details and/or Service Summary.

The CDWA Client/Individual Provider Support Team will attempt to identify potential Individual Provider matches and send the Individual Provider's information to the Client/AR. If CDWA is not able to contact the client to coordinate personal care, CDWA will notify the Case Manager via email. The Case Manager will notify the Client/Authorized Representative of potential Individual Provider matches.

CDWA is unable to guarantee an Individual Provider match will be made. The Case Manager is responsible for working with the Client/Authorized Representative to explore alternative personal care options if a match cannot be made.

The Client/Authorized Representative will be responsible for interviewing the Individual Provider (s) until an acceptable match is found based on schedule, needs, etc.

The Client/Authorized Representative will notify the CDWA Client/Individual Provider Support Team of their Individual Provider choice and keep the Case Manager updated throughout the process.

If more than one Individual Provider is chosen, CDWA will allocate hours per client's direction as the managing employer; if Client/Authorized Representative input is not provided, Individual Provider hours will be divided equally among the Individual Provider until client notifies CDWA otherwise.

CLIENT/INDIVIDUAL PROVIDER MATCHING PROCESS

An Individual Provider needs to be matched to a client in the CDWA system before the Individual Provider can complete the hiring process and provide services. New client/Individual Provider pairs need to be confirmed by the client, Individual Provider, or Case Manager before CDWA will match them in their system.

Case Managers will notify CDWA of a client/Individual Provider match via [CDWA's Contact Us website page](#).

- Under "Email Consumer Direct Care Network Washington", add their Name, Email, and Phone
- Choose "Case Manager" from the Select your Role drop-down
- Choose "Client/Individual Provider Match" from the Contact Reason drop-down
- Enter the Individual Provider information in the Message box



This information should be sent to CDWA as soon as a client/Individual Provider match is known. Providing this information to CDWA will result in faster client/Individual Provider pairing.

If this information is not shared by the Case Manager, the CDWA Client/Individual Provider Support Team will reach out to the Client/Authorized Representative via phone to confirm the match.

CDWA will determine the number of attempts that need to be made to contact the client, based on how quickly they can make the match. If CDWA is unable to contact the Client/AR, CDWA will call the potential Individual Provider, email the Case Manager to confirm the match, and get services started.

EMERGENT CARE NEEDS PROCESS

Sometimes a client has emergent care issues, such as:

- Left Hospital or Skilled Nursing Facility Against Medical Advice (AMA)
- Adult Protective Services Involvement
- Hospice
- Nursing or Wound Care involvement
- Other (with DSHS Supervisor approval)

When a client has emergent care issues and needs Individual Provider services urgently, the following steps should be taken:

- If the assessment has been completed, the Case Manager will:
 - Create a CDWA authorization.
 - Send the Assessment Details and Service Summary to CDWA using the “Send Documents to CDWA” menu option in CARE Web.
 - [Email CDWA](#) with the embedded Subject Line. CDWA applies email filters based on the subject and key words to direct the email internally to CDWA’s Client/Individual Provider Support Team.
 - Subject Line of email should read: “CDWA urgent hire required”
 - If the Individual Provider is already a CDWA employee, include the following information in the email, if known
 - Individual Provider name
 - Phone number
 - Email
 - Mailing address
 - If the Individual Provider is a new hire, send the Individual Provider to the [“Become a Provider”](#) tab on the CDWA website to begin the hiring process, include the following information in the email, if known
 - Individual Provider name
 - Phone number
 - Email
 - Mailing address



- Add the Client/Authorized Representative contact information if it is not noted in the client's Assessment Details and Service Summary.
- If the assessment has not been completed, the Case Manager will:
 - [Email CDWA](#) with the embedded Subject Line. CDWA applies email filters based on the subject and key words to direct the email internally to CDWA's Client/Individual Provider Support Team.
 - Subject of email should read: "CDWA urgent hire required"
 - Include basic information about the client in the email:
 - Name
 - Phone number
 - Mailing address,
 - Any information that will help CDWA create a Carina ad, such as, client is on hospice and appears to need assistance in the following areas...
 - If Individual Provider has been identified and is already a CDWA employee, include the following information in the email, if known:
 - Individual Provider name
 - Phone number
 - Email
 - Mailing address
 - If the Individual Provider is a new hire, send the Individual Provider to the "Careers" tab on the CDWA website to begin the hiring process, include the following information in the email, if known:
 - Individual Provider name
 - Phone number
 - Email
 - Mailing address
 - If the Individual Provider has not yet been identified, include the following basic client information in the email:
 - Name
 - Phone number
 - Mailing address
 - Any additional information that will help CDWA create a job post in Carina, such as, client is on hospice and needs assistance with the following Activities of Daily Living...
- One the assessment is completed, the Case Manager will:
 - Create a CDWA authorization
 - Send the Assessment Details and Service Summary to CDWA using the "Send Documents to CDWA" menu option in CARE Web.

CDWA will:

- Follow their urgent hire protocol, which includes setting up basic client information in the system so a client/Individual Provider match can be made.



- Assist the Individual Provider with the hiring process if needed or help an existing Individual Provider who needs to be matched with the client in CDWA's system.
- Post a Carina ad, if Individual Provider is not already identified, based on information from the Assessment Details and Service Summary, if provided, or the email from the Case Manager.
- Email the Case Manager when the Individual Provider has completed any necessary hiring activities, including Orientation & Safety (O&S) training if applicable, and has been issued an "OK to Provide Care" date.

FACILITY DISCHARGE PRE-AUTHORIZATION INDIVIDUAL PROVIDER REFERRAL TO CDWA

This only applies to clients who require an Individual Provider match prior to facility discharge or disenrollment from the TSOA or MAC programs.

The Case Manager will [email CDWA](#) with the embedded Subject Line, which should read "CDWA's new Client Pre-Authorization Individual Provider Referral". CDWA applies email filters based on the subject and key words to direct the email internally to CDWA's Client/Individual Provider Referral Support Team.

The following should also be included in this email:

- The client's Assessment Details and Service Summary to CDWA. This serves as confirmation to CDWA that the client is eligible for CDE services.
- The Client/Authorized Representative contact information if it is not noted in the client's Assessment Details and Service Summary.
- CDWA's Client/Individual Provider Support Team will use the client's Assessment Details and Service Summary to post the job in Carina.
- CDWA's Client/Individual Provider Support Team will attempt to identify potential Individual Provider matches and send the Individual Provider's information to the Client/Authorized Representative via phone. If CDWA is not able to contact the client by phone to coordinate personal care, CDWA will notify the Case Manager via email and the Case Manager will be expected to notify the Client/Authorized Representative of potential Individual Provider matches.
 - *CDWA is unable to guarantee an Individual Provider match will be made. The Case Manager is responsible for working with the Client/Authorized Representative to explore alternative personal care options if a match cannot be made.*
- Client/Authorized Representative will be responsible for interviewing the Individual Provider (s) until an acceptable match is found based on client's schedule, needs, etc.
- Case Manager will notify the CDWA Client/Individual Provider Support Team of the client's Individual Provider choice by e-mail.



- The CDWA Client/Individual Provider Support Team will assist the Individual Provider with the hiring process if needed or will help an existing Individual Provider who needs to be matched with the client in CDWA's system.
- The CDWA Client/Individual Provider Support Team will email the Case Manager when the Individual Provider has completed any necessary hiring activities, including Orientation & Safety (O&S) training if applicable, and has been issued an "OK to Provide Care" date.
 - The first date the Individual Provider could potentially work is dependent on the client's discharge date in coordination with the Client/Authorized Representative as the Managing Employer
- Case Manager will create the CDWA service authorization immediately following client's discharge from the facility or TSOA/MAC program.
- Case Manager will submit the client's Assessment Details and Service Summary to CDWA using the "Send Documents to CDWA" menu option in CARE Web

Case Manager will confirm that Individual Provider services have started either by contacting the client or CDWA for confirmation. Once confirmation has been received, the case may be transferred if applicable.

MAC AND TSOA ENROLLED PARTICIPANT & INDIVIDUAL PROVIDERS

When a care receiver chooses to receive care from CDWA, the Area Agency on Aging Case Manager/staff will need to do the following:

Referral Process in GetCare to CDE

- Ensure the person-centered care plan reflects personal or respite care services
- Click 'Send to CDE' button in GetCare
 - For TSOA Individuals – the button is located in the Care Plan Section in the care receiver's record and will show once the updated TSOA without a Caregiver assessment is locked.
 - For Dyads – the button is located in the Care Plan Section in the Caregiver Record and will show once the updated TCARE assessment is locked and a new care plan is initiated.
- Complete an Authorization Header to CDWA under the care receiver's record
 - Consumer Direct Care Network Washington (CDCN) ProviderOne ID 2148685-01
 - The care receiver will not be created in CDWA's system until this step has been completed.
 - Service Authorization subservice lines do not need to be created at this time. This allows the option for care receiver's or unpaid family caregivers, to utilize their step benefit level for other items/services, identified in their person-centered care plan, while the potential Individual Provider proceeds through the hiring process with CDWA.
- After the GetCare to CDE referral process is completed; AAA staff should contact CDWA with the potential Individual Provider's information, if known. Providing this information timely to CDWA will result in a faster care receiver and Individual Provider pairing.



- If no Individual Provider has been identified, direct the care receiver or Authorized Representative to begin searching for an Individual Provider. If the care receiver is unable to use Carina, refer them to CDWA for additional assistance with this process.
- If a potential Individual Provider who is not already employed by CDWA has been identified by the care receiver, the Individual Provider should be directed to CDWA's website to submit their online application.
- GetCare CDE notifications from CDWA will let the AAA staff know when an Individual Provider has been hired and is OK to provide care.

Authorizing to CDWA

- Upon receiving notification, the Individual Provider is near completion with the CDWA hiring process, or upon the care receiver's or care receiver's authorized representatives' choice, a CDWA subservice line authorization in the GetCare system should be entered.
 - For TSOA Individuals –
 - Ensure there is a locked GetCare care plan in place with personal care services identified.
 - Use service code: T1019,U6
 - For Dyads –
 - Ensure there is a locked TCARE care plan in place with respite care services identified.
 - Use service code: T1005, No Modifier

Communication with CDWA for the MAC and TSOA Programs

Potential INDIVIDUAL PROVIDER is Known:

- If the care receiver knows who they would like as an Individual Provider, they will email CDWA with the potential Individual Provider's information (AAA staff can assist the care receiver with notifying CDWA if the care receiver requests).
 - New/Potential Individual Provider: The CDWA Client Support Team will verify the new/potential Individual Provider is not in the CDWA system. Individual Provider should proceed through the [CDWA hiring steps/process](#). As the Individual Provider progresses through the CDWA hiring process, another contact to CDWA must be made by either the care receiver, care receiver's representative (cannot be the new/potential Individual Provider) or the AAA staff to match the new/potential Individual Provider and the care receiver together (*see Care Receiver/Individual Provider Matching Process instructions below*).
 - Existing/Active Individual Provider: The CDWA Client Support Team will confirm Individual Provider is Active and in good standing then will use this initial contact to match the Individual Provider with the care receiver.
 - **Email:** InfoCDWA@consumerdirectcare.com
 - **Subject of email:** "CDWA new client / new to Medicaid services" (CDWA will apply email filters based on the subject and key words to direct the email internally to CDWA's Client/Individual Provider Referral Support Team)



- **Include in email if known:** Individual Provider name, phone number, email, and mailing address

No Known Potential INDIVIDUAL PROVIDER:

- If a potential Individual Provider is **not** known, the CDWA Client/Individual Provider Support Team will reach out to the care receiver.
- If care receiver indicates they need assistance finding an Individual Provider; CDWA Client/Individual Provider Support Team will use the care receiver's TSOA Individual Assessment or the TCARE Caregiver Assessment and Referral Information for Respite Care Service Providers document and internal CDWA questionnaire to post the job in Carina.
 - *CDWA is unable to guarantee an Individual Provider match will be made.* The AAA staff will work with the care receiver or authorized representative to explore alternative personal or respite care support if a match cannot be made.
- The care receiver or authorized representative will be responsible for interviewing the Individual Provider (s) to determine if the match is acceptable based on schedule, needs, etc.
- If more than one Individual Provider is chosen, CDWA will allocate hours per the care receivers' or authorized representatives' direction; if the care receiver or authorized representatives' input is not provided, authorized hours will be divided equally among the Individual Providers until the care receiver or authorized representative notifies CDWA otherwise.

Care Receiver/Individual Provider Matching Process:

- An Individual Provider needs to be matched to a care receiver in the CDWA system before the Individual Provider can complete the hiring process and provide paid services. New care receiver/Individual Provider pairs need to be confirmed by the care receiver, authorized representative (cannot be the new/potential Individual Provider) or AAA staff before CDWA will match the Individual Provider /care receiver in their system.
- AAA staff may notify CDWA of a care receiver/Individual Provider match using the following methods:
 - Email: InfoCDWA@consumerdirectcare.com with details
 - Call: 866.214.9899, press 3 to get to the Hiring Team
 - CDWA website - <https://www.consumerdirectwa.com/contact/>
 - Under "Email Consumer Direct Care Network Washington", AAA staff should fill in their Name, Email, and Phone
 - Enter in the Care Receiver's ProviderOne ID
 - Choose "Client/Individual Provider Match" from the Contact Reason drop-down
 - In the Message box identify as the assigned primary case manager/AAA staff
 - Enter the Individual Provider information in the Message box
- Individual Provider matching information should be sent to CDWA as soon as a care receiver and Individual Provider match is known. Providing this information to CDWA will result in faster care receiver and Individual Provider pairing.
- If this information is not shared to CDWA, the CDWA Client/Individual Provider Support Team will reach out to the care receiver or authorized representative via phone to confirm a match. If CDWA is unable to contact the care receiver or authorized representative, CDWA will call the potential Individual Provider and email the AAA staff to confirm the match.



CDE to GetCare Notifications:

Functionality in GetCare system will provide AAA staff with important updates regarding care receivers personal or respite care services with the CDE. CDE to GetCare notifications are:

- Sent to AAA staff and Supervisors GetCare dashboards for the particular AAA with MAC/TSOA role/permissions.
- Notification type on the GetCare dashboard is CDE Notification. The status filter can be utilized to view All, Complete, or Incomplete notifications. The delete function on CDE Notifications has been disabled in GetCare.
- Intended to provide AAA staff advanced warning of changes that could impact care receiver care, such as a care receiver's INDIVIDUAL PROVIDER(s) losing eligibility to work
- To give notice to AAA staff so they can work with care receivers to address any potential gaps in care.
- Not sent for AAA staff to work with Individual Providers to get them back in compliance.

Emergent Care Needs Process:

Sometimes a care receiver has emergent care issues, such as:

- Left Hospital or SNF Against Medical Advice (AMA)
- APS Involvement
- Hospice
- Nursing or Wound Care involvement
- Other (with DSHS Supervisor approval)

When a care receiver has emergent care issues and needs Individual Provider services urgently, the following steps should be taken:

- If the TSOA without a Caregiver or TCARE assessment has been completed, the AAA staff will:
 - Complete the Referral process to CDE in GetCare steps outlined above.
 - Email CDWA at InfoCDWA@consumerdirectcare.com, to include the following information:
 - Subject of email: **"CDWA urgent hire required"** (CDWA applies email filters based on the subject and key words to direct the email internally to CDWA's Client/Individual Provider Support Team)
 - If the Individual Provider is already a CDWA employee, include the following information in the email, if known
 - ✓ Individual Provider name
 - ✓ phone number
 - ✓ email
 - ✓ mailing address
 - If the Individual Provider is a new hire, send the Individual Provider to the "Careers" tab on the CDWA website to begin the hiring process, include the following information in the email, if known
 - ✓ Individual Provider name
 - ✓ phone number
 - ✓ email
 - ✓ mailing address



- Ensure the Care Receiver and/or Designated Representative information is noted in the Contacts ribbon in GetCare so it populates on the TSOA without a Caregiver Assessment or the TCARE® Caregiver Assessment and Referral Information for Respite Care Service Providers document.
- If the TSOA without a Caregiver or TCARE assessment has not been completed, the AAA staff must:
 - Email CDWA at InfoCDWA@consumerdirectcare.com, to include the following information:
 - Subject of email: "CDWA urgent hire required" (CDWA applies email filters based on the subject and key words to direct the email internally to CDWA's Client/INDIVIDUAL PROVIDER Support Team)
 - Include basic information about the care receiver in the email:
 - ✓ name
 - ✓ phone number
 - ✓ mailing address,
 - ✓ any information that will help CDWA create a Carina ad, i.e., care receiver is on hospice and appears to need assistance in the following areas...
 - If Individual Provider has been identified and is already a CDWA employee, include the following information in the email, if known:
 - ✓ Individual Provider name
 - ✓ phone number
 - ✓ email
 - ✓ mailing address
 - If the Individual Provider is a new hire, send the Individual Provider to the "Careers" tab on the CDWA website to begin the hiring process, include the following information in the email, if known:
 - ✓ Individual Provider name
 - ✓ phone number,
 - ✓ email
 - ✓ mailing address
 - If the Individual Provider has not yet been identified, include the following basic care receiver information in the email:
 - ✓ name
 - ✓ phone number
 - ✓ mailing address
 - ✓ any additional information that will help CDWA create a job post in Carina, i.e. care receiver is on hospice and needs assistance with the following ADLs...

Once the TSOA without a Caregiver or TCARE assessment has been completed, the AAA staff must:

- Complete the 'Referral Process in GetCare to CDE' steps outlined above.



CDWA will:

- Follow their urgent hire protocol, which includes setting up basic care receiver information in the system so a care receiver/INDIVIDUAL PROVIDER match can be made.
- Assist the Individual Provider with the hiring process if needed or help an existing Individual Provider who needs to be matched with the care receiver in CDWA's system.
- Post a Carina ad, if Individual Provider is not already identified, based on information from the TSOA without a Caregiver Assessment or the TCARE® Caregiver Assessment and Referral Information for Respite Care Service Providers document, if provided, or the email from the AAA staff.
- Email the AAA staff when the Individual Provider has completed any necessary hiring activities, including Orientation & Safety (O&S) training if applicable, and has been issued an "OK to Provide Care" date.

Facility Discharge Pre-Authorization INDIVIDUAL PROVIDER Referral to CDWA

- The AAA staff will email the TSOA without a Caregiver Assessment or the TCARE® Caregiver Assessment and Referral Information for Respite Care Service Providers document to CDWA. This serves as confirmation to CDWA that the client is eligible for CDE services. The following should also be included in this email:
 - **Send an Email to:** InfoCDWA@consumerdirectcare.com
 - **Subject of email:** "CDWA's new Client Pre-Authorization INDIVIDUAL PROVIDER referral" (CDWA will apply email filters based on the subject and key words to direct the email internally to CDWA's Client/Individual Provider Referral Support Team).
 - The CDWA Client/Individual Provider Support Team will use the TSOA without a Caregiver Assessment or the TCARE® Caregiver Assessment and Referral Information for Respite Care Service Providers document to post the job in Carina.
 - The CDWA Client/Individual Provider Support Team will attempt to identify potential Individual Provider matches and send the Individual Provider's information to the care receiver/care receiver's representative via phone. If CDWA is not able to contact the care receiver by phone to coordinate personal care, CDWA will notify the AAA staff via email and the AAA staff will be expected to notify the care receiver/care receiver's representative of potential Individual Provider matches.

CDWA is unable to guarantee an Individual Provider match will be made. The AAA staff is responsible for working with the care receiver/care receiver's representative to explore alternative personal care options if a match cannot be made.
- Care receiver/AR will be responsible for interviewing the Individual Provider (s) until an acceptable match is found based on care receiver's schedule, needs, etc.
- AAA Staff will notify the CDWA Client/Individual Provider Support Team of the care receiver's Individual Provider choice by e-mail.



- The CDWA Client/Individual Provider Support Team will assist the Individual Provider with the hiring process if needed or will help an existing Individual Provider who needs to be matched with the care receiver in CDWA's system.
- The CDWA Client/Individual Provider Support Team will email the AAA staff when the Individual Provider has completed any necessary hiring activities, including Orientation & Safety (O&S) training if applicable, and has been issued an "OK to Provide Care" date.

The first date the Individual Provider could potentially work is dependent on the care receivers' discharge date in coordination with the care receiver/AR as the Managing Employer.

- AAA staff will create the CDWA service authorization immediately following care receiver's discharge from the facility.

PACE ENROLLED CLIENTS

PACE organizations (PO) are responsible for providing and paying for the Individual Provider services for their PACE enrolled participants. PACE organizations contract with Accentcare, a subcontractor that does INDIVIDUAL PROVIDER functions for them and works closely with CDWA.

PACE Organization Responsibilities:

The PACE organizations manage the following functions for PACE participants receiving Individual Provider services:

- Complete Authorizations in the ProviderOne System for Individual Provider services.
 - Authorizations with the user ID GutheBA in CARE are authorizations inputted in P1 by Beverly Guthery/Accentcare.
- Communication with the participant about the Individual Provider and the IND Individual Provider services they are receiving.
 - The PO works closely with the PACE participant to get an Individual Provider set up for them either via CDWA or a contracted home care agency.
- Perform home visits that include the INDIVIDUAL PROVIDER and participant and observe their living situations.
- Send copy of the care plan summary to CDWA.
 - Accentcare uploads the care plan created by the PO into a PACE specific email address created by CDWA for this purpose.
- Assignment of INDIVIDUAL PROVIDER hours and ongoing communication with CDWA about the INDIVIDUAL PROVIDER hours.
- Communicate with HCS/AAA if care plan changes to include an Individual Provider when an Individual Provider was not previously assisting the client.

HCS/AAA Staff Responsibilities:



- Confirm assessment is set up for in-home services and a PACE In-Home RAC is added to CARE.
- Ensure that tasks are assigned to the appropriate provider type and if informal support is being provided that it will not be impacted by the addition of the INDIVIDUAL PROVIDER.
- On the CARE Provider screen, add CDWA (P1# 214868501) as a provider in addition to PACE provider.
- On the CARE Support screen, assign CDWA to any task that the INDIVIDUAL PROVIDER will be expected to complete.
- If updates to CARE occurred, resend the Assessment Detail and MCO Service Summary to PACE org.

Note for HCS/AAA Staff with a PACE client:

- HCS/AAA staff should not change the status of authorizations created by user ID GutheBA as it disrupts IPs payments and creates rework for Accentcare to get the authorization back in place.
- HCS/AAA are not involved in setting up an IP for a client who has enrolled in PACE.
- HCS/AAA do not need to send a care plan summary to CDWA via CARE.

INDIVIDUAL PROVIDER MILEAGE WHEN A CLIENT TRANSFERS TO AN ADULT FAMILY HOME

Individual Providers can assist a client with moving into an Adult Family Home (AFH) and can claim mileage on the day that a client transitions. If the assessment for residential is moved to current prior to the transition, mileage is removed from the CARE plan.

When an assessment for residential is moved to current prior to the transition, CDWA can allow the INDIVIDUAL PROVIDER to claim mileage.

The Case Manager will take the following steps:

- Email the DSHS CDE mailbox (CDE@dshs.wa.gov) with the client's name, the Individual Provider's name, and the date that mileage needs to be paid. Include a note that the mileage is needed due to an AFH transition.
- The DSHS CDE team will notify CDWA.
- CDWA will work within their system to allow the Individual Provider to claim mileage.
- CDWA will notify the Individual Provider that the Individual Provider can claim mileage for that day.



INDIVIDUAL PROVIDER/CLIENT MATCH CONCERNS

Case Managers are required to notify CDWA when there are concerns about the care being provided to the client. Specifically, as per RCW 74.39A(4)(a)(b), the Case Manager must notify CDWA when:

- There is reason to believe an Individual Provider or prospective Individual Provider is not delivering or will not deliver the services identified in the plan of care; or
- The Individual Provider's performance is jeopardizing the health, safety, or well-being of the client.

CDWA will take appropriate action, including completing a new CC&S review as needed

NOTIFYING CDWA OF CHANGES TO HOUR ALLOCATION

Case Managers will use the authorization to communicate how many hours a client may allocate to their Individual Provider(s). CDWA receives this as updated information on a nightly batch and internally adjusts the available hours. CDWA has a portal for clients and Individual Provider s to use called Direct My Care. Clients can allocate hours in the portal. Individual Providers who live with the clients can claim their time in the portal. CDWA will use the following logic for allocation:

- For a 1:1 (one Individual Provider, one client), the entire authorization is allocated to the Individual Provider (up to the Work Week Limit (WWL) of the Individual Provider).
- A 1:1 allocation does not need to be confirmed in the portal. However, if the client wants to allocate less than the full number of hours, they can call CDWA, make the change in the portal, or have their Case Manager contact CDWA.
- For a 2+:1 (more than one Individual Provider, one client), CDWA will attempt to confirm allocations with the client. If unable, they will prorate/split the hours evenly. This is not preferred, because if the allocation is not sufficient, it may cause care to be interrupted until allocation is confirmed.
- CDWA cannot "schedule" hours and cannot shift hours without the directions of the client/AR or Case Manager on behalf of the client. Allocation of hours when there are multiple Individual Providers requires active engagement by the client/Authorized Representative.

UTILIZING COMMUNITY CHOICE GUIDE SERVICES FOR INDIVIDUAL PROVIDER HIRING PROCESS

Due to contract and policy rules, the role of a Community Choice Guide (CCG) is limited in terms of the type of assistance that may be provided in the Individual Provider hiring process. A CCG may assist a client in the following ways:

- Contacting CDWA when a specific Individual Provider is requested by the client. The CCG may call or email CDWA on the client's behalf and can include their (the CCG's) contact information.



- A Case Manager may include the CCG's contact information in the care plan as a contact for the results of a Carina job posting. This would give CDWA another point of contact instead of reaching out to the Case Manager when a match list has been generated.
- Setting up interviews with potential providers to determine if the match is acceptable according to the client's preferences.
- Assisting the client during the interview.
- Notifying CDWA that an Individual Provider has been selected.

COMMUNICATION WHEN CDWA CANNOT FILL AUTHORIZED HOURS

If authorized hours are not being utilized, CDWA will have a conversation with the client about any ongoing need for assistance to locate and hire another Individual Provider. If the client indicates that they no longer require assistance, CDWA will reach out to the case manager directly via e-mail.

HOW DO I KNOW IF AN INDIVIDUAL PROVIDER IS READY TO WORK?

Case Managers will receive an "OK to provide care" notification in CARE on the CDE Notifications screen. This notification will be sent when an Individual Provider is newly hired or there is a new match between a client and an existing Individual Provider.

WHAT IF CDWA CANNOT OPEN MY ENCRYPTED EMAIL?

If there is an issue with accessing secure emails to the InfoCDWA@consumerdirectcare.com address, CDWA staff will reach out directly to the Case Manager and request that the Case Manager email the CDWA staff directly at their CDWA email address. This allows CDWA staff to obtain a password and open the email.

WHAT IF A CLIENT IS HOSPITALIZED?

Contact CDWA to determine the number of hours the Individual Provider worked from the first of the current month to the date of the client's admission to the hospital. End date the authorization based on current policy.

HOW WOULD A CASE MANAGER CONTACT THE ASSIGNED SERVICE COORDINATOR (ASC) FOR A CLIENT, CARE RECEIVER, OR ASSOCIATED INDIVIDUAL PROVIDER?

Call the main number, 866-214-9899. Select Option 2 and enter the Client or Individual Provider's ProviderOne ID. The system will route you directly to the client's CDWA Assigned Service Coordinator if they are available at the time of your call. If the ASC is unavailable, you can leave a voicemail, and the ASC will call you back as soon as possible.

WHEN SHOULD I CALL THE CDWA CASE MANAGER LINE?

You can contact CDWA on the dedicated Case Manager line (866-932-6468) for escalations of issues or questions. This is a non-published number for Case Managers only and not for distribution to the public. It should not be used to inquire about new client and Individual Provider matches.

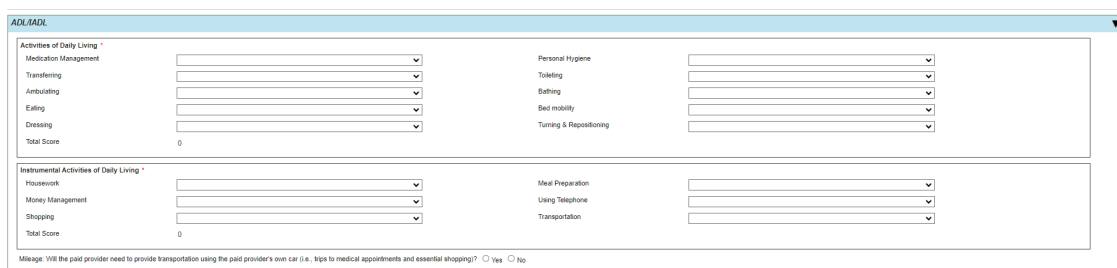
HOW IS MILEAGE ASSIGNED TO CDWA?

The CDE is “assigned” mileage by a status coding of ‘unmet’ or ‘partially met’ on the Medical Transportation and/or Essential Shopping screens within the assessment. If CDWA contacts staff requesting an authorization for mileage, check the Pending/Current assessment to make sure the assessment reflects this need.

For MAC and TSOA care receiver’s, the CDE is ‘assigned’ mileage by the ‘Yes’ selection on the TSOA without a Caregiver or TCARE assessment.

If CDWA contacts the AAA staff requesting an authorization for mileage, check the locked TSOA without a Caregiver or TCARE assessment Addendum for MAC/TSOA Dyads to ensure the assessment reflects Yes on “Will the paid provider need to provide transportation using the paid provider’s own car (i.e. travel to medical appointments and essential shopping?”

- TSOA without a Caregiver Assessment



- TCARE Assessment Addendum for MAC/TSOA Dyads

WHAT IF AN ASC OR CDWA REPRESENTATIVE CANNOT SEE TASKS FOR YOUR CLIENT?

Review the Supports screen to ensure tasks have been appropriately assigned to CDWA as a paid provider. If not, correct and re-submit AD/SS to CDWA. If tasks are assigned correctly, tell the Service Coordinator to refer the issue to their “data management team” at CDWA.

For MAC and TSOA Care Receivers check the CDE Transaction log in GetCare to ensure the assessment and client tasks were sent. If the CDE transaction log shows the successful send; tell the Service Coordinator to refer the issue to their “data management team” at CDWA.



HOW DO I ESCALATE UNRESOLVED ISSUES?

Most issues and complaints can only be addressed and answered by CDWA.

If HCS or AAA staff receive a complaint or have questions regarding a specific Individual Provider hiring issue the following actions should be taken:

1. Field staff will refer Individual Providers to CDWA (InfoCDWA@consumerdirectcare.com or 866-214-9899) for assistance or to file a formal complaint.
2. If field staff have an issue, they should contact CDWA on the Case Manager phone line or email at InfoCDWA@consumerdirectcare.com.
3. If field staff are having trouble getting their questions answered they should reach out to their regional CDWA contact. A CDWA contact list is available on the HCLA Intranet site.
4. If field staff have already sent it to the regional CDWA contact and have not gotten resolution, then they should send the issue to the State Director, [De'Shanel Childs](#) provide all the necessary background information including lack of response from previous attempts.
5. If the issue is still not addressed, contact the CDE Team at cde@dshs.wa.gov.

If DDA staff receive a complaint or have questions regarding a specific Individual Provider issue the following actions shall be taken:

1. Field staff will ask Individual Providers to contact CDWA either by phone, email, or text. Refer them to CDWA (InfoCDWA@consumerdirectcare.com or 866-214-9899) to get assistance or file a formal complaint.
2. If it's a payment issue that we previously addressed through our payment specialist in the old system, we will still address through our regional payment specialists.
3. For other issues, field staff should contact CDWA at 866-214-9899 (enter the client's P1 ID to be directed to the Service Coordinator) or email at InfoCDWA@consumerdirectcare.com.
4. If there is no resolution or issues remain confusing, CRM notifies supervisor.
5. Supervisor will reach out to their regional CDWA Program Manager. A [CDWA contact list](#) is available on the HCLA Intranet site.
6. If there is no resolution or issues remain confusing, supervisor notifies FSA (or designee)
7. FSA (or designee) will reach out to the CDWA area director;
8. If no response is received within 2 business days (or sooner if more urgent), FSA (or designee) escalates to the state director, [De'Shanel Childs](#), and provides all necessary background information including lack of response from previous attempts.
9. If still unresolved, FSA (or designee) will contact the CDE Team at cde@dshs.wa.gov.

*If the issue involves questions about DDA/HCLA processes, FSA (or designee) will contact the CDE Team at cde@dshs.wa.gov



CLIENT RESPONSIBILITY

Client Responsibility

Clients will pay any applicable client responsibility (participation) directly to CDWA, not to their Individual Provider. Clients will receive a monthly service statement from CDWA informing them of their client responsibility amount owed for that month. If clients don't pay their client responsibility, they will receive a 30-day termination letter warning them that their services provided by CDWA will be terminated unless the past due balance is paid within 30 days. Case Managers will receive notification in CARE when a client is at risk of losing their CDE services due to non-payment.

Unpaid Client Responsibility Process

Clients may be terminated from CDE services if their responsibility is not paid. Clients are notified via mail and telephone prior to CDE services being terminated. Individual Providers are notified via email and text messages. Notifications are issued 30 days, 15 days, 10 days, 5 days, and 1 day prior to service termination.

Case Managers will be notified, via the CARE CDE Notifications, when a client's CDWA services are at risk of termination.

Case Managers receive a notification via CARE at 30 days, 15 days, 10 days, and 1 day prior to the date of termination. During this time, Case Managers must work with clients to discuss alternative service options if all outstanding client responsibility is not paid in full. Prior to the 1-day notification, Case Managers should have a backup plan in place with the client. At no later than the 1-day notification, the Case Manager will:

1. Reach out to the client and confirm that services through CDWA are terminated effective the date on the notification.
 - a. In this situation the client is still eligible for personal care services from another provider; do not send a PAN.)
2. End date the CDWA authorization using the date identified on the notification.

Once the client meets their client responsibility payment requirements, CDWA will reactivate the client's account in their system, and will notify the Case Manager that the client responsibility account is paid. The Case Manager will use this information to open a new CDWA authorization with the start date being the date identified in the notification.

If the client pays participation before the end date identified on the notification and there is no break in service, the Case Manager will not adjust the authorization.

NOTE: Care receivers in the MAC and TSOA programs are not subject to client responsibility.

WORKING WITH ADULT PROTECTIVE SERVICES

APS information is confidential under RCW 74.34.095. This includes some communications with the CDE. APS will notify the CDE of a Substantiated finding (a finding to represent the action/inaction did impact the health, safety, or well-being of the client, or the plan of care was not delivered). An Unsubstantiated



or inconclusive finding means the Individual Provider's action/inaction did not jeopardize or cannot be confirmed that the client's health, safety, or well-being was jeopardized. APS does **not** provide a notification to the CDE of every allegation against an Individual Provider. APS will communicate concerns to the **Case Manager**. The Case Manager must share information that is relevant to the care planning with CDWA, but significant caution should be used on whether the investigation itself is relevant for care planning with CDWA.

It is appropriate for the Case Manager to contact CDWA regarding concerns about the care plan, the client's safety, or other concerns, but the APS investigation should not be the sole concern.

MEDICAID FRAUD REFERRALS

CDWA will report allegations of fraud to the Fraud In-Box at HCBSPProviderFraud@dshs.wa.gov. DSHS HQ staff will:

1. Review the allegation.
2. Determine if good cause should be granted based on feedback from CDWA and local office staff or if payment suspension is necessary.
3. Notify CDWA of the decision via email to CDWACompliance@consumerdirectcare.com.
4. Make the referral to the Medicaid Fraud Complaint Unit (MFCU) and provide updates as appropriate.
5. Complete overpayments if the referral is declined by MCFU

CDWA will send notice to the employee within 5 days of the payment suspension.

CDWA ADMINISTRATIVE FUNCTIONS

Character Competence and Suitability (CC&S)

The CDE is responsible for completing the CC&S when needed. HCS/AAA staff do not complete Character, Competence, and Suitability (CC&S) reviews for INDIVIDUAL PROVIDERS. CDWA may contact the Case Manager to provide input. Case Managers may also reach out to the CDE to provide additional information, or report concerns about a client/Individual Provider match. If a Case Manager has a concern about a current or potential Individual Provider/Client pairing, this information may be shared with the CDWA by sending an email to the appropriate CDWA supervisor, based on their contact list for Case Managers. All emails should be specific in their subject line. **For example:** Subject: Concerns with Individual Provider/Client pairing. CC&S may be needed.

INDIVIDUAL PROVIDER-Related PANs/Administrative Hearings



Case Managers staff no longer issue INDIVIDUAL PROVIDER specific Planned Action Notices (PANs), nor do clients or Individual Providers have hearing rights related to Individual Provider employment decisions as of full implementation of the CDE. Clients may use CDWA's dispute resolution process and Individual Providers may use CDWA's grievance and dispute resolution process to exercise due process.

Mileage and Training Authorizations

Mileage and training costs are included in the CDE rate. Case Manager no longer create separate authorization lines for mileage or Individual Provider training seat time.

Individual Providers claim mileage through CDWA's Direct MyCare portal, the Interactive Voice Response (IVR) system, or by calling CDWA. CDWA will be made aware of a client's eligibility for mileage through the assessment. Individual Providers will need to provide verification of driver's license and insurance to CDWA to be eligible for mileage reimbursement.

Travel Time:

Requests for Individual Provider travel time may be submitted by the client or Individual Provider Directly to CDWA. CDWA will approve or deny all requests for Individual Provider travel time.

Individual Provider Overtime/Work Week Limits (WWL)

Washington State statute limits the number of hours the Consumer Direct Employer (CDE) may pay any single provider in a work week (RCW 74.39A.525).

A work week limit (WWL) is defined as the total number of service hours an Individual Provider can provide in a work week. Service hours are defined as the time Individual Providers are paid by the CDE to provide personal care, relief care, skills acquisition training, or respite services under Medicaid state plan and 1915(c) waiver programs, 1115 waiver programs, Roads to Community Living (RCL), the Veteran Directed Care (VDC) program and programs funded solely by the state. The WWL and service hours do not include hours paid for required training, approved travel time, administrative time, or paid time off. All hours worked over 40 hours (including required training and approved travel time) will be paid as overtime.

Every Individual Provider is assigned a permanent WWL. Most Individual Provider have a permanent WWL of 40 hours. A relatively small number of Individual Provider who worked in January of 2016 have a permanent WWL that is more than 40. An Individual Provider's permanent WWL is greater than 40 hours if the average number of weekly service hours worked in January of 2016 was greater than 40. Permanent WWLs over 40 hours range individually from 40.25 to 65 hours per week.

The CDE tracks and manages the WWLs of all Individual Providers.

The client or their representative should contact the CDE if the Individual Provider needs their WWL temporarily increased. The CDE will follow the statutory guidelines to make a determination about temporary WWL increases. The CDE may contact the Case Manager to obtain additional information to make their decision.

Individual Provider Employment Verifications



CDWA uses The Work Number services from Equifax to help provide automated income and employment verifications.

Those wishing to verify an Individual Provider's employment with CDWA can:

- Visit www.theworknumber.com/verifiers, or
- Call The Work Number Client Service Center at 1-800-367-5690. The CDWA employer code is 29876.

CDWA's Electronic Visit Verification (EVV) Application

Individual Providers who do not live with the client they serve will utilize CDWA's EVV application, CareAttend. Individual Providers will also have the option to use CDWA's IVR system, or fob to claim time if they don't live with their client. A fob is a small device that is kept in the Client's home that displays a code at the start and end of their shift. Individual Providers would use the code as part of the clock in/clock out process. CDWA will provide training to Individual Provider on how to submit time.

Nurse Delegation

The Case Manager will open an authorization to Registered Nurse Delegator (RND) and send them the Nurse Delegation referral form. If the RND approves nurse delegation with an Individual Provider, the Case Manager will notify CDWA. CDWA will verify the Individual Providers credentials/training and will notify the RND if all requirements are satisfied. If Individual Provider lacks training, CDWA will initiate the training process and notify the RND once the Individual Provider is fully trained.

Please refer to [LTC Manual Chapter 13](#) for further guidance on when and how to make ND referrals.

Public Disclosure

Staff receiving a public records request for records relating to an Individual Provider should forward the request to: HCSPublicRecords@dshs.wa.gov.

The Public Records Coordinator (PRC) will review the request to determine what records are being requested, and who the owner of record is for the date range of the records requested.

- DSHS is the owner of Individual Provider records prior to the Individual Provider's first day of employment with the CDE.
- CDE is the owner of Individual Provider records that were created on or after their first day of employment with the CDE.

If the PRC determines the owner of record is the CDE, the requester will be referred to the CDWA: jeffh@consumerdirectcare.com. DSHS, will process records owned, maintained, or used by DSHS as usual.

In April 2022, the transition of Individual Providers to the CDE was concluded. The transition took place in phases and at the beginning of each phase, the PRCs received communication from the lead PRCs indicating which Individual Providers were employed by the CDE and no longer contracted with DSHS.

Collective Bargaining



The CDE will negotiate with the collective bargaining agent. A Rate Setting Board (RSB) has been established. Starting in 2022, this board will determine the labor and administrative rates that will be proposed to the legislature.

CDWA E-mail Correspondence

Specific email correspondences to CDWA are in place for CDWA to efficiently filter emails directly to the Client/Individual Provider Referral Support team.

To email CDWA when the **client is new to Individual Provider services or new to Medicaid**, click [here](#).

To email CDWA when a **client is leaving a facility or MAC/TSOA program and the hiring process needs to start prior to discharge**, click [here](#).

To email CDWA when a **client has an emergent care need**, click [here](#).

Emergency care needs include:

1. Left Hospital or SNF Against Medical Advice (AMA)
2. APS Involvement
3. Hospice
4. Nursing or Wound Care involvement
5. Other (with Supervisor approval)

To email CDWA when **related to Individual Provider background checks**, click [here](#).

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
10/2023	Natalie Lehl	Clarity and modifications in case management policy	
12/2023	Natalie	• Policy language updates to: • Working with Carina • Notifying CDWA of changes • New client authorizations • Communication when an INDIVIDUAL PROVIDER is ready to work	
07/2024	Natalie Lehl	• Updated Veteran Direct Care program name	
10/2024	Natalie Lehl	• Carina information flyers • Clarification on New to CDWA, New to Medicaid Authorizations • Add MAC/TSOA Policy • Fixed broken links	
03/2025	Natalie Lehl	• DDCCS Escalation Process updated • Corrected CDWA escalation contact	



		• Clarified process for sending/receiving documents to CDE and authorizing to CDWA • Updated Template	
07/2025	Natalie Lehl	• Updated HCLA/DDCS acronyms	
10/2025	Natalie Lehl	• Link to Notification Matrix added	
04/2026	Natalie Lehl	• Policy for sending historical service summaries added. • Additional step added to Medicaid Fraud Referral • Added additional resources and language options for Carina • Sending/receiving policy updated to align with CARE changes • CM instruction for contacting CDWA for CC&S added. • Added CDWA policy for notifying CMs of underused hours	

Adult Day Services

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Adult Day Services Program Manager

Kaila.Odell@dshs.wa.gov

Adultdayservices@dshs.wa.gov

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BACKGROUND

Adult Day Services (ADS)

Provide opportunities for adults with functional limitations to regularly attend a center where a variety of health, social, and supportive services are delivered in a safe, structured setting. Services are individualized to meet the unique needs of each participant and support their overall well-being, independence, and connection to their community.

For a general overview of Adult Day Services, refer to the [ADS Brochure DSHS 22-1731](#) which may also be used as a marketing and informational tool for clients and their families.

The primary goals of the ADS program are to:

- Provide both clinical and non-clinical services to address unmet client needs.
- Assist clients with activities of daily living (ADLs) to promote functional independence.
- Support clients in maintaining residency and engagement within their community or setting of choice.

Each client participating in ADS has a Negotiated Care Plan (NCP), and progress toward program interventions and goals is monitored and measured over time to ensure effectiveness and person-centered outcomes.

Table 12.1 Program Components

	ADULT DAY CARE (ADC)	ADULT DAY HEALTH (ADH)
Core services (e.g. help with ADLs, social services, health education, meals) are provided	Yes	Yes
Skilled nursing, therapy (e.g. PT), psychological/counseling services, and other services that require physician (or other prescriber) orders	No	Yes
Provide transportation to/from program	Assist client with resources	Yes

Visit [WAC-388-71-0702](#) for more details.

REMOTE/HYBRID PROGRAM	ADULT DAY CARE (ADC)	ADULT DAY HEALTH (ADH)
Core services (e.g. social services, health education) are provided	Yes	Yes
Skilled nursing, therapy (e.g. PT), psychological/counseling services, and other services that require physician (or other prescriber) orders	No	Yes

Note: Much of this chapter presents information through side-by-side comparisons of Adult Day Care (ADC) and Adult Day Health (ADH) programs. Where there are significant differences between these program types—or with the Remote/Hybrid ADS model—those distinctions are detailed in the respective sub-sections for Adult Day Care, Adult Day Health and Remote/Hybrid.

FUNDING & ELIGIBILITY

Adult Day Services (ADS) are available to clients who meet eligibility criteria under one or more approved Home and Community-Based Services (HCBS) funding sources. These services support adults with functional or health limitations who benefit from structured daytime programs that address their physical, social, and clinical needs.

Funding Sources: Please see LTCM [Chapter 7, 7d](#), etc. for more information on funding sources.

Eligible funding sources include, but are not limited to:

- Community Options Program Entry System (COPES)
- Roads to Community Living (RCL)
- New Freedom Waiver
- Medicaid Alternative Care (MAC) via the Area Agency on Aging (AAA)
- Tailored Support for Older Adults (TSOA) via the AAA
- Respite funds at ADCs that maintain an approved respite contract
- Senior Citizens Services Act (SCSA) funds for eligible clients aged 60 or older (verify with the ADC provider)
- Unique grants or other funding sources (verify with the ADC provider)
- Private pay

Eligibility Determination

Case Managers use the Comprehensive Assessment Reporting Evaluation (CARE) system to determine eligibility for Adult Day Services. Clients are eligible if they meet all the following criteria:

- Are age 18 or older; and
- Are assessed as needing one or more core services offered under Adult Day Care (ADC); and
- If applicable, are assessed as needing additional clinical or rehabilitative services provided under Adult Day Health (ADH).

Remote/Hybrid Participation

Remote or hybrid Adult Day Services (either ADC or ADH) may be authorized when in-person attendance is not feasible or appropriate due to medical, geographic, or safety factors.

Clients must meet certain requirements to qualify for Remote/Hybrid participation, such as:

- Living in a remote area where transportation to an ADS facility is not reasonably available.
- Having a medical condition that prevents transportation but still allows participation through virtual or remote means; or

- Temporarily being contagious or medically restricted (e.g., COVID-19 diagnosis, quarantine order, or temporary health-related isolation).

The overarching goal remains to transition clients for in-facility participation whenever possible. However, remote or hybrid participation may be authorized when it serves the best interests of both the client and the ADS program.

Case Manager Responsibilities:

- Evaluate eligibility and appropriateness for Remote/Hybrid participation on a case-by-case basis.
- Document rationale and authorization details within CARE; and Coordinate with the ADS provider regarding service delivery adjustments and review timelines

ADC Eligibility	ADH Eligibility
• Core Services: • Personal care • Routine health monitoring, overseen by a Registered Nurse. • Therapeutic activities • Supervised/protective environment as needed for client safety. WAC 388-106-0805	• All benefits included under ADC • Assessed as having an unmet need for skilled nursing or skilled rehabilitative therapy. • There is a reasonable expectation these services will improve, restore, or maintain the client's health. WAC 388-106-0300

Ineligibility Criteria

Clients are not eligible for Adult Day Services (ADS) when any of the following conditions apply:

- The client can independently perform the services or support that they would be provided through the Adult Day Care (ADC) or Adult Day Health (ADH) program, depending on their assessed service type.
- The client is not capable of safely participating in a group setting, based on behavioral, medical, or cognitive factors that would compromise the safety or experience of other participants.
- For Remote/Hybrid participants, the client can safely commute to the ADS facility and does not meet the criteria for remote service delivery.

<u>Ineligibility Criteria - ADC</u>	<u>Ineligibility Criteria - ADH</u>
• Have unmet needs that can be met in a more cost-effective manner. • Live in a nursing facility (NF), assisted living facility (ALF), adult family home (AFH), or other licensed residential or institutional facility.	• Live in a nursing home or other institutional facility (clients can live in an AFH or ALF) • Have care needs that: • Exceed the scope of authorized services the ADH can provide.

- Have care needs that: - Exceed the scope of authorized services the ADC can provide. - Can be met in a less structured setting. - Are being met by paid or unpaid caregivers.	- Do not need to be provided or supervised by a nurse or therapist. - Can be met in a less structured setting. - Skilled care needs are being met by paid or unpaid caregivers.
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REFERRALS

	ADC	ADH
1	Determine functional and financial eligibility.	
2	Based on CARE assessment results, discuss ADC/ADH/Remote option with client and/or their representative.	
3	If interested, provide clients and/or their representative with contact information for contracted ADC providers in their area so they can schedule a tour.	
4	After client has toured and agreed to attend, contact the client's chosen ADC provider. Complete the Adult Day Services Referral Form (DSHS Form 10-580) and fax or email the ADC provider the referral form along with the client's assessment details, service summary, and consent.	
5	Within 2 business days , the ADC provider must accept or deny the referral.	
6	If it is accepted, use CARE to conduct an interim, annual, or significant change assessment and: - Add ADC to the treatment screen. - Change status to "partially met" for all ADLs the client will receive help with at the ADC.	If it is not already completed, conduct an Initial, Significant Change or Interim assessment in CARE to complete the ADH screen, - Add ADH to the treatment screen. - Change status to "partially met" for all ADLs the client will receive help with at the ADH.
7	Authorize in-person ADC services in ProviderOne (P1), using: ** One-time intake code: S5102-UA - Full day (4 hours) code: S5102-HQ. - Partial day (less than 4 hours) code: S5100 in 15-minute units scheduled to attend	Authorize in-person ADH services in P1 using: **One-time intake code: S5102-CG 10-day trial period code: S5102-U9. Send PAN to client for approval of ADH intake and 10-day trial period, 10-day trial period RCL client, use code S5102-U9 - Full day (4+ hours) code: S5102-TG

	ADC	ADH
7A	Authorize ADC services in P1, for Remote/hybrid clients using: • ** One-time intake: code S5102-UA • Authorize in 15-minute units using code: S5100 U1. Full day in considered 4 hours billed at 16 units. • Providers can bill for a minimum of one (1) hour (4 units) per visit.	Authorize ADH services in P1 for Remote/hybrid clients using: • **One-time intake: code S5102-CG • Authorize visits in 15-minute units using code: S5100-U2. Full Day is considered four hours which would be billed as 16 units. • 10-day trial period: code S5102-U9. • Send PAN to client for approval of ADH intake and 10-day trial period, • 10-day trial period for RCL client, use code S5102-U9 • Providers can bill for a minimum of one (1) hour (4 units) per visit.
8	ADC Timeframes (from first day of attendance): • 10 paid service days: a) Complete intake evaluation in person b) Determine if and how it can/will meet the client's needs c) Develop preliminary service plan to-determine is client will be in-person or remote/hybrid. d) Give to client and/or their representative and to the case manager. • If not accepted, the preliminary service plan must include the reason(s) as to <i>why</i>. • 30 days: Develop and complete a Negotiated Care Plan (NCP) and send it to the case manager (<i>from accepting client to the ADC</i>)	ADH Timeframes (from first day of attendance): • 10 paid service days: a) Complete intake evaluation in person b) Develop preliminary service plan to determine if client will be in-person or remote/hybrid c) Obtain orders from client's health care provider for skilled services, and d) send preliminary service plan to case manager if client meets eligibility criteria. • 30 days: Develop and complete an NCP and send to the case manager (<i>from date of acceptance into ADH</i>)
9	Case manager will: • Provide the client's department service plan to the ADC center within five working days after the client or client's representative has signed it. • Send PAN to client for approval of ADC and Community First Choice (CFC) care plan hours.	Case manager will: • Send another PAN for approval of on-going attendance. • Review preliminary service plan. • Document a SER it was received. • Send copy to HIU. • Review NCP (same steps as preliminary).

	ADC	ADH
	• Review NCP • Document in a SER the NCP was received. • Send copy to the Hub Imaging Unit (HIU).	

****NEW: CASE MANAGERS NEED TO AUTHORIZE THE INTAKE FOR ALL PROGRAMS, ADC, ADH AND REMOTE/HYBRID. 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 PER HQ ADS PROGRAM MANAGER.**

ADULT DAY CARE (ADC)

Services

Adult Day Care (ADC) is a supervised, non-residential program designed to support adults with health or functional limitations who benefit from structured daytime services. ADC centers offer individualized opportunities for social engagement, routine health monitoring, and daily living assistance in a safe, community-based setting.

Services Provided

ADC programs provide or arrange for the following:

- Assistance with Activities of Daily Living (ADLs) to promote independence and personal care.
- Social services, including referrals for supports not covered under the COPES Waiver or RCL programs.
- Routine health monitoring by a Registered Nurse (e.g., baseline and periodic checks of vital signs, weight, and dietary needs).
- Therapeutic activities—such as recreation, relaxation, and group exercise—provided by qualified unlicensed staff or licensed professionals when physician orders are not required.
- Health education (e.g., nutrition or disease-management skills) delivered by qualified staff without physician orders.
- Nutritious meals and snacks, consistent with individual dietary requirements.
- Assistance arranging transportation to and from the ADC center.
- First aid and emergency care, including obtaining outside medical assistance when needed.

Applicability:

ADC serves adults whose health conditions do not require the direct intervention of a Registered Nurse or licensed rehabilitative specialist (e.g., Physical Therapist).

Refer to [WAC 388-71-0704](#) for additional program requirements.

ADC Remote/Hybrid

The Remote/Hybrid ADC model allows eligible clients to receive Adult Day Care services through secure telehealth platforms when in-person attendance is limited or not feasible. The ratio of remote to in-facility participation is determined individually, based on the client's needs and goals.

Service Delivery Requirements

- **Initial Intake and Assessment:**
 - Conducted in-person by a Registered Nurse or qualified staff at the ADC center primarily but if client cannot come to center, then the intake/assessment will be done at client's residence.
 - Clients must have an in-person reassessment at least quarterly following the initial intake.
- **Technology and Privacy Standards:**
 - Providers must maintain HIPAA-compliant IT policies and a Business Associate Agreement (BAA) with Zoom or Microsoft Teams, both approved by the Washington State HIPAA Compliance Officer (contact the ADS Program Manager for details).
 - Participant privacy must be always protected. ADC staff hosting telehealth sessions must be able to disable client cameras to ensure no video use occurs in private spaces such as bedrooms or bathrooms. Clients may control video settings at their discretion.
- **Program Content:**
 - Remote clients may join group sessions (e.g., nutrition education, community presentations, recreational or social events) via approved platforms.
 - Individual telehealth sessions may be used for health education, wellness checks, or routine engagement.
- **Assessment of Telehealth Readiness:**
 - Staff must evaluate whether the client can safely follow instructions and complete required activities independently.
 - Assess the client's and/or caregiver's technological ability to access telehealth services; provide training or refer to a Client Training contracted provider as needed.
 - Clients who are unable to follow instructions or physically perform required tasks without assistance are not appropriate candidates for telehealth ADC services.
- **Emergency Preparedness:**
 - ADC providers must maintain written emergency protocols for telehealth clients, including steps to take when a client cannot be reached or experiences a medical or behavioral emergency during a session.
 - Staff must receive training in identifying and responding to emergencies that could occur during telehealth service delivery.

Negotiated Care Plan (NCP) Review

When the ADC provider receives the DSHS plan of care, they will conduct their own intake/evaluation to assess their ability to meet the client's needs. The ADC must determine if it can meet the client's needs within **10 paid service days** of the client's first attendance date.

The ADC provider must develop an NCP within **30 days** of acceptance to the program which needs to be signed by the client or their representative. Care/case managers then review the NCP documentation for:

- Consistency with the client's DSHS authorized service plan.
- ADS services assigned to the ADC provider are being provided.
- How services and interventions provided by the ADC provider meet the client's identified needs along with the schedule of when and by whom they are or will be provided.
- Whether identified potential behavioral issues are documented and how they will be managed; **and**
- Contingency plan(s) for responding to emergent care needs or other crises.

After review:

- Enter a SER note via the initial, annual, or significant change assessment in CARE documenting receipt and review of the NCP.
- Send the client either the initial PAN or one specifically for ongoing ADC approval.

Continued authorization of services indicates approval of the NCP. ADC clients must be assessed for continued need and eligibility, at minimum, on an annual basis.

The ADC provider must report any changes in the client's condition or unanticipated absences of **more than 3 consecutive scheduled days**. **Report** to the client's case manager within 1 week. The case manager will determine if any updates to the assessment, service plan, or authorization are needed.

Authorizing Services

Authorize P1 payment for the intake evaluation for both ADC and ADC Remote/Hybrid.

Table 12.2 P1 Codes

ADC		CODE-COPES/RCL
ADC Intake *	One unit	S5102-UA
4 hours or more	Daily	S5102-HQ
Up to 4 hours	15-minute	S5100
REMOTE/HYBRID		CODES-COPES/RCL
ADC Intake *	One unit	S5102-UA
Up to 4 hours	15-minute	S5100-U1

Authorization and Service Continuation

- Authorization for client intake is a one-time approval per attendance cycle.
 - If a client discharges from services for six (6) months or longer and later returns, or if a significant change occurs in their CARE assessment, the intake code authorization must be reissued (“forced”) by the HQ ADS Program Manager.
- Current ADC rates are available on the ADS Rate Sheet [here](#).
- Transportation is not included in the ADC daily rate.
 - ADC providers are encouraged to assist clients in identifying transportation options; however, they are not required to provide or arrange transportation.
 - Refer to the P1 Manual for additional information regarding transportation guidelines and reimbursement parameters.

Authorization Duration:

- Authorize ADC services in P1 for up to one (1) year. In general terms the client can go to ADC three (3) times a week for four (4) hours each visit.
- Terminate authorization if any of the following occur:
 - The ADC provider fails to meet NCP requirements.
 - The client no longer meets ADC eligibility criteria; or
 - The client voluntarily discontinues participation in the ADC program.

ADULT DAY HEALTH (ADH)

Services

Adult Day Health (ADH) provides a supervised, non-residential program that combines core services from Adult Day Care (ADC) with additional skilled nursing, rehabilitation, and psychological support services.

- In addition to the core ADC services, ADH centers provide:
- Skilled nursing and skilled therapy (e.g., physical, occupational, or speech therapy).
- Psychological services, including assessment of psychosocial needs, cognitive status (e.g., dementia), potential abuse or neglect, and substance use (alcohol and/or drug misuse).
- Intermittent supportive counseling for participants and caregivers.
- Refer to [WAC 388-71-0706](#) for detailed service definitions and regulatory standards.
- Transportation - The cost of transportation is included in the ADH daily rate; therefore, ADH providers are responsible for providing or arranging transportation for program participants.
-

Physician Orders

- Physician orders are not required to begin the referral or intake process but must be obtained prior to initiating skilled services.
- The presence of physician orders does not automatically establish ADH eligibility, but such orders are useful in assessing the need for skilled nursing or rehabilitative therapy.

- **Electronic signatures** are permitted on person-centered service plans, orders, and other required documentation unless otherwise specified.
 - The person-centered service plan must be finalized and agreed to in writing in accordance with [42 C.F.R. § 441.540](#).
 - Signatures may be provided in any format that demonstrates the signatory's agreement with the person-centered service plan, including handwritten (wet), electronic, stamped, or other legally recognized signature formats.
 - The signature must clearly identify the signatory and be attributable to the individual signing the document.
 - Electronic signatures must comply with applicable federal and state requirements, including [chapter 1.80 RCW](#).

Provider Responsibilities:

- The ADH center must obtain written physician orders for all care provided or supervised by licensed nurses or therapists, as required by state practice laws.
- These orders must specify:
 - The scope and frequency of care to be provided.
 - The frequency required medical review by the prescribing provider.
- Orders must be in place before skilled services begin and must be updated as follows:
 - Upon initial authorization.
 - When a significant change occurs in the participant's condition or nursing interventions; or
 - At least annually, whichever comes first.

Refer to [WAC 388-71-0712](#) and [WAC 388-71-0714](#) for additional regulatory guidance.

Skilled Nursing Services

Skilled Nursing Services under ADH exceed the level of routine health monitoring and general health education provided in ADC. These services are medically necessary and are delivered with the reasonable expectation that they will improve, maintain, or slow the progression of a client's disease or functional decline.

- Skilled nursing services are provided by a Registered Nurse (RN) under physician authorization or by a Licensed Practical Nurse (LPN) under RN or physician supervision, in accordance with the Nurse Practice Act.
- Physician orders must be obtained:
 - When required by applicable state nursing practice laws.
 - Upon initiation of services; and
 - Updated whenever a significant change occurs in the client's condition, care plan, or at least annually.

Table 12.3 Skilled Nursing Services

INCLUDES	DOES NOT INCLUDE
• Skilled care and assessment of an unstable or unpredictable acute or chronic medical condition. • Skilled nursing tasks (e.g. medication administration, wound care, inserting or irrigating a catheter). • Time-limited training to teach the client and/or their caregiver self-care for newly diagnosed, acute, or episodic medical conditions (e.g. self-administration of an injection, colostomy care, disease self-management). • Evaluating and managing a plan of care when skilled nursing oversight is needed to ensure that complex, non-skilled care is achieving its purpose.	• Coaching or reminding the client. • Medication assistance when client is capable of self-administration <i>or</i> is having this need met by paid or unpaid caregivers. • Continued teaching/training when it is apparent the training should have achieved its purpose, or the client is unwilling or unable to be trained (excluding language barriers in the absence of a trained interpreter/translator). • Group teaching/training or therapy where 3 or more clients are simultaneously being treated or trained by the nurse. • Routine monitoring of a medical condition that does not require frequent skilled nursing intervention.

See [WAC 388-71-0712](#) for more details.

Skilled Rehabilitative Services

Adult Day Health (ADH) centers must offer one or more of the following therapeutic rehabilitative services as part of their program scope:

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech-Language Pathology (SLP)
- Audiology

Service Standards:

- Skilled rehabilitative services are considered medically necessary when provided with the reasonable expectation of improving, maintaining, or slowing the decline of a client's functional abilities.
- These services must be provided or directly supervised by a licensed therapist in accordance with each discipline's professional scope of practice and applicable state laws.
- Physician orders for rehabilitative services must be:
 - Obtained prior to initiation of services;

- Updated whenever a significant change occurs in the client's condition, treatment plan, or functional status; and
- Reviewed and renewed at least annually to ensure ongoing clinical appropriateness.

Table 12.4 Skilled Rehabilitation Therapy

INCLUDES	DOES NOT INCLUDE
• Assessing baseline mobility, strength, ROM, endurance, balance, and ability to transfer • Assess speech, swallowing, auditory, and communication disorders. • Providing 1:1 and group treatment to develop, restore, or maintain functioning, slow decline, or relieve pain. • Creating an individualized exercise, strength, mobility, or endurance plan) • Training clients and/or their caregivers in use of supportive or adaptive equipment • Providing other medically necessary services that can only be provided or supervised by a therapist. • Training/teaching clients and/or their caregivers in managing care needs. • Evaluating and managing a plan of care when skilled therapist oversight is needed to ensure complex, non-skilled care is effective.	• Reminding/coaching the client in tasks that are not essential to the skilled therapy or intervention per the client's service plan. • Monitoring a medical condition that doesn't require frequent skilled therapy interventions. • Massage therapy. • Teaching/training when it is apparent the training should have achieved its purpose, or the client is unwilling or unable to be trained (excluding language barriers in the absence of a trained interpreter/translator). • Group therapy/training where ratio of licensed therapists and staff assistants to clients is inadequate to ensure that for each client the group activity: ○ contributes to their planned therapy goal(s). ○ meets their complexity of individual needs.

See [WAC 388-71-0714](#) for more details.

ADH Remote/Hybrid

The Remote/Hybrid ADH model allows for telehealth delivery of Adult Day Health services when in-person participation is temporarily or permanently limited. The percentage of telehealth-based service delivery will vary based on each participant's individual needs and established care goals.

Service Delivery Requirements

- Initial Intake and Assessment:

- Conducted in-person by a Registered Nurse (RN) and, when applicable, a Physical Therapist (PT) or Occupational Therapist (OT) if those disciplines are included in the client's care plan.
- Assessments must occur either in the client's residence or at the ADH center.
- Clients must be seen in-person at least once per quarter following the initial intake and comprehensive assessment.
- Technology and Privacy Standards:
 - ADH providers offering telehealth services must maintain HIPAA-compliant IT policies and a Business Associate Agreement (BAA) with Zoom or Microsoft Teams, both approved by the Washington State HIPAA Compliance Officer.
 - Client privacy must be safeguarded. ADH staff hosting the telehealth session must be able to disable client cameras to prevent use in private settings such as bedrooms or bathrooms. Clients may enable or disable video at their discretion.
- Program Content:
 - Clients may attend group sessions for nutrition training, community presentations, and similar activities via Zoom or Teams, in addition to one-on-one therapeutic or nursing sessions.
- Telehealth Suitability Assessment:
 - During the initial assessment, the provider must evaluate the client's ability to follow directions and perform tasks independently.
 - If a client cannot follow instructions, perform required tasks safely, or lacks adequate caregiver assistance, they are not eligible for telehealth delivery.
 - The client's or caregiver's technological capacity must be evaluated. Training or support may be arranged through a Client Training contracted provider to support access to telehealth services.
- Emergency Preparedness:
 - ADH providers must maintain written emergency protocols for telehealth clients, including procedures when staff cannot reach a client or when emergencies arise during a session.
 - Staff must receive training in identifying and responding to emergency situations that may occur during telehealth service delivery.

Negotiated Care Plan (NCP) Review

Unlike Adult Day Care, ADH centers may either develop a preliminary service plan or a Negotiated Care Plan (NCP) within the first 10 paid service days of the client's attendance. If not completed within this period, the NCP must be finalized no later than 30 calendar days following intake.

- Review and Ongoing Requirements
 - Every 90 days, the ADH provider must review each service and goal in the NCP to determine whether skilled services are still required—or sooner if the client's condition changes.
 - Care/Case Manager Review
 - When reviewing an ADH NCP, the Care/Case Manager must verify:
 - Remains consistent with the client's DSHS-authorized service plan.
 - ADS services assigned to the ADH provider are being provided.
 - Physician or other health care provider orders are current and cover all skilled nursing and rehabilitative therapy services.
 - The client has consented to follow-up with the prescribing provider for continued skilled services.

- Goals are time-specific, measurable, and individualized, and do not exceed 90 days from the date of signature.
- The client's choices and preferences for care and services are clearly documented and accommodated.
- The NCP describes how each service or intervention addresses the client's identified needs, including frequency and responsible provider.
- Any behavioral concerns are documented along with management strategies.
- A contingency plan is in place for emergent care or crisis situations.
- A discharge or transfer plan is documented.
- After Review
- Enter a Service Episode Record (SER) note in CARE under the initial, annual, or significant change assessment, documenting receipt and review of the NCP.
- Send the client either the initial Payment Authorization Notice (PAN) or a subsequent PAN specific to ongoing ADH approval.
- Continued authorization of services constitutes approval of the NCP.
- Discharge or transfer plan.

After Review

- Enter a Service Episode Record (SER) note in CARE under the initial, annual, or significant change assessment, documenting receipt and review of the NCP.
- Send the client either the initial Payment Authorization Notice (PAN) or a subsequent PAN specific to ongoing ADH approval.

Continued authorization of services constitutes approval of the NCP.

ADH Service Authorization

- Authorize P1 payment for the intake evaluation plus 10 units of service for the trial period.
 - This 10-day trial period allows the ADH center to evaluate its ability to meet the client's needs and develop a preliminary service plan.
- Upon review and approval of the Negotiated Care Plan (NCP) and confirmation of client eligibility for ADH:
 - Approve P1 payment for up to 12 months. – The frequency of the visits should be listed in the NCP or by confirmation from the provider. It can be up to three (3) times a week for four (4) hours each visit. For ADH clients this is dependent on the necessary skilled tasks required.
 - The service authorization must include:
 - Name of the ADH center.
 - Number of authorized attendance days per week.
 - List of skilled nursing and/or rehabilitative therapy services to be provided.
 - Authorization timeframe, including start and end dates.

Table 12.5 P1 Codes

ADH	COPES/RCL	MODIFIER
Intake Evaluation*	S5102	CG
10-Day Trial Visit	S5102	TG
10-Day Trial Visit RCL	S5102	U9
Daily Rate (4-hour day)	S5102	TG

Current ADH rates are [here](#). Transportation *is* paid for within the daily rate for ADH. Refer to the P1 manual for further information. Continue to use P1 to enter, authorize, change, and terminate payments.

*Authorization for client intake is a one-time approval **per attendance** cycle. If the client discharges from services for 6 months or longer then returns or has a significant change in their assessment the intake code authorization will need to be forced by the HQ Program Manager. When terminating authorization for an Adult Family Home (AFH) client, send a notification to both the ADH and AFH provider. When terminating ADH based on ineligibility, list the effective date on the PAN 10 days later than the mailing. Clients should be given the opportunity to reduce the current number of attendance days to 1-2 days/week to ensure a successful and effective transition.

Assigning Needs to ADS Provider

The ADS provider is considered informal support and needs to be listed in CARE as the provider of the respective ADL tasks per the NCP.

Continue to add Adult Day Care program in CARE as a *Treatment* in the *Medical* screen, as applicable.

In CARE, you must consider Adult Day Care as Informal Support when assessing Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) *Status* and *Assistance Available* questions in the *Ongoing* section.

Use the status adjustment on the ADL and IADL, instead of a manual deduction for assessment where there is Adult Day Care Program in the plan of care. Change status to “*partially met*” for all ADLs and IADLs the client will receive assistance with at the Adult Day center.

Because the ADH provider is considered an unpaid caregiver, they need to be listed in collateral contacts on the CARE “Supports Screen”. ADH is listed on the “Treatment Screen” with the provider type as ADH.

Transferring Client from HCS to the AAA

For new in-home or ADH-only clients: HCS will transfer the case to the AAA when it receives an acceptable preliminary NCP. Complete the ongoing PAN and P1 authorization then complete the transfer. See [Chapter 3](#) on how to complete transfers.

RESOURCES

Related WACs, RCWs, MBs, Chapters and CMS Waivers

WAC-388-71-0702	Adult Day Services
WAC 388-71-0704	Adult Day Care
WAC 388-71-0706	Adult Day Health
WAC 388-71-0712	Skilled Nursing
WAC 388-71-0714	Skilled Rehabilitative Therapy
WAC 388-106-0805	Adult Day Care Eligibility
WAC 388-106-0300	COPES Services
H23-078	Assessing Adult Day Care (ADC) Informal Support
Chapter 7d	Into to Medicaid, State Plans, and 1915c Waiver COPES

Standards of Nursing Conduct / Nurse Practice

Everyone, upon entering the practice of nursing, assumes a measure of responsibility and trust and the corresponding obligation to adhere to standards of nursing practice. You are individually responsible and accountable for the quality of nursing service you provide to clients.

18.79 RCW	Nurse Practice Act
18.130 RCW	Uniform Disciplinary Act
WAC 246-840-700	Standards of nursing conduct or practice
WAC 246-840-710	Violations of standards of nursing conduct or practice

ACRONYMS

AAA	Area Agency on Aging
ADC	Adult Day Care
ADH	Adult Day Health
ADL	Activities of Daily Living
ADS	Adult Day Services
AFH	Adult Family Home
ALF	Assisted Living Facility
CARE	Comprehensive Assessment and Reporting Evaluation
CFC	Community First Choice
COPES	Community Options Program Entry System
DDCS	Developmental Disabilities Community Service
DSHS	Department of Social and Health Services
HCLA	Home and Community Living Administration
HCS	Home and Community Services
HIU	Hub Imaging Unit

NCP	Negotiated Care Plan
P1	ProviderOne
PAN	Planned Action Notice
RCL	Roads to Community Living
ROM	Range of Motion
SER	Service Episode Record

FREQUENTLY ASKED QUESTIONS (FAQS)

1. What CARE screens do I complete to authorize ADC?

- **Treatment Screen:**
Select ADC from the treatment list. This must be selected before assigning treatments to the provider.
- **Supports Screen:**
Assign the provider to the appropriate treatment(s).
- **P1 Screen:**
Authorize ADC using a daily code (4-hour minimum) or use the 15-minute unit code for service authorizations under 4 hours.

2. What CARE screens do I complete to authorize ADH?

- **Treatment Screen**
 - Document the clinical need and assign appropriate treatments.
- **ADH Screen:**
 - Use this screen to assist in determining eligibility (navigate to Medical >Treatments>ADH).
- **Care Plan.**
- Document frequency changes on the Treatment and Supports screens.
- This process will automatically generate a new Service Summary for the client's review and signature (or their authorized representative).

****If the client's needs are not currently identified, or the existing care plan no longer meets their needs, complete a new assessment.**

3. What do I do when there is a change in the number of weekly service days needed? If the client's needs are already identified in the assessment and only the number of days needs to be changed:

- Complete an Interim Assessment in CARE.
- Send a new Payment Authorization Notice (PAN) to the client.

- Update the P1 authorization.
- Document frequency changes on the Treatment and Supports screens.
- This process will automatically generate a new Service Summary for the client's review and signature (or their authorized representative).

4. What if a client wants to exchange all the in-home hours for ADC services?

- Clients cannot receive all their care via ADS.
- Clients can attend for less hours/days to get more of their care in-home or discontinue ADS altogether and receive all their care in-home or a residential setting.
- Document change in CARE and update P1 authorizations to the new provider. Follow the same process to change the ADC provider.

5. What if a client requests ADS between assessments?

- A new assessment is not needed if the care needs that qualified the client for ADC or ADH are already identified in the current assessment. Instead, reassign the need in CARE and update the authorization.
- If the client has a new need that is not identified in the assessment, complete a "Significant Change" reassessment.

6. What do I do if a client changes from ADC to ADH?

- New need (e.g. ADC client newly diagnosed with diabetes): Do a reassessment.
- Not a new need (e.g. ADC client receiving outpatient OT has been discontinued): Reassign need for OT to a new provider in CARE, send updated PAN, and adjust P1 authorizations.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
3/4/2026	Susan Worthington	Updated language, added clarity to funding sources, added clarity to informal supports in CARE, Electronic signatures.	H23-078



Nurse Delegation

Chapter 13 describes Department of Social and Health Services (DSHS) Nurse Delegation (ND) Program, how to determine eligibility, determining delegable tasks, case manager and nurse delegator responsibilities, the referral process, and how to authorize this service.

DSHS forms referenced are required to be used. Search by Form Number at [Electronic DSHS Forms](#). Most forms are available in Word and PDF.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Nurse Delegation Program Manager 360.725.2450 nursedelegation@dshs.wa.gov

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OVERVIEW

What is Nurse Delegation?

Nurse Delegation is a role within a Registered Nurse (RN) [Scope of Practice](#). It allows an RN to delegate specific skilled nursing tasks to nursing assistants or home care aides, also called Long-Term Care Worker (LTCW) for eligible clients who have partially met or unmet skilled nursing task needs. The laws and rules for Community Nurse Delegation are found in Revised Code of Washington (RCW) and Washington Administrative Code (WAC).

RCW 18.79.260 Registered nurse - Activities allowed - Delegation of tasks

- (1) A registered nurse under his or her license may perform for compensation nursing care, as that term is usually understood, to individuals with illnesses, injuries, or disabilities.
- (2) A registered nurse may, at or under the general direction of a licensed physician and surgeon, dentist, osteopathic physician and surgeon, naturopathic physician, optometrist, podiatric physician and surgeon, physician assistant, advanced registered nurse practitioner, or midwife acting within the scope of his or her license, administer medications, treatments, tests, and inoculations, whether or not the severing or penetrating of tissues is involved and whether or not a degree of independent judgment and skill is required. Such direction must be for acts which are within the scope of registered nursing practice.
- (3) A registered nurse may delegate tasks of nursing care to other individuals where the registered nurse determines that it is in the best interest of the patient.
 - (a) The delegating nurse shall:
 - (i) Determine the competency of the individual to perform the tasks.
 - (ii) Evaluate the appropriateness of the delegation.
 - (iii) Supervise the actions of the person performing the delegated task; and
 - (iv) Delegate only those tasks that are within the registered nurse's scope of practice.
 - b) A registered nurse, working for a home health or hospice agency regulated under chapter [70.127](#) RCW, may delegate the application, instillation, or insertion of medications to a registered or certified nursing assistant under a plan of care.



(c) Except as authorized in (b) or (e) of this subsection, a registered nurse may not delegate the administration of medications. Except as authorized in (e) or (f) of this subsection, a registered nurse may not delegate acts requiring substantial skill and may not delegate piercing or severing of tissues. Acts that require nursing judgment shall not be delegated.

(d) No person may coerce a nurse into compromising patient safety by requiring the nurse to delegate if the nurse determines that it is inappropriate to do so. Nurses shall not be subject to any employer reprisal or disciplinary action by the nursing care quality assurance commission for refusing to delegate tasks or refusing to provide the required training for delegation if the nurse determines delegation may compromise patient safety.

(e) For delegation in community-based care settings or in-home care settings, a registered nurse may delegate nursing care tasks only to registered or certified nursing assistants under chapter [18.88A](#) RCW or home care aides certified under chapter [18.88B](#) RCW. Simple care tasks such as blood pressure monitoring, personal care service, diabetic insulin device set up, verbal verification of insulin dosage for sight-impaired individuals, or other tasks as defined by the *nursing care quality assurance commission are exempted from this requirement.

(f) The delegation of nursing care tasks only to registered or certified nursing assistants under chapter [18.88A](#) RCW or to home care aides certified under chapter [18.88B](#) RCW may include glucose monitoring and testing.

Delegable Task Examples

Tasks that **may** be delegated for the stable and predictable client, include but are not limited to:

- Oral medication and administration
- Topical medication administration
- Nasal sprays
- Eye drops
- Gastrostomy tube feedings (including medication administration)
- Wound care must be simple, non-complex, does not require frequent nurse assessment and evaluation as determined by the delegating nurse.
- Blood glucose monitoring
- Insulin or non-insulin injectables for the treatment of diabetes
- Non-sterile tracheal and oral suctioning



NOTE: Other nursing tasks may be determined appropriate by the delegating nurse. Please also refer to the Washington State Board of Nursing for updated law and rule.

Tasks that are **prohibited by RCW and WAC** from being delegated are:

- Administration of medications by injection (by intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) with exception of insulin injections.
- Sterile procedures
- Central line maintenance
- Anything that requires nursing judgement.

To assist with decision making, the Washington State Board of Nursing has a delegation decision-tree. [WAC 246-840-940 Washington state nursing care quality assurance commission community-based and in-home care setting delegation decision tree.](#)

ELIGIBILITY FOR DELEGATION SERVICES

For delegation to occur, **clients must be assessed as stable and predictable by the delegating RN** and reside in an approved Home and Community Based setting.

Criteria for Delegation

- Stable and predictable condition means a situation in which the individual's clinical and behavioral status is known and does not require the frequent presence and evaluation of a registered nurse. [RCW 18.79.260\(3\)\(e\)\(iii\)](#)
- The Client can then possibly receive RN delegation for the LTCW to perform the skilled nursing task.
- Clients with medical conditions that are stable and predictable may receive nurse delegation if they reside in the following settings:
 - Their own home
 - Licensed Adult Family Homes (AFH).
 - Licensed Assisted Living Facilities (ALF); *or*



- Community residential programs for people with developmental disabilities, certified by DSHS.

See AUTHORIZING PAYMENT section [*Who Can Delegate*](#) for details.

- Before a client can receive delegation, you must determine that the client:
 - a) Has an “unmet” or “partially met” need for a skilled task (per CARE) such as medication management, and either:
 - a. Lacks the informal support to provide the delegated task, or
 - b. Is unwilling or unable to self-direct their care.
 - *See Chapter 3 [Chapter 3.docx \(live.com\)](#)
 - b) Resides in an approved community setting; *and*
 - c) Medicaid Care Services (MCS) and State Funded LTC for Non-Citizens receiving personal care under the state-funded programs can also receive RND services. See *Chapter 7g*.
 - Community First Choice (CFC)
 - CFC + Community Options Program Entry System (COPES)
 - Roads to Community Living (RCL)
 - New Freedom
 - Residential Support Waiver (RSW)
 - ALTSA only pays for ND if the client lives in an AFH.
 - Developmental Disability Administration (DDA) Services
 - MAC/TSOA

CASE MANAGER RESPONSIBILITIES

**If a nursing referral is not triggered in CARE, the case manager CAN use their professional judgement to MAKE a referral if the circumstances warrant a nurse consultation.

CARE Documentation

General

- Identify the client’s “unmet” or “partially met” need(s) for a skilled nursing service.
- Document need for RN Delegation in CARE or GetCare. [LTC Manual Chapter 3 Assessment and Care Planning](#).



- If there is NO delegator available, the LTCW cannot perform the delegated task and a plan for the accomplishment of the task from an informal support is required.
- A temporary Plan of Care must be developed if the LTCW does not have the appropriate training and credentials. This temporary plan must be put in place until the LTCW has completed all the requirements.
- If nurse delegation is in place, identify Nurse Delegation and IP or Agency as providers in the *Treatment* Section of the medical screen and assign the nurse delegator and paid personal care provider(s) to the task on the *Supports* screen. For medication management, assign the nurse delegator and paid personal care provider(s) on the *Supports* screen.
- When selecting providers from the Provider List in the Treatment screen, select all relevant future providers including the Nurse Delegator. Per the Assessor's Manual 39.1.2 - "This is done so that the care plan specifically indicates how the individual's ongoing care needs will be met."
- For treatments, if nurse delegation is not yet in place, identify Nurse Delegation and IP or Agency in the *Treatments* section as providers and add a comment that the task will be delegated when the provider completes the training. Indicate in the comments section that delegation is being set-up but is not yet in place.
- For medication management, if nurse delegation is not yet in place, state in the Comments box that the task will be delegated when the provider completes the training. Indicate in the comments section that delegation is being set-up but is not yet in place.
- In the meantime, if the treatment/medication management is being performed by an informal provider, identify the informal provider on the *Supports* screen and assign the task. Reassign the task to the delegating nurse and paid provider after the IP and/or agency provider has completed the Nurse Delegation training. See [LTC Manual Chapter 11 Consumer Directed Employer](#)
- For transferring a case, if delegation is in place at the time of transfer, the receiving agency is not required to do a reassessment unless the client's condition and needs have changed or unless the annual reassessment is due.

Service Episode Record (SER)

- Document **all** communication with the RND (this is important for billing and tracking), to include:
 - Referrals, when sent and when returned.
 - Referrals for the Skin Observation Protocol
 - Phone calls and/or emails
 - Changes in client's condition



- Client’s authorized representative changes (or their contact information)
- Financial eligibility changes

Medication Screen

- Select “must be administered.”
- If applicable, indicate which medication is delegated.
- If applicable, indicate which medications do not require delegation.

Treatment Screen

- Select provider type who will be performing the delegated task for the temporary plan of care.
- Indicate that the LTCW is providing the delegated task and describe the treatment being provided.
- Indicate the provider for each treatment being provided.

Supports Screen

- If the treatment/medication management is being performed by an informal provider, identify the informal provider on the *Supports* screen and assign the task. Reassign the task to the delegating nurse and paid provider after the IP and/or agency provider has completed the Nurse Delegation training. See [LTC Manual Chapter 11 Consumer Directed Employer](#).

ADDITIONAL RESOURCES

- [LTC Manual Chapter 11 Consumer Directed Employer](#).
- [Care Web Help](#)
- [Chapter 8 Residential Services](#)
- [Chapter 7g State Funded Programs](#)

Examples from CARE

New treatment
✕

Treatment

Application of medication for current skin conditions
▼

Received in the last 14 days?

Yes

No

Need

Yes

No

Provider list

	Provider	Frequency	
+	AFH/Assisted Living Facility ▼	QD (once daily) ▼	✕
	▼	▼	✕

Comments

Client

Family/Informal supports

IP Family

IP Non-family

Agency

IP/Agency

Nurse delegation

Dental Provider

Clinic/practitioner's office

Home health agency

AFH/Assisted Living Facility staff

Adult Day Care

Adult Day Health

Mental health

Facility RN/LPN

Facility staff

Self-directed care (IP only)

Outpatient rehabilitation

Hospice

Private duty nursing

✓ Add treatment

Medication management
✕

At most, how many times per day does the client take medications?

What are the routes?

+	Oral	—
	Topical	—

What is the client's ability to manage their medications?

▼

Does the client need assistance with taking medications daily?

Yes	No
-----	----

Who will assist with medication(s)?

Informal or Healthcare Provider
Formal
Both
Client Declines

Limitations		
+	Chokes/gags	-

Caregiver instruction(s)		
+	Administer eye or ear drops, per orders	-
	Document medication taken	-
	Re-order medications	-
	Report adverse reactions	-

Comments

The client also needs his medications crushed in applesauce, fed to him, and requires a nurse delegator for this assistance.

✓ Update medication management

- **Comments:** This can remind why the client needs delegation and that one has been referred.



GetCare Documentation for TSOA

- Ensure the medication management level of assistance coding in the most current NFLOC assessment is “must be administered” or “must be administered daily”.
 - If neither of these are selected, then the care receiver is not eligible for ND services related to medication management.
- Document in a Progress Note that the Home Care agency confirmed their LTCW assigned to the client meets the ND training requirements. This would be the Agency Provider (AP).
- Add the RND’s name and contact information to the Contacts section.
- Ensure the ND service has been included in the care plan including what task(s) are being delegated.
- Scan and upload the [Nurse Delegation Referral and Communication Form 01-212](#) that was sent the RND into the client’s Electronic File Cabinet.
 - Upload page 2 of this Referral form when the RND returns it to you with the results of the initial ND assessment.
 - Document all contacts with the RND in a progress note.

REFERRALS FOR NURSE DELEGATION

General timeframe Factors for Responding to All Nursing Referrals:

- Business Week Monday-Friday; Excludes Holidays and Weekends.
- Time Clock starts next business day. Example: Assessment Done Friday 5/1 (2 business days clock starts) Monday 5/4.
- All staff must make sure to manage the coverage to stay within timeline.
- A plan for the accomplishment of the nursing task by an informal support is required when there is not a formal support in place.

LTCW

- Ensure the LTCW has active credentials and training to be delegated.
 - For In-home clients:



- CDWA Chapter 11
- Agencies must ensure their employees meet all the appropriate credentials.
- Clients in an AFH or ALF: facility management is responsible for having staff already trained to provide delegated tasks when they accept a client who requires ND. (This may need to be confirmed prior to sending RN referral).

RN Delegator

- Contact a contracted RND, (preferably by phone for initial contact) to verify they are available and accepting new clients.
 - Contracted Nurse Delegators DSHS **Intranet** site;
 - Contracted Nurse Delegator DSHS **Internet** site
- Once verification has been obtained from the RND, authorize ND in CARE or GetCare and send a referral to the RND.
 - Make referral using [Nurse Delegation Referral and Communication Form 01-212](#). It must include:
 - Authorization number
 - Client demographics
 - ACES ID #
 - Current CARE or GetCare assessment
 - Individual support plan (if applicable)
 - Positive behavior support plan (if applicable)
 - [Consent Form 14-012](#) (Release of Information)

Nurse Delegation Referral Timeframe

- 2 business days - CM is required to make referral.
- 2 business days - Nurse is required to confirm receipt of the referral.
- 5 business days - Nurse will review file and reach out to client, family member(s) or POA/Guardian and make phone contact and home visit. *** **If the nurse is unable to make timeline, document all efforts and barriers, inform case manager supervisor, and make contact as soon as possible.**
- 10 business days - Complete all documentation.



Skin Observation Protocol (SOP) Referral

Please refer to steps below:

When a client triggers the SOP during assessment/reassessment and there is currently an RND serving that client, send the a referral using the [HCS/AAA Nursing Services Referral Form 13-776](#).

- The RND must use these forms and return to CM:
 - HCS/AAA Nursing Services Referral Form 13-776.
 - Basic Skin Assessment (13-780).
 - Pressure Injury Assessment and Documentation (13-783) (For each pressure injury assessed).

Nurse Delegator For HCS/AAA SOP/Nursing Triggered Referrals

In the situation where the Nurse Care Consultant (NCC) or RN Case Manager is unavailable, authorized staff may refer the Nursing Trigger – Skin Observation Protocol, to any available Contracted Nurse Delegator, who will address all other nursing triggers at the same time. All RNs are expected follow the listed timeframes for SOP. ** Please refer to [DDA Policy 9.13](#) for DDA SOP referral

Staff will use this form to send a referral to the RND HCS/AAA Nursing Services Referral Form (#13-776)

- [HCS/AAA Nursing Services Referral Form 13-776](#).
- [Basic Skin Assessment \(13-780\)](#).
- [Pressure Injury Assessment and Documentation \(13-783\)](#) (For each pressure injury assessed).

*Staff must ensure that you receive the above forms are received back in the specified timeframe.

➤ **Triggered Nursing Referral Timeframe SOP (ALTSA):** [Chapter 24 Nursing Services](#)

- 2 business days - CM is required to make referral.
- 2 business days - Nurse is required to confirm receipt of the referral.
- 5 business days - Nurse will review file and reach out to client, family member(s), or POA/Guardian and make phone contact. **** **If the nurse is unable to make timeline, document all efforts and barriers, inform case manager supervisor, and make contact as soon as possible.**
- 20 working days to make visit if necessary and complete documentation.
- Total 29 working days



➤ Triggered Nursing Referral Timeframe (excluding SOP):

- 2 business days - CM is required to make referral.
- 2 business days - Nurse is required to confirm receipt of the referral.
- 10 business days - Nurse will review and use nursing judgment if phone contact and/or visit to client is necessary and will document all actions. **** If the nurse is unable to make timeline, document all efforts and barriers, inform case manager supervisor, and make contact as soon as possible.**
- 15 business days - Complete all documentation.
- Total 29 working days

Authorizing Payment

Only RNs or Home Health agencies under Nurse Delegation contract with DSHS can be paid to provide ND services.

Assisted Living Facility

- Home and Community Services (HCS) will not pay an RN to delegate in a licensed ALF. The payment relationship for RN delegation is between the nurse and the ALF facility.
- If a licensed ALF also has a contract as a DDA Group Home, DDA may pay for ND services.

Adult Family Home

- RNs who own an AFH may also be paid for ND services in addition to their daily rate when they have a DSHS RN Delegation contract.
**However, ALTSA will not pay an RN delegator to provide services in an Private Duty Nursing contracted AFH. That is considered a duplication of services.

Authorized Delegation Units

- RND is authorized for 100 units per month with P1 Service Code H2014 with Modifier U5 for the duration of the client's CARE plan. The system will allow you to authorize services for 1200 units for up to 12 months.
- If a client needs more than the maximum number of authorized units (100 u/month), the RND is responsible for requesting additional units through the Nurse Delegation Program Manager (NDPM). [DSHS Form 13-893 Nurse Delegation: Request for Additional Unit](#). Once approved, the NDPM will notify CM and RND.



Note: For DDA clients, ND services may be provided to individuals served by certified community residential programs for the developmentally disabled. See [DDA Policy 6.15](#)

Transferring Cases

If the LTCW does not have the required credentials and training before you transfer the case, you must:

- Provide information to the LTCW on the training requirements and process.
- Encourage the LTCW to complete all requirements as soon as possible.
- Ensure a temporary plan of care is in place to meet the client's nursing needs until the LTCW has fulfilled the requirements.
- Communicate to the receiving agency the current plan and the future plan of the LTCW performing the delegated task once training has been completed and then document in SER that communication occurred (and method of communicating).

The receiving agency must monitor the training and registration process for the LTCW. After the LTCW's training and registration requirements have been met, the agency needs to send a referral to a contracted ND with the authorization for payment.

Note: These instructions do not pertain to MAC/TSOA cases.

Authorization of Nurse Delegation services; hospital or institutional

- When a client resides in or admitted to an institutionalized setting, the case manager may request a DSHS contracted Nurse Delegator to assess the client to determine the appropriateness of delegation and begin the delegation process.
- Services will be authorized under an ALTSA Recipient Aid Category (RAC) 3490 State Only Adjusted Payment (SOAP) or DDA RAC 3930 State Funded Community Support Services.

Authorization of Nurse Delegation services for a new client who is not currently on services

- Please follow steps below:
 1. We must use state only funds via ALTSA RAC 3490 State Only Adjusted Payment (SOAP) or DDA RAC 3930 State Funded Community Support Services to pay for nurse delegation services while client is in a hospital or institutional setting.



2. Add the RAC on the RAC eligibility screen with start/end dates that match the dates of service that the client is in the institutional setting.
3. Create a social service authorization for nurse delegation services.
4. Because the client does not yet have personal care or other community services the service line will generate the following error, #30115 "Nurse Delegation services can only be authorized with certain other service.
5. This error should be forced by the ALTSA Nursing Delegation Program Manager or the DDA case manager's supervisor or a DDA Payment Specialist.

Authorization of Nurse Delegation services for an existing client

➤ Please follow steps below:

1. We must use state only funds via the ALTSA RAC 3490 State Only Adjusted Payment (SOAP) or DDA RAC 3930 State Funded Community Support Services to pay for nurse delegation services while client is in an institutional setting.
2. We will need to add the RAC and split the social service authorization to reflect the dates the client is not in a community setting.
3. Add a RAC on the RAC eligibility screen with start/end dates that match the dates of service that the client is in the institutional setting.
4. On the current nurse delegation authorization service line, complete the following:
 - Change the start date on the current service line to match the start date of the 3490/3930 RAC.
 - Change the end date on the same service line to match the end date of the 3490/3930 RAC.
 - Change the number of units to reflect the units approved for the time client is in the institutional setting.
 - Enter a comment.
 - Hit "Submit." By changing the start date, end date, and the units the service line will split resulting 3 service lines; 1 service line will be for dates prior to institutional admission, dates during admission, and dates after discharge.
5. Because the client is not eligible for community services like personal care while in an institutional setting, the service line should generate the following error: #30115 "Nurse Delegation services can only be authorized with certain other service."
6. This error should be forced by the ALTSA Nursing Delegation Program Manager or the DDA case manager's supervisor or a DDA Payment Specialist.



Splitting Social Service Lines in CARE

Examples

- 1) The client lives in a residential setting, and they were authorized nurse delegation services from 5/1/2023 to 12/31/2023. Client was admitted to the hospital on 9/4/2023 and will discharge 9/10/2023:
 - Update RAC eligibility screen:
 - Change the end date on the residential RAC to 9/3/2023.
 - Add the 3490 or 3930 RAC for 9/4/2023-9/9/2023.
 - Add a new residential RAC with a start date of 9/10/2023 and an end date that matches the end of the plan period.
 - Update the current nurse delegation authorization:
 - Change the Start date to 9/4/2023.
 - Change the End date to 9/9/2023.
 - Update the Units to reflect what was approved during these dates.
 - By changing **both** date fields **and** another data field (like the units or reason code) this edit is going to result in **3** service lines; one line will end 9/3/23, 1 line will go from 9/4/23-9/9/23, and another line will start at 9/10/23 with an end date that matched the original end date. After the service line splits, you will want to update the approved units on each of the affected lines.
 - Update the Reason Code
 - Add a processing comment.
 - Select the submit button.

- 2) The client lives in a residential setting, and they were authorized nurse delegation services from 5/1/2023 to 12/31/2023. Client was admitted to the hospital on 9/4/2023 and will discharge 9/10/2023. A bed hold was approved for 9/4/2023-9/9/2023 resulting in the RND service line ending 9/3/2023:
 - Update RAC eligibility screen:
 - Change the end date on the residential RAC to 9/3/2023.
 - Add the 3490 or 3930 RAC for 9/4/2023-9/9/2023.
 - Add a new residential RAC with a start date of 9/10/2023 and an end date that matches the end of the plan period.



- Create 2 new service lines for the RND service (complete the authorization service line reason code):
- Create 1 line that will match the dates of the SOAP RAC.
- Create another line that has a start date matching the new residential RAC and an end date that matches the end of the plan period.

DELEGATOR RESPONSIBILITIES

See “[Nurse Delegation Forms](#)” for full list of forms, titles, and how to access.

- Respond to DSHS/AAA staff within two working days of receiving referral. Sign and return Page 1, [DSHS Form 01-212 Nurse Delegation Referral and Communication](#)
- Verify the LTCW’s have approved training and credentials to become delegated. [DSHS Form 10-217 Nurse Delegation Nursing Assistant Credentials and Training](#)
- Obtain consent using [DSHS Form 13-678 Pg 1 Nurse Delegation: Consent for Delegation of Nursing Tasks](#) from the client or the client’s authorized representative to provide delegation.
- Assess the client and document findings, to ensure they are stable and predictable, and their overall care needs to determine whether delegation is appropriate for the specific situation and task. (DSHS does not have an approved assessment form, the delegating RN must use their own form to document assessment)
- Communicate the results within 5 business days of the initial assessment to the CM or NCC, utilizing page 2 of the [DSHS Form 01-212 Nurse Delegation Referral and Communication](#).
- Complete [DSHS Form 14-484 Nurse Delegation Nursing Visit](#) at each nursing visit including LTCW training and observation.
- Teach the LTCW to perform the nursing task(s). Use form [DSHS 13-678 Pg 2 Nurse Delegation Instructions for Nursing Task](#)
- Assess and monitor the LTCW’s performance and continued appropriateness of the delegated task(s) every **90 days** or more frequently as needed.
 - If the LTCW is delegated to administer insulin, the RND will assess the client and monitor continued competence of the LTCW. The frequency is determined by the RCW and WAC for Nurse Delegation. [RCW 18.79.260](#) and [WAC 246-840-930](#)



- The RND can determine to assess each LTCW more frequently if necessary.
- Document using [DSHS Form 14-484 Nurse Delegation Nursing Visit](#)
- Document and perform all delegation activities as required by law, rule, policy, and contract.
- When rescinding ND, work with the CM/NCC, the client, and other identified parties; and
 - Nurse completes [DSHS Form 13-680 Nurse Delegation Rescinding Delegation](#)
 - [WAC 246-840-960](#) states the registered nurse delegator may rescind delegation of the nursing task. The registered nurse delegator initiates and participates in developing an alternative plan for continuing the task. Please refer to WAC for more details.
- Respond as required to the CM request for the **Skin Observation Protocol** (Chapter 24) if currently serving the client.
- Report client changes in condition or needs to CM.
- Use ProviderOne for billing for documented services in a timely manner. Please use a billing tracker for records. May use DSHS Form 06-200 Nurse Delegation Billing
- Respond to ND Program Manager inquiries regarding billing, contract monitoring, and other concerns related to role performance.
 - The Program Manager is responsible for monitoring the nurse’s contractual performance including communication, frequency of visits, documentation, and payments/billing.

CONSUMER DIRECTED EMPLOYER CHAPTER 11

1. Individual Provider (IP)

- CM opens authorization to RN delegator and sends the RN the delegation referral form.
- If the RN delegator approves nurse delegation with an IP, the CM will notify CDWA by phone/email.
- CDWA will verify the IP(s) credentials/training & will notify the RND if all requirements are satisfied.
- If IP lacks training, CDWA will initiate training process & notify the RND once the IP is trained.



2. **Agency Provider (AP)** may obtain their training through a DSHS agency approved community trainer. The Agency is responsible for ensuring the AP meets the requirements for delegation.

[Find a Training Class](#) (DSHS)

- Nurse Delegation 9 hours
- Nurse Delegation – Diabetes 3 hours
- Basic Training
- Mental Health & Dementia Specialty

Training for Long-Term Care Worker (LTCW)

Basic Training

Includes one of the following:

- a) Fundamentals of Care
- b) Revised Fundamentals of Care
- c) The 40-hour Basic Training is part of the HCA curriculum (HCA training is 75 hours)
- d) In DDA Supported Living agencies, the DDA 32-hour training meets the Basic Training requirement up to January 1, 2016.
 - If employed after January 1, 2016, the 40-hour CORE Basic Training is required for all DDA SL employees.

Requirements

The LTCW must:

1. Have one of the following ACTIVE credentials from the Washington Department of Health per [RCW 18.79.260](#):
 - a) Nursing Assistant-Registered (NA-R)
 - b) Nursing Assistant-Certified (NAC)
 - c) Home Care Aid-Certified (HCA-C)
2. Complete the 9-hour “Nurse Delegation for Nursing Assistants” training in addition to the Basic Training
3. **PLUS**, the 3-hour “Special Focus on Diabetes” training if they will be administering insulin.
4. Provide proof of completing Basic Training:



- NAC or HCA-C: Assumed through state certification.
- NA-R: See Exempt or Non-Exempt Table

EXEMPT	NON-EXEMPT
If the LTCW worked 1 day from January 1, 2011, to January 6, 2012, they are exempt from taking the Basic Training. Needs to provide proof of working 1 day within this timeframe <u>and</u> provide their Basic Training certificate.	The LTCW is required to take the 40-hour Basic Training if: • They did not work 1 day January 1, 2011, to January 6, 2012, <u>or</u> • Is unable to provide proof of employment <u>and</u> their Basic Training certificate. A non-exempt NA-R must be dually credentialed until passage of the Prometric test. Upon passing the test, the NA-R credential does not need to be renewed annually. Only the HCA-C credential needs to be renewed annually.

RELATED RCWS AND WACS

RCW 18.79	Nursing Care
RCW 18.79.260	Activities Allowed – Delegation of Tasks
RCW 18.88A	Nursing Assistants
RCW 74.39.050	Self-Directed Care (Individuals with functional disabilities)
WAC 246-840	Practical and Registered Nursing
WAC 246-840-910	Delegation of Nursing Tasks to Nursing Assistants or Home Care Aides
WAC 246-840-930	Criteria for Delegation
WAC 246-840-940	Delegation Decision Tree
WAC 246-335-420	Home Care Agency Delivery of Services
WAC 246-945	Medication Assistance
WAC 246-980-010-990	Home Care Aide Rules



WAC 388-71 RCW 74.39A.250	Home and Community Services and Programs Individual Provider
WAC 388-76 WAC 388-78A WAC 388-112A	Adult Family Home Minimum Licensing Requirements Assisted Living Facility Licensing Rules Residential Long-Term Care Services Training
WAC 388-106 WAC 388-106-0300 WAC 388-106-1900 WAC 388-110 WAC 388-112A	Long-Term Care Services Services Provided Under COPES Services Provided Under MAC and TSOA Contracted Residential Care Services Residential Long-Term Care Services Training

ACRONYMS

AFH	Adult Family Home
ALF	Assisted Living Facility
ALTSA	Aging and Long Term Support Administration
CFC	Community First Choice
CM	Case Manager
CNC	Community Nurse Consultant
COPES	Community Options Program Entry System
DDA	Developmental Disability Administration
DOH	Department of Health
DSHS	Department of Social and Health Services
HCA-C	Home Care Aide Certified
IP	Individual Provider
LTCW	Long-Term Care Worker
MAC	Medicaid Alternative Care
NA-C	Nursing Assistant Certified
NA-R	Nursing Assistant-Registered
ND	Nurse Delegation
RAC	Recipient Aid Category
RCL	Roads to Community Living
RND	Registered Nurse Delegator
RSW	Residential Support Waiver



SEIU Service Employees International Union
SER Service Episode Record
TSOA Tailored Supports for Older Adults

WEB RESOURCES AND FORMS

DSHS/ALTSA

[Individual Providers - Home Care Aide Certification](#)

[Nurse Delegation Program](#)

[DSHS Contracted Nurse Delegator \(internal\)](#)

[DSHS Contracted Nurse Delegator \(external\)](#)

[ALTSA Long-Term Care Policy Manual](#)

Department of Health (DOH)

[Washington State Board of Nursing](#)

[WA State Credential Verification for RNs, LPNs, and ARNPs](#)

[Multistate \(MSL\) RN or LPN in another state use: Nursys.com](#)

**** Primary source verification of licensure for an RN or LPN practicing in Washington State with an out of state MSL is not available on the Provider Credential Search.**

Nurse Delegation Forms:

[DSHS Forms page:](#)

01-212	ALTSA Nurse Delegation Referral & Communication Case/Resource Manager
06-200	Nurse Delegation Billing Form
10-217	Credentials and Training Verification
13-678 Page 1	Consent for Delegation Process (available in 9 languages)
13-678 Page 2	Instructions for Nursing Task
13-678A	PRN Medication

CHAPTER 13: Nurse Delegation

Long-Term Care Manual



13-678B	Assumption of Delegation
13-680	Rescinding Delegation
13-681	Change in Medical Orders
13-893	Request for Additional Units
13-903	DDA Request for Additional Units
13-484	Nursing Visit



Older Americans Act Legal Assistance Services

Chapter 14 Older Americans Act Legal Assistance Services Program purpose is to provide information about activities to develop, strengthen, and carry out programs for the prevention, detection, assessment, treatment of, intervention in, investigation of, and response to elder abuse, neglect, and exploitation and increase access to services provided for seniors. This is a required program under the Older Americans Act (OAA). Each state sets a minimum percentage of the Area Agencies on Aging (AAA) OAA, Title III-B budget for legal services. Washington State has set this percentage at 11%.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Caroline Wood State Unit on Aging, Legal Assistance Developer
360.725.3466 caroline.wood@dshs.wa.gov

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BACKGROUND

Long-Term Care Manual Chapter 14, provides supporting procedures, processes, and resources to Area Agencies on Aging within Washington State required to provide Older American Act, Legal Service Programs, in accordance with CFR 1321.93

LEGAL SERVICE PROCEDURES

Area Agencies on Aging must select the legal assistance provider(s) that best demonstrate the capacity to conduct legal assistance, which means having the requisite expertise and staff to fulfill the requirements of the Act and all applicable Federal requirements for provision of legal assistance.

The provider shall exhibit the capacity to

1. Retain staff with expertise in specific areas of law affecting older individuals with economic or social need, including the priority areas of law identified in the act;
2. Demonstrate expertise in specific areas of the law that are given priority in the act.

The provider receives referrals from community agencies including AAAs, DSHS field offices, case managers and Information and Assistance/Aging and Disability Resource Center (I&A/ADRC) providers. Appropriate referrals fit a priority area of law.

PRINCIPLES AND PROGRAM DEFINITIONS

The Legal Services Program provides access to the justice system by offering representation by a legal advocate (attorney, paralegal, or law student). The focus is on socially and economically needy older individuals who are experiencing civil legal problems. This service will often be the only way for these individuals to obtain trained legal help.

Legal problems must be within the priority areas that are established to reflect local needs. Legal Services Programs are to foster a cost-effective, high-quality service that is integrated into the aging services network. Providers should develop and maximize the use of other available resources.

TARGET POPULATION

The target population is persons aged 60 and older for OAA Title III B legal assistance.

The program is prioritized to serve those with the greatest economic need and greatest social need, particularly low-income minority older individuals, older persons with limited English proficiency (LEP), older persons residing in rural areas, and older persons with disabilities.



SERVICES PROVIDED

Nothing in this section or the program standards is intended to prohibit any attorney from providing any form of legal assistance to an eligible client, or to interfere with the fulfillment of any attorney's professional responsibilities to a client.

1. At a minimum, the following forms of individual legal assistance are provided:
 - a) Legal advice;
 - b) Brief legal services such as phone calls, letter writing, document review and drafting, or negotiation;
1. Representation at administrative hearings;
 - c) Representation in court;
 - d) Referral to other legal resources.
2. The following optional services may also be provided:
 - a) Education and training;
 - b) Backup and training for the I&A/ADRC Program, Case Managers, and the Long-Term Care Ombudsman Program volunteers;
 - c) Resource development designed to expand services. Resource development includes coordination with Legal Services Corporation (LSC) grantees, training private attorneys, and pro bono program development;
 - d) Organizational representation of elder citizens' organizations, groups and coalitions who work on priority areas of the law and on issues and advocacy affecting low-income seniors.

PRIORITY AREAS OF LAW

Aging Network, DSHS staff may refer cases to the Legal Services providers. Attorneys resolve cases based on a classification of the case or problem. Each provider may have a different system of classification, which may be based on the possible legal remedy or the local situation. What a non-attorney classifies as a housing problem may be classed by the lawyer or paralegal as a due process case.

It is important to provide the Legal Services screener with a concise, but detailed, set of facts to allow for a decision to interview for representation, or to refer the case, or to help make a referral to another, more appropriate resource.

As resources are limited, clients with problems in the locally preferred major categories must receive services before clients with problems in other categories.

1. Major Statutory Categories:
 - a) Income and public entitlement benefits
 - b) Health Care
 - c) Long-term care
 - d) Nutrition
 - e) Consumer Law
 - f) Housing
 - g) Utilities
 - h) Protective services;



- i) Abuse
 - j) Neglect
 - k) Age Discrimination
 - l) Defense of/from guardianship
“Defense of guardianship” means advice to and representation of older individuals at risk of guardianship and older individuals subject to guardianship to divert them from guardianship to less restrictive, more person-directed forms of decisional support whenever possible, to oppose appointment of a guardian in favor of such less restrictive decisional supports, to seek limitation of guardianship and to seek revocation of guardianship; (ii) Defense of guardianship includes: (A) Representation to maintain the rights of individuals at risk of guardianship, and to advocate for limited guardianship if a court orders guardianship to be imposed; assistance removing or limiting an existing guardianship; or assistance to preserve or restore an individual’s rights or autonomy; (B) Representation to advocate for and assert use of least-restrictive alternatives to guardianship to preserve or restore an individual’s rights and or autonomy to support decision-making, or to limit the scope of guardianship orders when such orders have or will be entered by a court; and (C) A legal assistance provider proceedings of older individuals who seek to become guardians only if other adequate representation is unavailable in the proceedings, and the provider has exhausted, and documents efforts made to explore less restrictive alternatives to guardianship
2. Statutory vs. Real Priorities and Abilities:
- a) Some statutory priority cases are not addressed by local legal services providers. One example is litigation of age discrimination cases which are costly and may be fee generating. Therefore, direct legal assistance providers should help identify causes of age discrimination and, where appropriate, refer older people to other legal channels including the Equal Employment Opportunity Commission.
 - b) Similar situations exist with respect to abuse, neglect, financial exploitation and defense of guardianships.
In Washington State, the cost of an attorney to defend an alleged incompetent person in a guardianship case is paid for by the county. Abuse, neglect and financial exploitation are either fee generating or are handled by an Assistant Attorney General or local prosecuting attorney. Often, community education and the establishment of referral sources will be more appropriate than litigation.
 - c) Fee generating cases are often hard to define and the legal services provider is best able to do this.

IDENTIFYING & REFERRING PEOPLE WITH LEGAL NEEDS

Some types of cases are easy to identify. People who are denied services need advice on how to proceed in filing or asking for a fair hearing. They may need substantive representation at the hearing. Evictions and utility shut-off cases require hearings and may lead to negotiations with housing authorities or lawsuits.



Other cases are not so easy. Some people may want to apply for long-term care, but do not want to have a lien on their house. Someone may need help with the legality of caring for a grandchild or in dealing with the managed care provider.

The current best practice is to “over-refer” because of the changes in the legal services system.

Feedback from the provider as to appropriateness of the referral will allow refinement of the process over time. For certain types of cases there will be other resources in the local community. This process of referral and feedback may be set up as a formal system, or the referral source will ask for this

feedback as referrals are made. The attorney can disclose whether a referral is appropriate or that a different referral would be more appropriate, but the substance of the case often cannot be discussed.

- Example: If your community has a strong elder law section of the bar or a strong estate planning group then questions pertaining to gifts and asset planning can and should be referred to them. However, there may be a benefit to having groups such as the Northwest Justice Project (NJP) make these referrals. The community may receive pro bono services for certain clients, or the attorney may be better able to classify the case. Most attorneys are willing to answer questions about how they do referrals and what they need from a referral source.

Ongoing regular informal communication between the AAA and the legal services provider must ensure awareness of the legal needs of the targeted population in the community and ensure that the local priorities reflect local legal needs.

Making Referrals

Which agency should I make referrals to?

1. Legal Services in Washington State

a) **Northwest Justice Project (NJP)**

NJP has received the federal Legal Services Corporation (LSC) contract. As an LSC, NJP is the highest tiered provider of legal services meeting the federal guidelines and standards required to be recognized as Washington State’s LSC. NJP provides intake services and screening statewide.

By making referrals to the local NJP the client will either be helped by their staff or sent on to the appropriate office. This may be pro bono work; or regarding a fee generating case, to an attorney who will do the case without a retainer fee. This will allow efficient sorting of cases and easier access to services.

Northwest Justice Project will be able to classify the problem, do some initial interviewing, and place the case with the most appropriate provider.

Project CLEAR (Coordinated Legal Education, Advice and Referral)

Outside King County



All Ages Call 1-888-201-1014
For Seniors (age 60 and over) Call CLEAR*Sr statewide 1-888-387-7111

Inside King County

All Ages Call 2-1-1
People facing foreclosure Call 1-800-606-4819

2. Most AAAs contract with Northwest Justice Project. Some AAAs still contract with providers other than Northwest Justice Project in their local areas.

How do I make a Legal Services referral?

1. Develop a concise statement of facts which you know or have been communicated by the client.
2. Call the local NJP office. Try to do this while the client is present or have the client make the call. You may also give the information to the legal representative of the client.
3. Follow up by contacting the client or legal representative.

INTAKE/CASE HANDLING STANDARDS

Each legal assistance provider must have procedures for the following:

1. **Non-Acceptance of Cases:** A procedure that determines the circumstances and criteria under which cases are not accepted. There must also be a means of communicating this non-acceptance to the client.
2. **Case Acceptance:** Providers must have a uniform written case acceptance process. This process includes consideration of the following criteria:
 - a) Age
 - b) Type of legal problem
 - c) Priority of legal problem
 - d) Minority or limited English-speaking status
 - e) Fee generating possibilities
 - f) Extent of legal expertise required
 - g) Impact on present caseloads
 - h) Urgency of problem
 - i) Available alternatives
3. The provider should have criteria for emergency case acceptance.
 - a) **Retainers:** Every client whose case is accepted for representation, signs and receives a copy of a retainer agreement which may be supplemented by a letter.
 - b) **Grievance Procedure:** A grievance procedure must exist for individuals who believe they have been improperly denied service or who are dissatisfied with the legal assistance provided. The procedure is set up to attempt to resolve grievances at the lowest possible level.

RESOURCES

Rules and Policies

Older American's Act

[Section 307 OAA, at 42 USC 3027 Older Americans Act Title III, Part B, Legal Assistance](#)

Legal Assistance

[45 CFR 1321.93](#)

Support

[Northwest Justice Project](#)
[Washington Law Help Seniors 60+](#)

Acronyms

AAA	Area Agencies on Aging
ADRC	Aging and Disability Resource Center
HCLA	Home and Community Living Administration
I&A	Information and Assistance
LSC	Legal Services Corporation
NJP	Northwest Justice Project
OAA	Older Americans Act

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
9/3/2025	Caroline Wood	1. ALTSA to HCLA 2. OAA final rule change language 3. Columbia Legal Services in King County is no longer contracted to serve OAA clients in 2020 4. Omit detailed resource section due to difficulty in keeping source current, in favor of source reference of policy and state resourced legal service corporation	H25-042
10/23/17	Caroline Wood	1. General formatting updates for easier reading 2. Created clear Section Summary with integrated hyperlinks/bookmarks 3. Removed obsolete reference links to training tools 4. Added extensive Resource options for Legal Services to support aging services network, Older American Act priorities, target marketing, and language support options 5. Added new DSHS Legal Assistance Developer contact information while deleting obsolete contact information 6. Core content and structure remains unchanged	H17-078
07/07/2006	Patty McDonald	1. The Legal Services chapter has been revised in the new HTML format and the chapter has been updated with revised program definitions.	H06-053



APPENDIX

APPENDIX A: Northwest Justice Project – Washington State Office Locations

SEATTLE - MAIN OFFICE (King)

401 Second Avenue S, Suite 407
Seattle, WA 98104
206-464-1519
1-888-201-1012
Fax: 206-624-7501
Client Intake - call 211

ABERDEEN (Grays Harbor & Pacific)

218 N. Broadway, Suite 1
Aberdeen, WA 98520
360-533-2282
1-866-402-5293 toll free
1-888-201-1014 (CLEAR - Client Intake)
Fax: 360-533-2932

BREMERTON - Satellite Office

216 6th Street
Bremerton, WA 98337
360-377-6378
Fax: 360-377-6385

EVERETT OFFICE (Snohomish)

2731 Wetmore Avenue, Suite 410
Everett, WA 98201
425-252-8515
1-888-201-1017
1-888-201-1014 (CLEAR - Client Intake)
Fax: 425-252-5945

LONGVIEW (Cowlitz & Wahkiakum)

1338 Commerce Avenue, Suite 210
Longview, WA 98632
360-425-1537
1-866-402-7971
1-888-201-1014 (CLEAR - Client Intake)
Fax: 360-578-0241

OMAK - Satellite Office

28 N. Main Street [alley entrance]
P.O. Box 3569
Omak, WA 98841

BELLINGHAM (Whatcom, Skagit, San Juan, Island)

1814 Cornwall Avenue
Bellingham, WA 98225
360-734-8680
1-800-562-8836
1-888-201-1014 (CLEAR - Client Intake)
Fax: 360-734-0121

COLVILLE - Satellite Office

132 West 1st Avenue
Colville, WA 99114
509-684-7652
1-800-303-7050
Fax: 509-684-4541

KENT - Satellite Office

124 4th Avenue S, Suite 240
Kent, WA 98032
253-480-6125
1-855-682-0795
Fax: 253-852-6050

OLYMPIA (Thurston, Mason, Lewis)

711 Capitol Way S., Suite 704
Olympia, WA 98501
360-753-3610
1-888- 212-0380
1-888-201-1014 (CLEAR - Client Intake)
Fax: 360-753-0174

PORT ANGELES (Clallam & Jefferson)

1020 Caroline Street
Pt. Angeles, WA 98362
360-452-9137
1-866-402-4452

CHAPTER 14: Older Americans Act Legal Assistance Services

HCLA Long-Term Care Manual



509-422-2345
Fax: 509-422-2866

SPOKANE (Spokane, Whitman, Lincoln, Ferry, Pend Orielle, & Stevens)

1702 W. Broadway
Spokane, WA 99201
509-324-9128
1-888-201-1019
1-888-201-1014 (CLEAR - Client Intake)
Fax: 509-324-0065

TRI CITIES (Benton, Franklin, Walla Walla, Columbia, Garfield, & Asotin)

1313 N. Young Street, Suite D
Kennewick, WA 99336
509-547-2760
1-800-310-6076
Fax: 509-547-1612

WALLA WALLA - Satellite Office

38 E. Main, Suite 207
Walla Walla, WA 99362
509-525-9760
1-800-289-0581
1-888-201-1014 (CLEAR - Client Intake)
Fax: 509-525-9895

YAKIMA (Yakima & Kittitas)

311 N. 4th Street, Suite 201
Yakima, WA 98901
509-574-4234
1-888-201-1018
1-888-201-1014 (CLEAR - Client Intake)
Fax: 509-574-4238

1-888-201-1014 (CLEAR - Client Intake)
Fax: 360-452-4053

TACOMA (Pierce & Kitsap)

715 Tacoma Avenue South
Tacoma, WA 98402
253-272-7879
1-888-201-1015
1-888-201-1014 (CLEAR - Client Intake)
Fax: 253-272-8226

VANCOUVER (Clark, Klickitat, & Skamania)

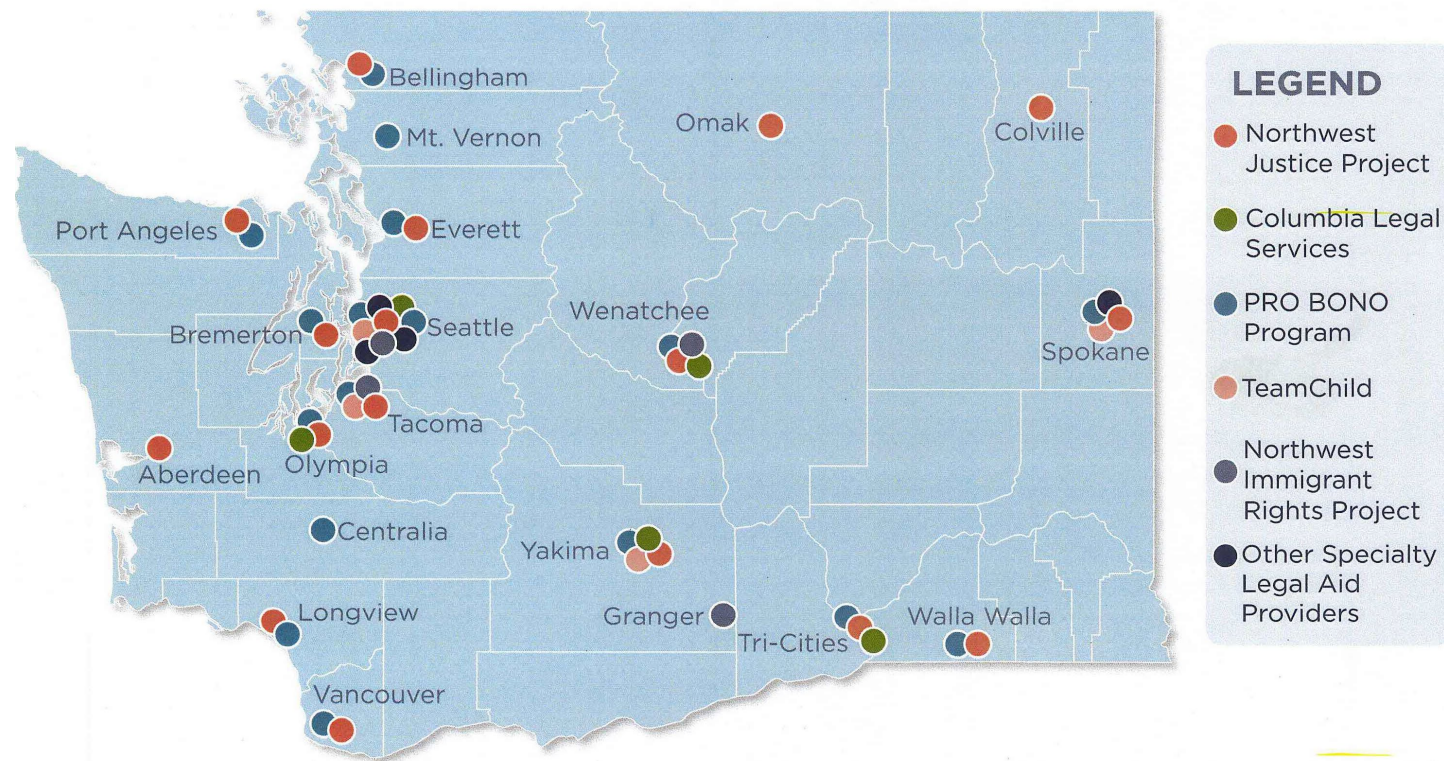
500 W. 8th, Suite 275
Vancouver, WA 98660
360-693-6130
1-888-201-1020
1-888-201-1014 (CLEAR - Client Intake)
Fax: 360-693-6352

WENATCHEE (Chelan, Douglas, Okanogan, Grant, & Adams)

300 Okanogan Avenue, Suite 3A
Wenatchee, WA 98801
509-664-5101
1-888-201-1021
1-888-201-1014 (CLEAR - Client Intake)
Fax: 509-665-6557

APPENDIX B. Map of Civil Aid Legal Providers

CIVIL LEGAL AID PROVIDERS





Communicating with Individuals with Limited English Proficiency (LEP) or Sensory Disability (SD) in Medicaid Programs – Guidance for AAA staff

The purpose of this chapter is to explain requirements to communicate effectively with persons who do not or have limited ability to speak, read, write, or understand English ensuring equal access to Home and Community Living Administration (HCLA) administered Medicaid services and programs, to describe language assistance services and explain how to use them.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Linda Garcia Language and Disability Access Program Manager
360.968.9745 linda.garcia1@dshs.wa.gov

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AUTHORIZING SOURCES

Title VI of the Civil Rights Act of 1964 42 U.S.C. § 2000d	https://www.justice.gov/crt/fcs/TitleVI-Overview
Americans with Disabilities Act (ADA) of 1990 42 U.S.C. chapter 126	https://www.ada.gov/pubs/adastatute08.htm
Title 34 CFR (Education) 104 and 45 (Public Welfare) CFR 84 Nondiscrimination on Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance	https://www.federalregister.gov/documents/2017/01/03/2016-31236/nondiscrimination-on-the-basis-of-disability-in-programs-or-activities-receiving-federal-financial
RCW 49.60.030 Freedom from Discrimination	https://app.leg.wa.gov/RCW/default.aspx?cite=49.60.030
RCW 74 Public Assistance	https://app.leg.wa.gov/RCW/default.aspx?Cite=74
National CLAS Standards	https://thinkculturalhealth.hhs.gov/clas/standards
WAC 10-08-150	https://app.leg.wa.gov/WAC/default.aspx?cite=10-08-150
WAC 388-03	https://apps.leg.wa.gov/WAC/default.aspx?cite=388-03
WAC 388-271	https://app.leg.wa.gov/WAC/default.aspx?cite=388-271

IDENTIFYING APPLICANTS OR CLIENTS WITH LEP OR SD

AAA staff must identify clients' communication needs at the initial contact, during assessment and re-assessment interviews and:

- Inform or remind clients of their right to request Language Access services,
- Document the client's specific communication need on the client demographics section of the appropriate application (CARE or GetCare) if applicable,
- If the client has a legal decision maker, AAA staff must document this in the client's electronic record. Include in documentation if the decision maker needs documents translated and into which language.

TYPES OF LANGUAGE ACCESS (LA) SERVICES AAA STAFF MUST PROVIDE

AAAs are expected to provide effective, equitable, understandable, and respectful quality care and services in a manner that is culturally and linguistically appropriate, recognizing different communication needs when communicating orally or in writing and using appropriate Language Access (LA) services or assistive technology.

Types of LA services for effective oral communication with clients:

1. Bilingual or Multilingual Employees providing direct services in needed language(s).
2. Contracted Interpreter Services:
 - a. *Spoken Language Interpreter Services* in-person, over the phone (OPI) or video remote interpreting (VRI) technologies.
 - b. *Sign Language Interpreter Services* in-person, video remote, or by using assistive technology devices.

Types of LA services for effective written communication with clients:

1. Contracted Translation Services into non-English languages.
2. Materials in Large Print.
3. Braille Transcription Services.
4. Audio Recordings of Written Materials.
5. Other – Closed or Open Captioning of videos; Communication Access Real-Time Transcription, Accessible websites, etc.

LA Services should be provided:

- at no cost to clients,
- in a timely manner,
- by qualified providers and be of high quality,
- in coordination with knowledgeable professionals – SMEs,
- in consideration of individual situation, and
- with cultural awareness and respect.

BILINGUAL OR MULTILINGUAL EMPLOYEES

AAA staff who provide direct services to clients in a language(s) other than English, including Sign Languages, must, at the minimum, demonstrate a proficiency through a process established by the AAA.

CONTRACTED INTERPRETER SERVICES

AAA staff must use interpreters when AAA bilingual staff cannot meet the language needs of the applicant/client.

Spoken Language or Sign Language Interpreter Services in-person, over the phone (OPI) or video remote interpreting (VRI) technologies

AAA can choose to use DES Master Contracts for:

- Interpreter Services, Over the Phone and Video Remote (currently #18222),
- Sign Language Interpreter ASL (currently # 02120 and # 03930) administered by the Office of the Deaf and Hard of Hearing (ODHH) of DSHS, or
- Develop their own contracts.

AAA must pay for all professional in-person and remote interpreter services – over-the-phone interpreting (OPI) or video-remote-interpreting (VRI) provided to the applicants or clients they serve.

Find DES Interpreter Services contracts here: [DES Language Access Contract Search](#)



Communicating with clients using spoken or sign language interpreter services:

1. Document the use of contracted interpreter services (In-person, telephonic and video remote) at every interaction with the client.
2. Spoken language interpreters providing LA services to the clients must be certified, authorized, or recognized by DSHS Language, Testing and Certification (LTC) program ([WAC 388-03-30](#)) and comply with the DSHS code of professional conduct ([WAC 388-03-50](#).) Some languages of limited diffusion may not have DSHS certified/authorized professional interpreters. In these cases, the contracted interpreter agency must qualify these interpreters.
3. Sign Language interpreters providing LA services to the clients must maintain their certification through the Registry of Interpreters for the Deaf (RID) www.rid.org and comply with the [Code of Professional Conduct](#).
4. Interpreter service is a purchased service and may not be authorized as a client service.
5. Applicants or clients with LEP or SD (Title XIX, MAC and TSOA) may secure, at their expense, the services of their own interpreter. This **does not** waive the AAA's responsibility to arrange and pay for a professional certified or authorized interpreter. AAA staff must **not allow** the following to serve as interpreters:
 - a. Paid Individual Provider (IP) - to avoid possible conflict of interest;
 - b. Children under the age of 18 years even if they are not a family member or relative.
6. Staff may use a family member or a friend of the client over the age of 18 in case of **emergency**. Family members and friends cannot receive payment for interpreter services.

For the purposes of this chapter, emergency means "When no professional interpreter, or translator is available in or out of the state of Washington for a particular language, either in person, by video remote or telephonically and would cause an extensive delay in services for the applicant/client. Staff must document in CARE or GetCare the emergency use of an uncertified or unauthorized interpreter at every interaction with applicant/client.
7. If staff use a family member/friend over the age of 18 to assist in communicating with the applicant or client, they must document in the client's electronic record:
 - a. attempts to secure a professional interpreter;
 - b. use of family member or friend to assist in communication; and
 - c. for SD, use of other options for communication, such as Telecommunication Relay Services (TRS) 711 or 1-800-974-1548, Video-Remote Interpreting (VRI), or other assistive technology.

Note: AAA staff will not need special equipment when calling or receiving calls from individuals with SD. To learn more about TRS, please visit ODHH website page on [Telecommunication](#).

CONTRACTED TRANSLATION SERVICES (WRITTEN MATERIALS)

AAA staff must provide written documents to clients with LEP or SD in the languages or formats clients can read and understand at no charge to the clients and without significant delay.

- AAA staff must not rely on family and friends for providing translation services.
- If the client with LEP or SD is illiterate or has cognitive limitations and has a formal or informal decision maker, AAA staff must provide documents in a language or a format that the decision maker can read and document it in the client's electronic record.
- If the client is illiterate and cannot read English or their primary language, AAA staff must document it in the client's electronic record and describe how staff obtained consent or required signature.

Translating client specific letters

AAAs can choose to use DES Master Contract– Translation Services-Written Word (currently #03824), Category 5 Client Specific or develop their own contract. AAAs must pay for all professional translation services provided to the applicants or clients they serve.

Find DES Translation Services contract here: [DES Language Access Contract Search](#).

Translating documents generated in the CARE and GetCare systems into foreign languages and getting those documents in Large Print (LP)

AAA staff must use the current HCLA vendor for translations of CARE and GetCare system generated documents and follow the established process for requesting document translation into foreign languages or converting into Large Print (LP) format.

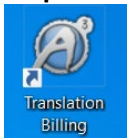
Use Translation-Billing EXE application generating secure email when requesting translated document(s) or needing document(s) in LP.

Step by step instructions for requesting CARE or GetCare documents in client's language or in LP:

Inside the Firewall:

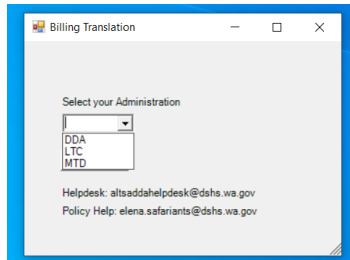
Step 1 - Create a separate PDF for each document needing translation, naming it according to the selection ("Planned Action Notice - PAN" or "Service Summary - SS" or "Assessment Details – AD", etc.) you make in the "Translation-Billing EXE" application; do not merge documents together and do not scan or ZIP (compress) them.

Step 2 – Find "Translation-Billing EXE" application.



This will be an icon on your desktop that can be loaded by your local IT staff.

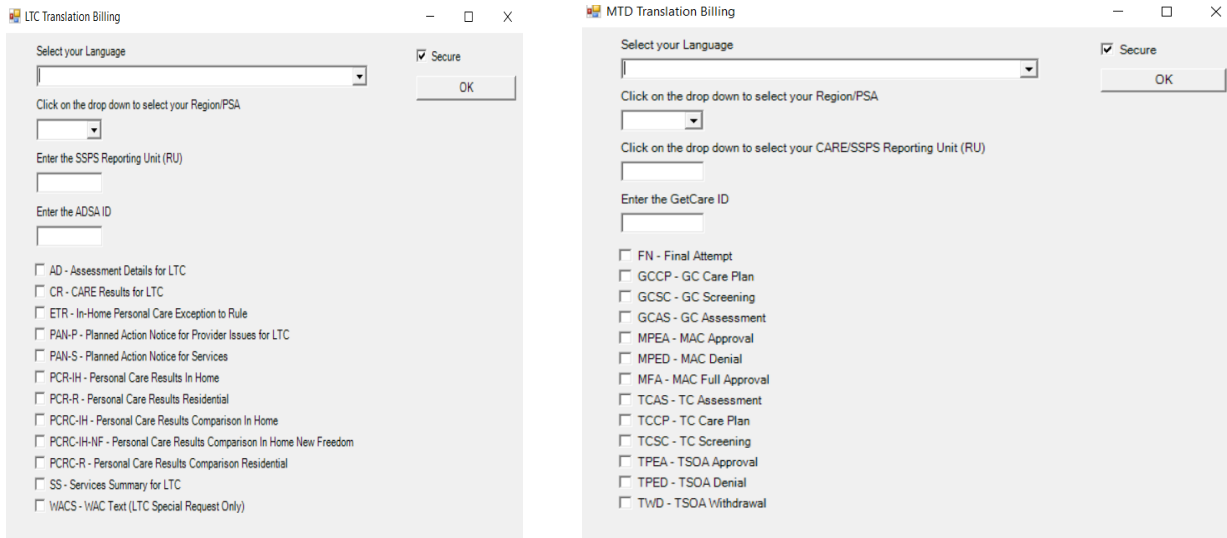
Step 3 – Run “Translation-Billing EXE” application for CARE or GetCare documents. Once launched, it will prompt you to identify information about your administration/program.



Step 4 - After making initial selection (LTC or MTD), the user will need to **enter** and **select** from the drop down list the following required data fields:

- Language Code
- Region/PSA
- Reporting Unit (RU)
- Client’s ADSA/CARE ID
- Document Type(s): Check the boxes corresponding to the document type(s) you need translated for each client. You must send a separate email for each client who needs translation of the documents. However, you may send multiple documents to be translated for a specific client in one email.

NOTE: If any of the fields are unfilled or filled with incorrect or extraneous information such as attached files do not match the file names in the “Subject” line, PDFs are not created directly from the CARE or GetCare system, etc., the vendor may decline your request for translation and request you resubmit it.



LTC Translation Billing

Select your Language: [dropdown] ☒ Secure [OK]

Click on the drop down to select your Region/PSA: [dropdown]

Enter the SSPS Reporting Unit (RU): [text box]

Enter the ADSA ID: [text box]

☐ AD - Assessment Details for LTC
☐ CR - CARE Results for LTC
☐ ETR - In-Home Personal Care Exception to Rule
☐ PAN-P - Planned Action Notice for Provider Issues for LTC
☐ PAN-S - Planned Action Notice for Services
☐ PCR-IH - Personal Care Results In Home
☐ PCR-R - Personal Care Results Residential
☐ PCRC-IH - Personal Care Results Comparison In Home
☐ PCRC-IH-NF - Personal Care Results Comparison In Home New Freedom
☐ PCRC-R - Personal Care Results Comparison Residential
☐ SS - Services Summary for LTC
☐ WACS - WACS Text (LTC Special Request Only)

MTD Translation Billing

Select your Language: [dropdown] ☒ Secure [OK]

Click on the drop down to select your Region/PSA: [dropdown]

Click on the drop down to select your CARE/SSPS Reporting Unit (RU): [dropdown]

Enter the GetCare ID: [text box]

☐ FN - Final Attempt
☐ GCCP - GC Care Plan
☐ GCSC - GC Screening
☐ GCAS - GC Assessment
☐ MPEA - MAC Approval
☐ MPED - MAC Denial
☐ MFA - MAC Full Approval
☐ TCAS - TC Assessment
☐ TCCP - TC Care Plan
☐ TCSC - TC Screening
☐ TPEA - TSOA Approval
☐ TPED - TSOA Denial
☐ TWD - TSOA Withdrawal

After completing all the data fields click OK; a secure e-mail will automatically be created, and time stamped with the filled “To” and “Subject” fields.

DO NOT CHANGE THESE E-MAIL FIELDS! The codes mean something to the contractor and help make the process more efficient.

Step 5 – In the body of the e-mail you may include special handling instructions or additional information such as the name of the language marked as OT (other) in the EXE application.

Step 6 – Attach the PDF document(s) for translation to the e-mail you created in Step 1 and properly selected in Step 4.

Step 7 – Pause and double check your translation request and then press “**Send**” from your E-mail system. Once you submit your request, your request cannot be changed.

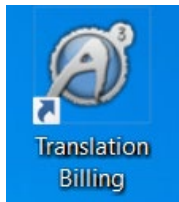
Step 8 – The Contractor will acknowledge the receipt of your request and return the translated documents through the secure email.

NOTE: Make sure you do not send new translation requests in the same email chain of old requests.

Outside the Firewall:

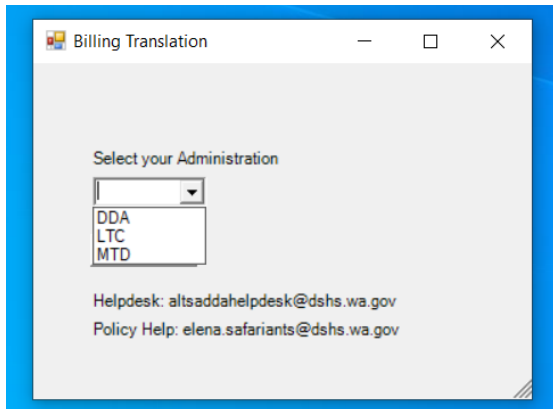
Step 1 - Create a separate PDF for each document needing translation, naming it according to the selection (“Planned Action Notice - PAN” or “Service Summary - SS” or “Assessment Details – AD”, etc.) you make in the “Translation-Billing EXE” application; do not merge documents together and do not scan or ZIP (compress) them.

Step 2 – Find “Translation-Billing EXE” application.



This will be an icon on your desktop that can be loaded by your local IT staff.

Step 3 – Run “Translation-Billing EXE” application for CARE or GetCare documents. Once launched, it will prompt you to identify information about your administration/program.



Billing Translation

Select your Administration

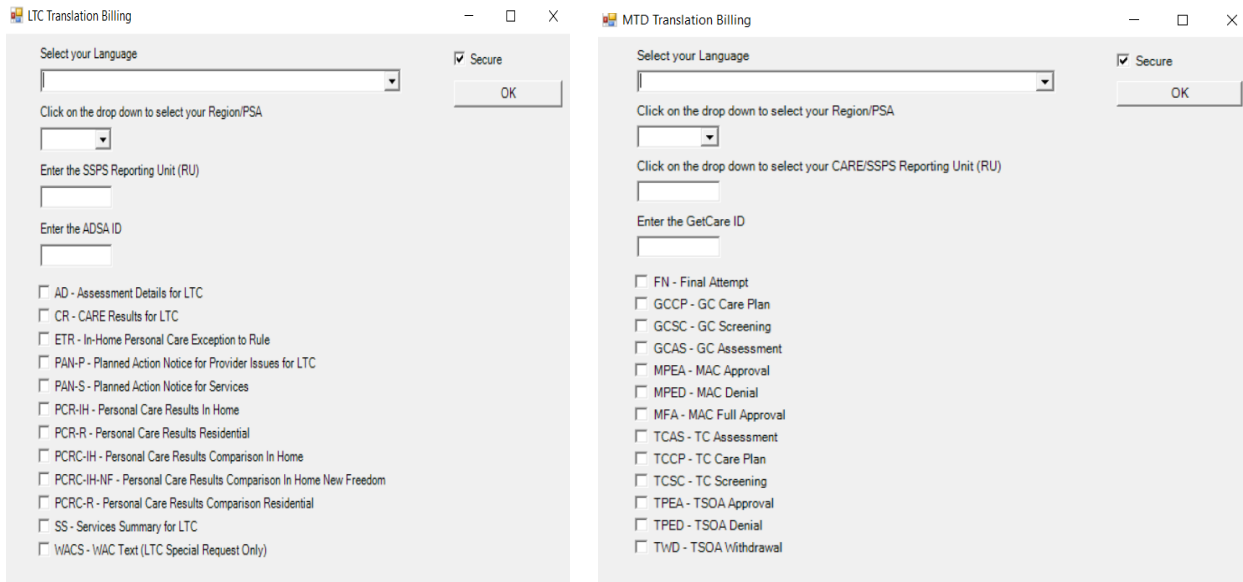
DDA
LTC
MTD

Helpdesk: altsaddahelpdesk@dshs.wa.gov
Policy Help: elena.safariants@dshs.wa.gov

Step 4 - After making initial selection (LTC or MTD), the user will need to **enter** and **select** from the drop down list the following required data fields:

- Language Code
- Region/PSA
- Reporting Unit (RU)
- Client's ADSA/CARE ID
- Document Type(s): Check the boxes corresponding to the document type(s) you need translated for each client. You must send a separate email for each client who needs translation of the document(s). However, you may send multiple documents to be translated for a specific client in one email.

NOTE: If any of the fields are unfilled or filled with incorrect or extraneous information such as attached files do not match the file names in the "Subject" line, PDFs are not created directly from the CARE or GetCare system, etc., the vendor may decline your request for translation and request you resubmit it.



LTC Translation Billing

Select your Language

Click on the drop down to select your Region/PSA

Enter the SSPS Reporting Unit (RU)

Enter the ADSA ID

☐ AD - Assessment Details for LTC
☐ CR - CARE Results for LTC
☐ ETR - In-Home Personal Care Exception to Rule
☐ PAN-P - Planned Action Notice for Provider Issues for LTC
☐ PAN-S - Planned Action Notice for Services
☐ PCR-IH - Personal Care Results In Home
☐ PCR-R - Personal Care Results Residential
☐ PCRC-IH - Personal Care Results Comparison In Home
☐ PCRC-IH-NF - Personal Care Results Comparison In Home New Freedom
☐ PCRC-R - Personal Care Results Comparison Residential
☐ SS - Services Summary for LTC
☐ WACS - WAC Text (LTC Special Request Only)

MTD Translation Billing

Select your Language

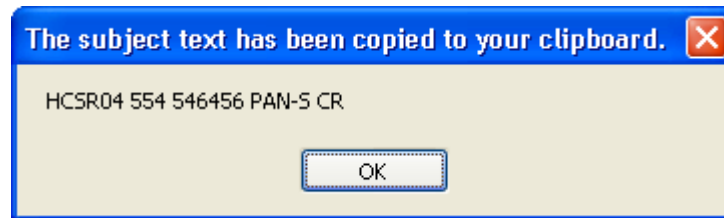
Click on the drop down to select your Region/PSA

Click on the drop down to select your CARE/SSPS Reporting Unit (RU)

Enter the GetCare ID

☐ FN - Final Attempt
☐ GCCP - GC Care Plan
☐ GCSC - GC Screening
☐ GCAS - GC Assessment
☐ MPEA - MAC Approval
☐ MPED - MAC Denial
☐ MFA - MAC Full Approval
☐ TCAS - TC Assessment
☐ TCCP - TC Care Plan
☐ TCSC - TC Screening
☐ TPEA - TSOA Approval
☐ TPED - TSOA Denial
☐ TwD - TSOA Withdrawal

Step 5 - After completing all the data fields, the following message will be displayed containing the data you just entered:



DO NOT CHANGE THESE E-MAIL FIELDS! The codes mean something to the contractor and help make the process more efficient.

If you have Outlook, it will also generate a new email message with the “To:” and “Subject:” lines completed. Click “OK”.

If you **DO NOT** have Outlook, take the following steps:

Step 6 - Access your e-mail system and

- create an e-mail addressed to wa.translations.2123@prisma.com;
- navigate to the subject line of this e-mail;
- press and hold the CTRL key and type the letter V. This will place the information that you completed in **Step 4** into the subject line of your e-mail.

Step 7 - **Attach** the document(s) for translation to e-mail and press “**Send**” from your agency’s secure e-mail system.

Receiving your Translated CARE and GetCare Documents

When the Contractor has completed translation of your document, they will send a secure e-mail back. Open and save and/or print each document individually.

Turnaround time frames for CARE and GetCare document translation

- a. 4 business days for correspondence which requires keying-in or formatting of previously translated text in all languages.
- b. 8 business days for correspondence which requires keying-in, formatting, and new translation.
- c. 10 business days for 10 or more pages requiring keying-in, formatting, and new translation.

NOTE: Staff should only communicate with the Contractor using the Translation-Billing EXE application. Contractor will email case management staff through this system. Case management staff should follow up on job orders through the same email chain. This makes it easier for the Contractor to follow up and bill local offices correctly. Make sure you do not send new translation requests in the same email chain for old requests.



Paying for translation of CARE/GetCare/TCARE documents

Contractor will determine what requires translation and keying-in and will bill in accordance with the contractual agreement:

- DSHS/HCLA will pay for the translation of the system's templates.
- AAAs are responsible for the cost of translating the text inserted into the templates.

Sending translated CARE documents to Hub Imaging Unit (HIU)

When sending CARE documents to the Hub Imaging Unit (HIU) for the Document Management System (DMS), send English and translated versions of all documents together with the exception of documents listed below. These documents in English are stored in CARE; send only translated versions of:

- Assessment Details (*only send for translation if the client has requested a copy*);
- CARE Results (CARE Results are only sent when the PCR/PCRC does not print as part of the PAN. This should only occur for the New Freedom Program);
- Planned Action Notices for Providers and Services;
- Personal Care Results Comparison (PCR/PCRC) – In-home and Residential; and
- Service Summary not generated and stored in CARE*. (If the Service Summary record is not stored in CARE, send the English version along with the translated version to HIU).

NOTE: The English documents are the official versions and must be signed by the client (and/or representative) with LEP and retained in the client record along with a copy of the translated document. When obtaining signatures, both the English and translated version must be sent to the client (and/or representative) at the same time. As best practice, it is recommended that staff request that both the English and translated versions be signed on the same date and returned, to reduce the risk of legal complaint..¹

Storing MAC and TSOA translated documents in GetCare File Cabinet

For MAC and TSOA programs, the translated version of documents must be stored in the client's GetCare electronic file cabinet. GetCare stores the English versions of system-generated documents.

Translating DSHS official forms, publications, and other general communication materials or getting those in Large Print (LP)

- Always check the [DSHS Forms intranet](#) and [internet site](#) to find translated forms by entering the DSHS form number, title, language needed, or program.
- For DSHS publications, check [Publications Library](#) to find already existent translations by entering DSHS publication number, program/topic, or language.
- Please check these sites periodically for the most current version of the documents for downloading, as documents undergo revisions.

¹ If using Voice Signature, see Voice Signature Script attachment in Chapter 3 Appendix.



- Please check HCS [Translated Documents](#) to find program documents not listed on the DSHS Forms website or in Publications Library.
- If you do not find the document in the language needed, you will need to initiate a new translation request. AAA designated staff will contact Linda Garcia at (360) 968-9745 or dshshclalep@dshs.wa.gov indicating the document number or name and the language(s) needed.
- DSHS/HCLA will be responsible for payments on translations of DSHS forms, publications and program specific documents.

Best practice: Field staff should send translated documents at the same time as the English version to applicants/clients.

Materials in Large Print (LP)

Generally, LP documents have font size of 18 or 20 point. If the client needs DSHS forms, publications, and program specific documents in LP, please ask what size font is most convenient. You can request DSHS forms in LP by contacting Linda Garcia at atdshshclalep@dshs.wa.gov.

If client needs CARE/GetCare documents (such as PANs, Care Plans, etc.) converted into LP, AAA staff may request LP the same way they request translations into foreign languages using Translation-Billing EXE application and choosing LP – Large Print from the dropdown list in “Select your Language” section.

Braille Transcription

For clients who are blind and read documents transcribed in Braille, submit the request by sending needed documents as attachments and indicating Braille Grade (1 or 2) via secure email to Linda Garcia at atdshshclalep@dshs.wa.gov. Include the client’s name and ACES number. DSHS/HCLA will be responsible for payments.

The Contractor – WSSB Ogden Resource Center will send completed Braille transcription directly to the client along with the copy of the original document.

AAA staff will obtain the client’s consent or required signature on the original document, as documents in **Braille cannot be photocopied or signed**. If the client has a guardian or DPOA, document that the guardian or person with DPOA discussed decisions related to client’s care prior to obtaining a signature or receiving consent.

The HCLA Language & Disability Access program manager will send an email to the requestor that will include:

- A statement that the text was transcribed into Braille and sent to the client;
- The date when the packet was mailed and UPS tracking number;
- A notification if the packet was returned as undeliverable and the date of the notification.

AAA staff will document this information in client’s electronic record.

Documents in other alternate formats

If you need documents in other alternate formats (recordings, real-time transcriptions, etc.), please contact Language and Disability Access Program Manager, Linda Garcia at (360) 968-9745 or dshshclalep@dshs.wa.gov.

RESOURCES

<https://www.lep.gov/>

<https://www.ada.gov/effective-comm.htm>

[Federal Register :: Nondiscrimination in Health Programs and Activities](#)

Acronyms

AAA	Area Agency on Aging
AD	Assessment Details
ADA	Americans with Disabilities Act
ALTSA	Aging and Long-Term Support Administration
ASL	American Sign Language
AT	Assistive Technology
CARE	Comprehensive Assessment Reporting Evaluation
CFC	Community First Choice
COPEs	Community Options Program Entry System
DES	Department of Enterprise Services
HIU	Hub Imaging Unit
IP	Individual Provider
LA	Language Access
LEP	Limited English Proficiency
LP	Large Print
LTC	Language, Testing and Certification
MAC	Medicaid Alternative Care
ODHH	Office of Deaf and Hard of Hearing
OPI	Over the Phone Interpreter
PAN	Planned Action Notice
PCR	Personal Care Results
PCRC	Personal Care Results Comparison
PSA	Program Service Area
RID	Registry of Interpreters for the Deaf
RU	Reporting Unit
SD	Sensory Disability
SS	Service Summary

TSOA	Tailored Supports for Older Adults
VRI	Video Remote Interpreter
WAC	Washington Administrative Code

Glossary

WORD	DEFINITION
Area Agency on Aging (AAA)	A unit of local or tribal government designated by the state to address the needs and concerns of all older persons at the regional and local levels.
Auxiliary Aids	Includes qualified interpreters, assistive listening systems (loop FM, and infrared), television captioning and decoders, video tapes, both open and closed captioned, TTYs, transcriptions, readers, taped texts, Braille, and large print materials. Any similar device or service needed to make spoken or aural (heard) language accessible is also considered an auxiliary aid.
Certified or Authorized Interpreter (for Spoken Languages)	A person who has passed the required DSHS interpreter examination, offered by DSHS Language Testing and Certification (LTC) program, or has passed a DSHS recognized interpreter examination offered by another organization.
Certified or Authorized Translator (for written documents)	A person who has passed the required DSHS written translation examination, offered by DSHS LTC, or has passed a DSHS recognized written translation examination offered by another organization.
Certified or Qualified Sign Language Interpreter	A person who obtained national interpreter certification (certified) by taking national performance and knowledge tests and/or has demonstrated ability (qualified) to interpret or transliterate effectively, accurately, and impartially, both receptively and expressively.
Client	A person who applies for, or receives, Medicaid LTSS services from DSHS.
Emergency	When no professional interpreter, or translator is available in or out of the state of Washington for a particular language, either in person, by video remote or telephonically and would cause an extensive delay in services for the applicant/client. Staff must document in CARE or GetCare the emergency use of an uncertified or unauthorized interpreter at every in-person interaction with applicant/client.
Interpretation	As used in this document, the transfer of an oral communication from one language to another.
Language Access (LA) Services	Describes services that agencies use to bridge the communication barrier with individuals who cannot effectively communicate in English. It's a full spectrum of oral, written, and assistive technology services available to ensure access to programs and services for population with limited English proficiency (LEP) or Sensory Disability (SD).



Limited English Proficiency (LEP)	A limited ability or inability to speak read and/or write English well enough to communicate effectively. Clients determine if they are limited in their ability to speak, read, write, or understand English. <i>This definition includes persons with sensory disabilities.</i>
Sensory Disability (SD)	A disability of the senses (e.g. sight, hearing, smell, touch, taste, spatial awareness), generally refers to disabilities related to hearing, vision, speech, or a combination (e.g. hard of hearing, deaf, partially sighted, or low vision and/or blind, deaf/blind, or physically unable to speak.)
Sign Language and Sign Systems	Visual or tactile ways of communicating thoughts, ideas, and feelings through American Sign Language or manual signs and gestures with specifically defined vocabulary.
Translation	The transfer of written communication from one language to another.
Primary/Preferred Language	The language that a client identifies as the language in which the person prefers to communicate verbally and/or in writing.
Written Communication	DSHS publications, Department forms and documents that: • Describe services, client’s rights and responsibilities, or changes in benefits, eligibility or service; • Request information from a client, a response on the part of a client, or notify a client of an adverse action; or • Require a client’s signature or informed consent.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/10/2025	Linda Garcia	• Moved chapter info to template with new DSHS logo & made general formatting changes. • Updated table of contents • Added ALTSA LEP email address to translating dshs forms, publications, etc. section • Added ALTSA LEP email address to Materials in Large Print Section • Added ALTSA LEP email address to Braille Transcription section • Added ALTSA LEP email address to Documents in Other Alternate Formats section • Replaced link under Resource section – Nondiscrimination in Health Programs • Moved Definitions into glossary • Added acronym section	H25-010



7/15/2025	Linda Garcia	• Added Revision History • Changed ALTSA to Home and Community Living Administration in header. • Updated language under chapter purpose section. • Updated Table of Contents • Updated Revision History to include date & MB number for previously released updates.	H25-039
9/25/2025		• General spelling and grammar corrections. • Clarified language under “Communicating with Clients using spoken language interpreter services” section. • Clarified language under “Sending translated CARE documents to Hub Imaging Unit (HIU)”. • Replaced link to DES contract site with DES Language Access Contract Search • Replaced old Inbox address link with new Inbox address – dshshclalep@dshs.wa.gov – throughout document. • Added additional guidance to Braille section • Replaced references to ALTSA with HCLA. • Updated Revision History	



Communicating with Individuals with Limited English Proficiency (LEP) or Sensory Disability (SD) – Guidance for HCLA and DDA staff

The purpose of this chapter is to explain requirements to communicate effectively with persons who do not or have limited ability to speak, read, write or understand English ensuring equal access to services and programs administered by the Home and Community Living Administration. In this chapter we will describe language assistance services and explain how to use them.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Linda Garcia

HCLA Language and Disability Access Program Manager

360.968.9745

linda.garcia1@dshs.wa.gov

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AUTHORIZING SOURCES

Title VI of the Civil Rights Act of 1964 42 U.S.C. § 2000d	https://www.justice.gov/crt/fcs/TitleVI-Overview
Americans with Disabilities Act (ADA) of 1990 42 U.S.C. chapter 126	https://www.ada.gov/pubs/adastatute08.htm
Title 34 CFR (Education) 104 and 45 (Public Welfare) CFR 84 Nondiscrimination on Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance	https://www.federalregister.gov/documents/2017/01/03/2016-31236/nondiscrimination-on-the-basis-of-disability-in-programs-or-activities-receiving-federal-financial
RCW 49.60.030 Freedom from Discrimination	https://app.leg.wa.gov/RCW/default.aspx?cite=49.60.030
RCW 74 Public Assistance	https://app.leg.wa.gov/RCW/default.aspx?Cite=74
National CLAS Standards	https://thinkculturalhealth.hhs.gov/clas/standards
WAC 10-08-150	https://app.leg.wa.gov/WAC/default.aspx?cite=10-08-150
WAC 388-03	https://apps.leg.wa.gov/WAC/default.aspx?cite=388-03
WAC 388-271	https://app.leg.wa.gov/WAC/default.aspx?cite=388-271
DSHS AP 7.20	OJCR - DSHS-AP-07-20.pdf - All Documents (sharepoint.com)
DSHS AP 7.21	OJCR - DSHS-AP-07-21.pdf - All Documents (sharepoint.com)
<u>DSHS AP 18.82</u>	OJCR - DSHS-AP-18-82.pdf - All Documents (sharepoint.com)

IDENTIFYING APPLICANTS OR CLIENTS WITH LEP OR SD

HCLA and DDA staff must identify and document clients' communication needs at the initial contact, during assessment and re-assessment interviews and

- Inform or remind applicants/clients of their right to request Language Access services at no cost to them and document it in electronic service record (e.g. Service Episode Record – SER);
- Document specific communication need of the client on the Client Demographics screen in CARE;
- If the client has a legal decision maker, HCLA and DDA staff must document this in electronic service record. Include in the documentation if the decision maker needs an interpreter and/or documents translated and into which language.

TYPES OF LANGUAGE ACCESS (LA) SERVICES HCLA AND DDA STAFF MUST PROVIDE

All agencies receiving federal financial assistance are required to provide effective, equitable, understandable, and respectful quality care and services in the manner that is culturally and linguistically appropriate, recognizing different communication needs when communicating orally or in writing and using appropriate Language Access (LA) or Assistive Technology (AT) services.

Staff will use LA or AT services when establishing, implementing or monitoring a client's plan of care and communicating with a client and/or client's formal or informal support or decision makers with LEP or SD.



Types of LA and AT services for effective oral communication with clients:

1. Bilingual or Multilingual Employees providing direct services in needed language(s).
2. Contracted Interpreter Services:
 - *Spoken Language Interpreter Services* in-person, over the phone (OPI) or video remote interpreting (VRI) technologies.
 - *Sign Language Interpreter Services* in-person or by using video remote and other assistive technology devices.

Types of LA and assistive technology services for effective written communication with clients:

1. Contracted Translation Services into non-English languages
2. Materials in Large Print
3. Braille Transcription Services
4. Audio Recordings of Written Materials
5. Other – Closed or Open Captioning of videos; Communication Access Real-Time Transcription, Accessible websites, etc.

LA Services must be at no cost to clients and provided:

- In a timely manner;
- By qualified providers and be of high quality;
- In coordination with knowledgeable professionals – Subject Matter Experts (SME);
- In consideration of individual situation; and
- With cultural awareness and respect.

BILINGUAL OR MULTILINGUAL EMPLOYEES

HCLA and DDA staff who provide direct services to clients in a language(s) other than English, including Sign Languages, must, at the minimum, demonstrate through the process established by DSHS:

- Their proficiency in English and ‘target’ language – a foreign or sign language employee intends to use when communicating with clients;
- Knowledge of frequently used terminology; and
- Cultural awareness and sensitivity.

The role of Bilingual/Multilingual employees is to work directly with and assist clients as required in their job description. Bilingual/multilingual employees should not interpret or translate in a third-party capacity on a regular basis. They may periodically interpret or translate in non-client-related situations, or in brief, emergent client-related situations.

For more details, see [DSHS-AP-18-82.pdf](#)



Currently, **DSHS Language Testing and Certification (LTC)** program offers tests to all employees regardless of whether they are in a designated dual language position. Employees who wish to take tests simply need to contact LTC at oeabltc@dshs.wa.gov to begin the process. If they would like to test using their work time, they will need their supervisor's permission; they can also test using their leave time if they wish – in this case, they do not need to get supervisor's approval. For additional information, visit [Language Testing & Certification - Home \(sharepoint.com\)](#).

CONTRACTED INTERPRETER SERVICES

HCLA and DDA staff must use interpreters when:

- Applicant or client requests the LA service
- Establishing eligibility for services for clients with LEP or SD
- Client with LEP or SD accesses services provided by HCLA and DDA
- Necessary for Quality Assurance purposes

Staff must consider the availability of interpreter resources. Staff should consult with their administration's Language Access Advisor for assistance in determining the most appropriate method of verbal communication – in-person, over-the-phone (OPI), or video remote interpreting (VRI).

In-Person Spoken Language Interpreter Services

Staff must use interpreters for spoken languages who are certified, authorized, or recognized by DSHS Language Testing and Certification (LTC) program ([WAC 388-03-30](#)) and comply with the DSHS code of professional conduct ([WAC 388-03-50](#)). Some languages of limited diffusion may not have DSHS certified/authorized professional interpreters. In these cases, the interpreter services contractor must qualify these interpreters.

Applicants or clients with LEP or SD may secure, at their expense, the services of their own interpreter. This **does not** waive HCLA and DDA staff responsibility to arrange and pay for a professional (certified, authorized or recognized) interpreter.

Rules for communicating with clients using spoken language interpreter services

1. Document the use of contracted spoken language interpreter services (in-person, telephonic, and video remote) at every interaction with the client.
2. Staff shall not authorize spoken language interpreter service as a client service. Interpreter service is a purchased service.
3. HCLA and DDA staff shall **not allow** to serve as interpreters:
 - Paid Individual Providers (IP) - to avoid possible conflict of interest;
 - Children under the age of 18 years even if they are not a family member or relative.
4. Staff may use a family member or a friend of the client over the age of 18 in case of emergency. For the purposes of this chapter, emergency means "When no professional interpreter, or translator is available in or out of the state of Washington for a particular language, either in person, by video remote or telephonically and would cause the applicant/client an extensive delay regarding application or reauthorization of services". Family members and friends cannot receive payment for interpreter services.



5. If staff used a family member/friend over the age of 18 or other Language Access services or auxiliary aids to assist in communicating with the applicant or client, they must document the following in the client's electronic record:
 - Attempts to secure a professional interpreter;
 - Use of a family member or friend to assist in communication; and
 - Use of other options for communication, such as OPI or VRI modalities.

Requesting Spoken Language In-Person Interpreter Services

1. Use current language access service contracts to request In-person interpreter services: DSHS Interpreter Service contract #2534-60325, currently **Universal Language Service (ULS)**. DSHS must use the ULS on-line scheduling system to request interpreters and manage job requests - [UniversalLanguage Service portal](#)

To request access to the ULS on-line scheduling system for **new Requesters**, please send an email to linda.garcia1@dshs.wa.gov. The email should contain the following information:

- First name
- Last name
- Email address
- Location/account they should be assigned to (e.g., HCS Region 1 - Kennewick, APS Region 1 – Colville, DDA (DDCS) - Bellingham Field Service Office, etc.)

NOTE: To access the Universal Language Service portal, staff will use Single Sign On (SSO). Staff will not need to create or enter a username and password.

Universal Language Service Requestor Guides can be found on the [Language Access SharePoint site](#).

NOTE: Universal Language Service DSHS contract #2534-60325 provides language services following the guidelines of the **Collective Bargaining Agreement (CBA)** and should be used before other language contracts for pre-scheduled appointments. The Language Access Provider (LAP) CBA can be found at the following link: [2025-2027 Washington Federation of State Employees - Language Access Providers \(WFSE LAP\)](#)

2. In the event the vendor, who provides CBA covered services, is unable to fulfill an interpreter request, staff should use the **DES** Spoken Language Interpreter Services contract, currently **#18222**.¹
 - a. To request pre-scheduled interpreter services from vendors under DES contract 18222, staff must complete form [DSHS Form 17-123](#).² See [Using DES 18222](#) guide for instructions.
 - b. Clearly document your attempts to obtain an interpreter under the contracted CBA vendor.
 - c. Vendors who have agreed to provide interpreter services under DES contract 18222 can be found on the DES contract summary page - <https://apps.des.wa.gov/DESContracts/Home/ContractSummary/18222>

¹ This contract can be used for non-CBA pre-scheduled IPI, OPI & VRI services.

² Check DSHS Forms site to ensure use of most current form.



3. If no DES vendor has language resources for an in-person appointment, DSHS staff can seek **off-contract** interpreter services providers.
 - a. Use [DSHS Form 17-123](#)³ for placing a request and complete the “ [Documentation for Using Non-Contracted Vendors](#)” form to justify going off the contract.
 - b. These forms serve as backup documentation to invoices from vendors. Thoroughly complete each form and obtain required signatures.
 - c. Give a copy of each form to your Business Manager and save a copy in the client file.
 - d. Send copies of completed forms to HCLA Language and Disability Access Program Manager at dshshclalep@dshs.wa.gov.

NOTE: Do not use these forms when using a family member or a friend of the client.

Over the Phone and Virtual Remote Interpreter Services for spoken languages (OPI/VRI)

Pre-Scheduled language access needs:

Use when...

- a. DSHS staff are unable to procure an **In-Person** interpreter for a **pre-scheduled** appointment. Staff may use DSHS contract 2534-60325 to request Over-the-Phone interpreter (**OPI**) or Video Remote Interpreter (**VRI**) services using the Universal Language Service portal (see the Universal Language Requester Guides which can be found on the [Language Access SharePoint](#) site).⁴
- b. These services are to be used for **pre-scheduled** appointments only as outlined within the Collective Bargaining Agreement.
- c. If a request for a pre-scheduled telephonic or video remote interpreter cannot be filled under DSHS CBA contract 2534-60325 (Universal), staff may use a vendor under DES contract #18222. See “[Using DES 18222](#)” guide for instructions.

On-Demand language access

Use when...

- a. The individual with LEP needs urgent/emergent assistance;
- b. A qualified in-person or OPI/VRI interpreter is not available for a pre-scheduled appointment;
- c. There are no qualified in-person or OPI/VRI* interpreters serving language(s) or dialect(s) needed.
- d. Staff are also allowed to utilize On-Demand OPI services when they become aware within 24 hours before the start of a pre-scheduled appointment that a qualified in-person interpreter will not be available.

HCLA and DDA employees have access to On-Demand OPI and VRI⁵ resources through DSHS contracts with three Contractors:

³ Check DSHS Forms site to ensure use of most current form.

⁴ Whenever possible attempt to use an in-person interpreter. However, if the CBA vendor cannot fulfill this request, please submit a pre-scheduled OPI or VRI request to the CBA vendor. If OPI or VRI services are not appropriate, use DES 18222 for in-person. The requester determines the appropriate modality.

⁵ On-Demand **VRI** services are only available from the Universal Language Service contractor.



- Language Link
- 911 Interpreters
- Universal Language Services

Language Link and 911 Interpreters - Account codes/numbers have been set up for APS, HCS, MSD/OAS, RCS, and DDA with both vendors.

Universal Language Services – Staff will be assigned an individual PIN by the vendor to be used when accessing On-Demand services via the telephone or VRI services via the Facetok platform.

Staff **must not share** account codes/numbers assigned for their individual region, division, section, or program with others. They must also not share their individual PIN with other users.

For information on rates, specific accounts, instructions on how to place a call, or to request a PIN⁶ please contact:

- Linda Garcia, Language and Disability Access Program Manager
(360) 968-9745, linda.garcia1@dshs.wa.gov

Sign Language Interpreter Services

Use Sign Language contracts administered by the DSHS/HCLA Office of the Deaf and Hard of Hearing (ODHH). They oversee two sets of contracts:

1. Statewide contracts managed in partnership with [Department of Enterprise Services \(DES\)](#) for **general** requests.⁷
 - In-person interpreting (IPI) or scheduled video interpreting (VI)
 - Schedule as far in advance as possible
2. Direct DSHS contracts for **crucial/urgent** appointments.
 - In-person interpreting (IPI) only
 - Use for short notice appointments (usually less than 2 weeks to 7 days)

See more information on the ODHH [Sign Language Interpreter Contracts and Resources](#) | [DSHS](#) page.

1. Communicating with clients using ODHH Sign Language Interpreter Services contracts

- a. To request a sign language interpreter, complete the appropriate online Sign Language Interpreter request form.
 - [General Sign Language Interpreter Request Form](#)
 - [Emergency or Crucial Online Request](#)

⁶ When requesting access to the Universal On-Demand contract, please include the user's full name, email address, and account/location. Staff will receive an email containing their PIN, from the contractor, once access granted.

⁷ For general requests use vendors listed under ASL DES contracts #06125 and #02526.



- b. To use ODHH online request forms, your division/region/program must have an account⁸, and requesters must have an access code.
 - To request and access code, send an email to signlanguageinterpreters@dsht.wa.gov
 - In the subject line, enter ACCESS CODE REQUEST, for a prompt response.
 - In the body of the email, ask to be added to the account available for your division/region/program.
 - You will receive an email from ODHH with the access code. Keep this access code for future use.
- c. Make sure to provide all required information and as much detail as possible on the request form. This helps the contractor understand the specific need and book an appropriate interpreter or team. The interpreter will sign an online service verification form later. You do not need to sign this.
- d. Sign Language interpreters providing LA services to the clients maintain their certification through the Registry of Interpreters for the Deaf (RID) www.rid.org and comply with the [Code of Professional Conduct](#).
- e. Document the use of the contracted Sign Language interpreter services at every encounter with the client in the client's electronic record.

If you have questions about **Sign Language Interpreter Services** contracts, contact: Berle Ross, Sign Language Interpreter Services Program Manager - (360) 339-4559, Email: berle.ross@dsht.wa.gov.

For more information about services available for individuals who are Deaf, Deaf-Blind, hard of hearing, Deaf and disabled, late-deafened, or speech disabled, please contact [ODHH - Office of the Deaf and Hard of Hearing](#).

2. Calling or receiving calls from someone who has a Sensory Disability

You do **not** need any special equipment when calling or receiving calls from individuals who are Deaf, Deaf-Blind, hard of hearing or speech disabled. [Telecommunication Relay Service](#) (TRS) uses operators, called communications assistants (CAs), to facilitate these telephone calls between people with hearing and speech disabilities and other individuals.

Please visit website of the ODHH to learn about how people who are Deaf, Deaf-Blind, hard of hearing, Deaf and Disabled, late-deafened, or speech disabled use different ways to make phone calls:

Telecommunications - <https://www.dshs.wa.gov/altsa/odhh/telecommunication>

CONTRACTED TRANSLATION SERVICES (WRITTEN MATERIALS)

HCLA and DDA staff must provide written documents to the clients with LEP or SD in the languages or formats clients can read and understand at no charge to the clients and without significant delay.

- Staff must not rely on family and friends to provide translation services.

⁸ If you are unsure if your division/region/program has an existing account, check with your regional Language Access Coordinator or manager or look for the account in the Purchaser dropdown menu on the online request form.



- If the client with LEP or SD is illiterate and cannot read English or their primary language, staff must provide documents in a language or a format that the client prefers and document it in the client's electronic record. Staff must also document it in the client's electronic record how they obtained consent or required signature.
- If the client with LEP or SD has cognitive limitations and has a formal or informal decision maker, staff must provide documents in a language or a format that the decision maker can read and document this in the client's electronic record.

Translating DSHS official forms, publications, and other general communication materials (Categories 1-4) or getting those documents in large print (LP)

Always check the following:

- [DSHS Forms intranet](#) and [internet site](#) to find translated forms by entering the DSHS form number, title, language needed, or program.
- [Publications Library](#) to find already existent translations by entering DSHS publication number, program/topic, or language.
- HCS [Translated Documents](#) to find program documents not listed on the DSHS Forms website or in Publications Library.
- Voter Registration - [Agency-based Voter Registration Forms | WA Secretary of State](#) for availability of translated materials.

Please check these sites periodically for the most current version of the documents for downloading, as documents undergo revisions. If you do not find the document in the language needed, you will need to initiate a new translation request.

You can request translation of DSHS Forms, DSHS Publications, and other general communication materials (materials other than DSHS forms or publications) by reaching to the following persons:

- HCLA staff will contact Linda Garcia at (360) 968-9745 or dshshclalep@dshs.wa.gov
- DDA staff will contact Nikki Paulis at nichole.paulis@dshs.wa.gov or Dallas Hightower at (360) 407-1538 or Dallas.Hightower@dshs.wa.gov (backup)

Please indicate the document number, name and the language(s) needed.

Getting DSHS Forms in Large Print (LP)

If the client requires a DSHS form in Large Print (LP) English, please ask applicant or client what size of font is most convenient. In general, LP documents have a font size of 18 or 20 point.

- ❖ You can request DSHS forms in LP by contacting Linda Garcia at (360) 968-9745 or dshshclalep@dshs.wa.gov.

Best practice: All English and translated forms and publications (new or revised) must be posted on the Forms or Visual Communications websites at the same time. Field staff should send translated documents at the same time as the English version to applicants/clients.



Client Specific Translations

- To request translation of letters, notices, DSHS forms filled by client or staff, reminders, etc. please use [DSHS Form 17-120](#).⁹
- Staff may send Translation Request and client specific documents needing translation to any of the vendors listed in the "To:" section of form 17-120. See the "[Client Specific Translation Requests](#)" guide.
- **Remember** to add the word [secure] to the subject line of your email to protect client's information.
- Contact your Translation Coordinator if you have any questions regarding this category of translation work.

State Online Language Translation Request Application (SOLTRA) for HCLA and DDA Financial Staff Only

[SOLTRA Translation Application](#)

This application, developed and maintained by DSHS/ESA IT staff, generates order forms, logs and tracks client-specific translation requests completed by contracted vendors.

Only public benefit specialists (PBS) of HCS and DDA have access to this system. To request access for SOLTRA, contact: Linda Garcia at (360) 968-9745 or dshshclalep@dshs.wa.gov.

A screenshot of a web browser displaying the SOLTRA Translation Request Registration form. The browser's address bar shows the URL "http://apps.esa.dshs.wa.id/lep/?RegID=3008/Submit". The form is titled "SOLTRA Translation Request Registration:" and includes a sub-header "Please take a moment to verify the information we have about you:". The form fields are as follows: "You will Register as:" with the value "McDonald, Patty"; "Your Supervisor is:" with the value "Moss, Bill"; "Your Organization is:" with the value "ALISA"; "Your CSO/Region/Contact Center Team is:" with a dropdown menu showing "ALISA" selected, and a red asterisk indicating it is required; "Your telephone number is:" with a text box containing "2559" and a note "(include area code)". At the bottom of the form, there is a red text prompt "Please make any corrections and" followed by a "Submit Registration" button. The browser's taskbar at the bottom shows several open tabs, including "ALISA Main Page (4)", "ASTM F2089 - 15 Standard...", "ALISA Main Page (2)", and several "http--one.dshs.wa.id-Polici..." tabs.

⁹ Check DSHS Forms site to ensure use of most current form.

Translating documents generated in the CARE system into foreign languages and getting those documents in large print (LP)

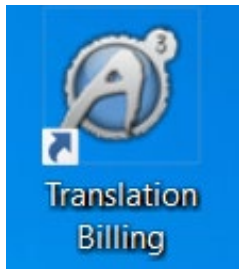
HCLA and DDA staff must use the current vendor for translations of CARE system generated documents and follow the established process for requesting documents translation into foreign languages or converting into Large Print (LP) format.

Use Translation-Billing EXE application generating secure email when requesting translated document(s) or needing document(s) in LP.

Step by step instructions for requesting CARE documents in client's language or in LP:

Step 1 – Create document PDF separately for each document needing translation, naming it according to the selection (“Planned Action Notice - PAN” or “Service Summary - SS” or “Assessment Details – AD”, etc.) you make in the “Translation-Billing EXE” application; do not merge documents together and do not scan or ZIP (compress) them.

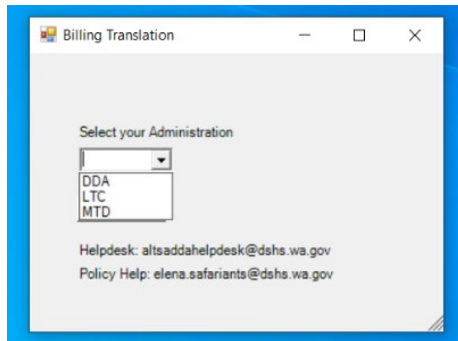
Step 2 – Find “Translation-Billing EXE” application.



This will be an icon on your desktop that can be installed by local IT staff or manually by:

1. Accessing the Software Center. Click the search field on your lower left task bar **“Type here to search”** and then type **“Software Center.”**
2. After entering the center, search for **“Translation Billing.”**
3. Click and install the application.

Step 3 – Run “Translation-Billing EXE” application for CARE documents. Once launched, it will prompt you to identify information about your administration/program.



Step 4 – After making initial selection (DDA or LTC), you will need to **enter** and/or **select** from the drop down list the following required data fields:

- Language Code
- Region
- Reporting Unit (RU): You must know or find out about your Reporting Unit and **enter** or **select** it.
- Client's ALTA/CARE ID
- Document Type(s): Check the boxes corresponding to the document type(s) you need translated for the client. You must send a separate email for each client who needs translation of the documents.

NOTE: If any of the fields are unfilled or filled with incorrect or extraneous information, attached files do not match the file names in the "Subject" line, PDFs are not created directly from the CARE system, etc. the vendor may decline your request for translation and request you resubmit it.



DDA	LTC
DDA Translation Billing Select your Language ☒ Secure OK Click on the drop down to select your Region/PSA Enter the SSPS Reporting Unit (RU) Enter the ADSA ID ☐ AD (DDA) - Assessment Details ☐ CR (DDA) - CARE Results ☐ CRM-NEV - New Case Manager assignment letter ☐ ETR - In-Home Personal Care Exception to Rule ☐ PAN-Eligible - Planned Action Notice for Eligibility (Eligible) ☐ PAN-Not Elig - Planned Action Notice for Eligibility (Not Eligible) ☐ PAN-P (DDA) - Planned Action Notice for Provider Issues ☐ PAN-S (DDA) - Planned Action Notice for Services ☐ PAN-WVR Denial - Planned Action Notice for DDD Waiver Request ☐ PAN-WVR On-DB - Planned Action Notice for DDD Waiver Request ☐ PCR-IH (DDA) - Personal Care Results In Home ☐ PCR-R (DDA) - Personal Care Results Residential ☐ PCRC-IH (DDA) - Personal Care Results Comparison In Home ☐ PCRC-R (DDA) - Personal Care Results Comparison Residential ☐ SS (DDA) - Service Summary ☐ WAC - WAC text (DDA Only)	LTC Translation Billing Select your Language ☒ Secure OK Click on the drop down to select your Region/PSA Enter the SSPS Reporting Unit (RU) Enter the ADSA ID ☐ AD - Assessment Details for LTC ☐ CR - CARE Results for LTC ☐ ETR - In-Home Personal Care Exception to Rule ☐ PAN-P - Planned Action Notice for Provider Issues for LTC ☐ PAN-S - Planned Action Notice for Services ☐ PCR-IH - Personal Care Results In Home ☐ PCR-R - Personal Care Results Residential ☐ PCRC-IH - Personal Care Results Comparison In Home ☐ PCRC-IH-NF - Personal Care Results Comparison In Home New Freedom ☐ PCRC-R - Personal Care Results Comparison Residential ☐ SS - Services Summary for LTC ☐ WACS - WAC Text (LTC Special Request Only)

After completing all the data fields click OK; a secure e-mail will automatically be created with the filled “To” and “Subject” fields.

NOTE: DO NOT CHANGE THESE E-MAIL FIELDS! The codes mean something to the contractor and help make the process more efficient.

Step 5 – In the body of the e-mail you may include special handling instructions or additional information such as the name of the language marked as OT (other) in the “Translation-Billing EXE” application a duplicate file or modifications to a prior submitted request.

Step 6 – Attach the document(s) for translation to e-mail you created in Step 1 and properly marked in Step 4.

Step 7 – Pause and double check your translation request and then press “**Send**” from your E-mail system. Once you submit your request, your request cannot be changed.

NOTE: You must communicate to Prisma any submission mistakes or if you believe you might have submitted a duplicate request.

Step 8 – The Contractor will acknowledge the receipt of your request and send the translated documents by return email through the secure email of the “Translation-Billing EXE” application.

NOTE: Make sure you do not send new translation requests in the same email chain of old requests.

Receiving your Translated CARE Documents

When Contractor has completed translation of your document, they will send a secure e-mail back. Open and save and/or print each document individually.



Turnaround time frames for CARE documents translation

- 4 business days for correspondence which requires keying-in or formatting of previously translated text in all languages.
- 8 business days for correspondence which requires keying-in, formatting, and new translation.
- 10 business days for 10 or more pages requiring keying-in, formatting, and new translation.

NOTE: Staff should only communicate with the Contractor using the translation billing- "Translation-Billing EXE" application. Contractor will email HCLA/DDA staff through this system. HCLA/DDA staff should follow up on job orders through the same email chain. This makes it easier for the Contractor to follow up and bill local offices correctly. Make sure you do not send new translation requests in the same email chain for old requests.

Sending translated documents to Hub Imaging Unit (HIU)

When sending documents to the Hub Imaging Unit (HIU), staff must send English and translated versions together of all documents with the exception of documents listed below. These documents in English are stored in CARE; send only translated versions of:

- Assessment Details (only send for translation if the client has requested a copy.)
- CARE Results (CARE Results are only sent when the PCR/PCRC does not print as part of the PAN. This should only occur for the New Freedom Program.)
- Planned Action Notices for Providers and Services.
- Personal Care Results Comparison (PCR/PCRC) – In-home and Residential; and Service Summary not generated and stored in CARE: If the Service Summary record is not stored in CARE, send the English version along with the translated version to HIU.

NOTE: While the English documents are the official versions, the client (and/or representative) with LEP must sign both the English and translated versions. The English and translated versions must always be sent to the client (and/or representative) with LEP at the same time and should be signed on the same date.¹⁰

Materials in Large Print (LP)

If the client needs anything other than DSHS forms and CARE documents in LP, please ask what size of font is most convenient for the client to read. In general, LP documents have font size of 18 or 20 point. You can request DSHS ALTA and DDCS documents in LP by contacting:

- **HCLA** – Linda Garcia, dshshclalep@dshs.wa.gov
- **DDA** – Nikki Paulis, nichole.paulis@dshs.wa.gov or
Dallas Hightower, dallas.hightower@dshs.wa.gov

¹⁰ If using Voice Signature, see Voice Signature Script attachment in Chapter 3 Appendix.



Braille Transcription

For clients who are blind and read documents transcribed in Braille:

- **HCLA** staff must place the request by sending needed documents as attachments and indicating Braille Grade (1 or 2) via secure email containing the client's name and client identifier (e.g. ACES or ADSA ID) if available, to Linda Garcia at dshshclalep@dshs.wa.gov.
- **DDA** staff must place the request by sending needed documents as attachments and indicating Braille Grade (1 or 2) via secure email to Nikki Paulis at nichole.paulis@dshs.wa.gov or Dallas Hightower at dallas.hightower@dshs.wa.gov.

The Contractor (WSSB Ogden Resource Center) will send completed Braille transcriptions directly to the client along with the copy of the original document.¹¹

Staff will obtain the client's consent or required signature on the original document, as documents in **Braille cannot be photocopied or signed**. If the client has a guardian or DPOA, you must document that the guardian or DPOA discussed decisions related to their care prior to obtaining a signature or receiving consent.

HCLA Language and Disability program manager or **DDA** Translations Coordinator will send an email to the requestor that will include:

- A statement that the text was transcribed into Braille and sent to the client;
- The date when the packet was mailed and UPS tracking number;
- A notification if the packet is returned as undeliverable and the date of the notification.

NOTE: Staff will document this information in client's electronic record.

Documents in other alternate formats

If you need documents in other alternate formats (recordings, real-time transcriptions, etc.), contact:

- Linda Garcia, Language and Disability Access Program Manager
(360) 968-9745, dshshclalep@dshs.wa.gov

Tips for Working with Spoken and Sign Language Interpreters

Spoken and sign language interpreters are trained professionals bound by a code of ethics, which includes adherence to strict confidentiality. The interpreter is there to facilitate communication only and can neither add nor omit any information exchanged by communicating parties at any time. See [Working with Spoken Language Interpreters](#) and [Working with Sign Language Interpreters](#).

¹¹ Please ensure the client's mailing address is correct in CARE.



Documenting the use of language access services

Staff must document the use of contracted spoken language interpreter services and the use of translation services at every interaction with the client.

Best Practices:

- a. If using interpreter services, best practice is to add the name of the language access vendor, the certified interpreter's ID number and/or interpreter's name to the client's case record.
- b. If a worker who is a certified bilingual employee and is authorized to provide direct services to LEP, deaf, and/or deaf-blind clients, is providing own interpretation, this should be noted in the case record.
- c. When using written translation services, best practice is to document when form, publication or other communication materials is sent for translation, when translation(s) was received, when sent to client, when sent to Barcode, etc...
- d. If using a friend or family member of the client due to an emergency, staff must document the following in the client's electronic record:
 - Attempts to secure a professional interpreter;
 - Use of family member or friend to assist in communication; and
 - Use of other options for communication, such as OPI or VRI modalities.

RESOURCES

Glossary

WORD	DEFINITION
Area Agency on Aging (AAA)	A public or private non-profit agency designated by the state to address the needs and concerns of all older persons at the regional and local levels.
Auxiliary Aids	Includes qualified interpreters, assistive listening systems (loop FM, and infrared), television captioning and decoders, video tapes, both open and closed captioned, TTYs, transcriptions, readers, taped texts, Braille and large print materials. Any similar device or service needed to make spoken or aural (heard) language accessible is also considered an auxiliary aid.
Certified or Authorized Interpreter (for Spoken Languages)	A person who has passed the required DSHS interpreter examination, offered by DSHS Language Testing and Certification (LTC) program or has passed a DSHS recognized interpreter examination offered by another organization.
Certified or Authorized Translator (for written documents)	A person who has passed the required DSHS written translation examination, offered by DSHS LTC, or has passed a DSHS recognized written translation examination offered by another organization.



Certified or Qualified Sign Language Interpreter	A person who obtained national interpreter certification (certified) by taking national performance and knowledge tests and/or has demonstrated ability (qualified) to interpret or transliterate effectively, accurately, and impartially, both receptively and expressively.
Client	A person who applies for, or receives, services from DSHS or AAA.
DSHS Certified Bilingual Employee	A DSHS staff member who has passed the required DSHS Bilingual Skills Test(s) or sign language evaluation and is authorized to provide direct services to LEP, deaf, and/or deaf-blind clients and employees.
Emergency	When no professional interpreter, or translator is available in or out of the state of Washington for a particular language, either in person, by video remote or telephonically and would cause an extensive delay in services for the applicant/client. Staff must document in CARE the emergency at every in-person interaction with applicant/client.
Interpretation	As used in this document, the transfer of oral communication from one language to another.
Language Access (LA) Services	Describes services that agencies use to bridge the communication barrier with individuals who cannot effectively communicate in English. It's a full spectrum of oral, written, and assistive technology services available to ensure access to programs and services for population who are limited English proficient (LEP) or have Sensory Disability (SD).
Limited English Proficiency (LEP)	A limited ability or inability to speak read and/or write English well enough to communicate effectively. Clients determine if they are limited in their ability to speak, read, write or understand English. <i>This definition includes persons with sensory disabilities.</i>
Sensory Disability (SD)	A disability of the senses (e.g. sight, hearing, smell, touch, taste, spatial awareness), generally refers to disabilities related to hearing, vision, speech, or a combination (e.g. hard of hearing, deaf, partially sighted or low vision and/or blind, deaf/blind, or physically unable to speak.)
Sign Language and Sign Systems	Visual or tactile ways of communicating thoughts, ideas, and feelings through American Sign Language or manual signs and gestures with specifically defined vocabulary.
Translation	The transfer of written communication from one language to another.
Primary/Preferred Language	The language that a client identifies as the language in which the person prefers to communicate verbally and/or in writing.
Written Communication	• DSHS publications, forms and documents that: ○ Describe services, clients' rights and responsibilities, or changes in benefits, eligibility or service; ○ Request information from a client, a response on the part of a client, or notify a client of an adverse action; or ○ Require a client's signature or informed consent.



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		• Client Specific Translations – added links to DSHS Form 17-120, added instructional document to Appendix • Tips for Working with Spoken and Sign Language Interpreters – moved embedded documents to Appendix. • Added section on Documentation • Added Glossary • Added Revision History • Added Appendix	
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		references to Four Corners & replaced with new Universal Language Service contract number and information. Added link to Universal requester guides on the Language Access SharePoint site. • Braille section: Added additional instruction for Braille requests • Appendix deleted. Links created to all documents. DES 18222 Instructions revised, ULS New Requester Account instructions and ALTSA interpreter example documents archived. • Updated Revision History to include date & MB number for previously released updates	
9/25/2025		• Replaced references to ALTSA with HCLA. • Replaced references to DDA with DDCS. • Made corrections to spelling, grammar, and formatting as needed. • Replaced old language access Inbox address link with new language access Inbox address – dshshclalep@dshs.wa.gov – throughout document. • Requesting Spoken Language In-Person Services section - DES contract 18222 – link directed to updated version of “Using DES contract 18222” instruction sheet dated 9/23/2025. • Added guidance on using DES 18222 to “OPI/VRI pre-scheduled language access needs” section and added link to “Using DES contract 18222” instruction sheet dated 9/23/2025. • Added information for new On-Demand contractor. • Client Specific Translations – Linked to most current version of instruction sheet dated 9/23/2025. • Updated Revision History	H25-057

7/15/2026		• Replaced references to ALTSA with HCLA • Replaced references to DDCS with DDA • Made corrections to spelling, grammar, and formatting as needed. • Updated email address for the Language, Testing, and Certification inbox • Requesting Spoken Language In-Person Services section - DES contract 18222 – link directed to updated version of “Using DES contract 18222” guide dated 4.2026. • OPI/VRI pre-scheduled language access needs section - added link to “Using DES contract 18222” guide dated 4.2026. • Client Specific Translations – Link directed to updated version of “Client Specific Translation Requests” guide dated 5.2026 • Added information to Sign Language Interpreter Services section – ▪ Added link to Department of Enterprise Services contract summary page ▪ Added links to the ODHH online sign language request forms for General Requests and Crucial/Emergent Requests. ▪ Added guidance on how to request an access code from ODHH. ▪ Added link to ODHH internet site. • Updated Revision History	





Assistive Technology Program – State Only Fund

Chapter 16 describes how we provide financial assistance for assistive technology services and devices for adults who are eligible for:

- Adult Protective Services
- Older Americans Act programs
- Waiver services

These adults have **no other funding source** for the assistive technology request and live at home or in other settings.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Linda Garcia Assistive Technology Program Manager
360.968.9745 linda.garcia1@dshs.wa.gov

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POLICY OVERVIEW

It is the Home and Community Living Administration (HCLA) policy that the state-funded services under this program be consumer-driven and demonstrate respect for the rights of persons with disabilities to live as safely and independently as possible in their own community. **State Funds for this program are limited per fiscal year.**

Program funds cover expenses for assistive devices and services, which have no *other funding source*. The program targets to

- Increase the person's functional independence;
- Maximize the person's health and safety;
- Emphasize the central role of the individual in planning for and using the service or device;
- Increase the availability of assistive technology in rural areas and to individuals with limited English speaking abilities;
- Increase the likelihood that adults will stay in their own homes and communities.

PROCEDURES

The Assistive Technology (AT) Program – State only Fund may authorize the purchase of equipment/devices and/or services when there is *no other funding source* available.

Determining Need and Eligibility

When determining need and eligibility for the Assistive Technology Fund, staff must:

1. Document the need based on input from the person with the disability, for specific assistive devices and services in CARE SER notes;
2. Explore all other funding sources **before** submitting the final request to the AT Fund. Other possible funding sources include:
 - a) Durable Medical Equipment (DME) – administered through the Health Care Authority;
 - b) Waiver services such as Specialized Medical Equipment and Supplies, Environmental Modifications and Client Training (COPES only provides DME, and non-DME);
 - c) New Freedom Waiver;
 - d) Roads to Community Living and Washington Roads;
 - e) Community First Choice State Plan (PERS Units only available under Community First Choice State Plan);
 - f) Community Transition or Sustainability Services - CTSS (WAC 388-106-0960, 0965.)



The AT Fund can purchase specialized medical equipment and supplies if the equipment is denied by the funding source or not a covered service under the state plan (see Core Services, Chapter 7). The AT Fund will not supplement HCBS Waiver services such as Specialized Medical Equipment and Supplies and Environmental Modification. The discharge allowance should be used first if an individual is leaving a nursing facility. Other possible funding sources include Medicare, Division of Vocational Rehabilitation, Veterans Administration, Labor and Industries, and private insurance.

When determining need and eligibility outside of CARE for APS or Older Americans Act clients, staff must via secure email to AT Fund Program Manager:

1. Document the need based on input from the person with the disability, for specific assistive devices and services.
2. Gather any other pertinent information from other people involved in the individual's life such as other case workers, family, medical providers, etc.
3. Explore all other funding sources before submitting the final request to the AT Fund.

Service Authorization and Approval Requirements

1. Consult the AT Fund Program Manager, Linda Garcia, at (360) 968-9745, or email at linda.garcia1@dshs.wa.gov to see if there are available funds in the AT Fund or to discuss the client's disability issues, resources and other potential funding sources. **Because funding is limited, do not start the process before you contact the AT Program Manager.**
2. Participants of the program may contact AT Fund Program Manager directly by email or by calling 360-968-9745 to discuss AT needs and resources.

To request approval for AT project services, staff must provide:

- The specific nature of the request;
- CARE Service Summary and Assessment Detail if available;
- The name of the service or device;
- The costs of the service/device, if known;

Email the request to Linda Garcia at HCLA headquarters, at linda.garcia1@dshs.wa.gov.

The AT Fund Program Manager will authorize approval, ordering and payment for the requests and services. HCLA Headquarters fiscal staff will process reimbursements to the vendor. Northwest Access Fund (www.nwaccessfund.org) is the contracted vendor who will assist the



person with the disability to research, purchase the approved equipment, and provide training on how to properly use and maintain equipment.

Summary

The Case Manager/Social Worker must supply the following information to the AT Fund Program Manager within 10 working days of discussion with the AT Fund Manager:

- The specific nature of the request;
- The name of the service or device;
- The costs of the service/device, if known;
- Specific information about the person with the disability, CARE documents if available.

All requests are taken on a first come first serve basis. There are no waiting lists.

The AT Program Manager will deny requests upon depletion of the annual allocated funds.

Case management staff may submit additional AT Fund requests for the same client at the beginning of each state fiscal year.

RESOURCES

Glossary

WORD	DEFINITION
Assistive Technology (AT)	Devices and services that facilitate the ability of people by making the most of functional opportunities in all environments.
Assistive Technology Devices	Any item, piece of equipment, or product system, whether acquired commercially off-the-shelf, modified or customized, that increases, maintains, or improves the functional capabilities of individuals with disabilities. AT devices include, but are not limited to environmental control devices, communication devices and DME equipment, minor vehicle modifications under \$10,000. The modification to the privately owned by the individual vehicle must not cost more than the vehicle is worth.
Assistive Technology Services	Services that assist persons with disabilities to select, acquire, or use assistive technology devices. AT services include but are not limited to: OT and PT evaluations, short-term training, selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices. Because of the limited funding, services for this project are short-term, less than four months.
Durable Medical Equipment (DME)	Equipment, that can withstand repeated use, and which use serves a medical purpose when supplied to individuals with an illness, injury or disability. DME



	includes, but is not limited to wheelchairs, walkers, specialty beds, and mattresses.
Non-Durable Medical Equipment	Single or multiple use supplies that are time-limited, such as diapers or catheter bags.

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Family Caregiver Support Program Policy and Procedure Manual

Policies and procedures for Area Agency on Aging staff working in the TCARE Screening and Assessment tool. The TCARE tool is imbedded in the GetCare system.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Dana Allard-Webb, Family Caregiver Support Services Program Manager

dana.allard-webb@dshs.wa.gov

After December 24, 2025, contact Rosalyn Alber rosalyn.alber@dshs.wa.gov

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FCSP, TCARE information and training resources

CLC/GetCare

<https://www.waclc.org/consite/index.php>

TCARE Assessor Training

<https://certification.tailoredcare.com/login/index.php>

Medicaid Alternative Care (MAC)

<https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/medicaid-alternative-care-mac>

Tailored Supports for Older Adults (TSOA)

<https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/tailored-supports-older-adults-tsoa>

FAMILY CAREGIVER SUPPORT PROGRAM (FCSP) BACKGROUND

Supporting unpaid family caregivers keeps Washington families together and means less people will need to access more costly in-home and residential services. These unpaid family caregivers need support to help prolong their ongoing caregiving activities as well as ensure their own mental and physical health stays intact while coping with related challenges. Research suggests that it is helpful to understand how a caregiver is feeling about their role to tailor the support to their individual needs.

The Family Caregiver Support Program (FCSP), established in 2000, is available in every county in Washington and offers unpaid family caregivers tailored services and resources. There are two goals for the FCSP:

- To provide information and support to unpaid family or other unpaid caregivers (whose care receivers are not involved with the Medicaid funded Long-Term Care service system), and
- To postpone or prevent the need for more expensive forms of care for adults (care receivers) needing ongoing care or supervision.

In 2007, the legislature revised 74.41.050 RCW mandating development of an evidence-based tailored caregiver assessment and referral tool. There was also legislative intent to have greater consistency in both policy and services within the FCSP. The Tailored Caregiver Assessment and Referral (TCARE®) protocol was the model that best matched the legislative mandate and intent. The company that officially oversees the management of TCARE® is Tailored Care (TCARE® Incorporated). Find more information regarding TCARE at tcare.com

Beginning July 2009, Washington started using the TCARE® tool for FCSP. The TCARE® process is based on the premise that providing the right service at the right time best supports those unpaid family caregivers who are burdened by their caregiving responsibilities. TCARE® includes screening,



assessment, consultation and service planning elements, designed to be utilized with the FCSP and is administered through the Area Agencies on Aging (AAA).

TCARE® is a theory-driven protocol designed to identify measures of caregiver stresses and produce recommended services and supports to address those stressors. The goals, strategies and services are determined based on the results of a screening and assessment using multidimensional measures of caregiver stresses and uplifts, depression scores, identity discrepancy as well as care receiver Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) scores. This protocol identifies and prioritizes services using a person-centered planning process targeted to support the caregiver's abilities to provide care for the care receiver as well as to better care for themselves.

The certified TCARE assessor is tasked with helping caregivers build insight into their caregiving journey so they can use information and skills provided to prepare them for future needs of their care receiver. Skilled and supported caregivers are more likely to navigate a caregiving journey with better physical and mental health.

Aging and Long-Term Support Administration (HCLA) administers FCSP through funds primarily received from state and federal monies as well as other funding and unpaid supports.

FCSP CAREGIVER ELIGIBILITY

Who is Eligible to Receive FCSP Services?

Under the Washington State FCSP, an eligible "family caregiver" is an individual who is a spouse, relative neighbor or friend who has primary responsibility for the care of an adult with a functional disability* and who does not receive financial compensation for the care provided. (RCW 74.41)

Under the **National FCSP (Title III E – Older Americans Act)**, family caregivers are:

- Adult family members or other informal caregivers providing care to individuals 60 years of age and older
- Adult family members or other informal caregivers providing care to individuals of any age with Alzheimer's disease and related disorders
- Older relatives, including parents, age 55 and older providing care to adults ages 18-59 with disabilities

National FCSP (Title III E – Older Americans Act) Definition of Greatest Economic and Social Need

- For the purposes of prioritization of local services, Greatest Economic Need is defined in accordance with 45-CFR-1321.3.

*The term functional disability refers to any reduction in the adult's ability to perform essential activities of everyday life. These activities are necessary to maintain health, independence and quality in an adult's life.



Can Caregivers who Live Outside of Washington Participate in FCSP?

Please refer to local AAA policy.

It is not a state requirement that caregivers live in the state of Washington. Caregivers must be caring for a care receiver who lives in Washington.

What is Considered Financial Compensation?

If an individual receives wages for the care they provide to the care receiver, these wages are considered financial compensation. However, if transportation or lodging/room & board is offered to a family member to make it possible for them to provide care, these types of costs are allowable and not considered as financial compensation.

How is the Caregiver Age Requirement Different from State (SFCSP Funding Rules) to National (NFCSP Funding Rules)?

The age of the caregiver is not specified under the statute for the State FCSP(SFCSP), whereas under the National FCSP(NFCSP) the caregiver must be an adult, 18 and over, in order to be served.

What is the Priority Caregiver Population for State FCSP (SFCSP)?

The state legislature's priority population for the State FCSP (SFCSP) is unpaid family caregivers whose care receivers are not receiving Medicaid funded, Long-Term Care Services (e.g., CFC/ COPES, Medicaid Personal Care or MAC/TSOA). The SFCSP is viewed as a resource to help divert care receivers from the Medicaid long-term care system by way of supporting the unpaid caregiver. When SFCSP support is requested for an unpaid family caregiver whose care receiver is getting a Medicaid funded long-term care service, an Exception to Policy (ETP) should be utilized to track total caregivers served whose care receivers use Medicaid services.

What is the Current Eligibility Threshold for Step 3 for any New Unpaid Caregiver Who Enrolls in the FCSP?

In order for a family caregiver to access the full TCARE® system (screening, assessment, consultation/care plan and services as recommended by the TCARE® algorithm) a family caregiver must have either:

- One high score in any of the three caregiver measures (relationship, objective, stress) or in depression or identity discrepancy; or
- A total of three medium scores in the caregiver measures scales, inner struggle or family role as indicated in the TCARE® screen.

Statewide eligibility thresholds may be changed in the future depending on available funding and/or demand.

NOTE: Please verify your local AAA eligibility policy.

FCSP PROCESSES

At all levels of planning for caregiver services, FCSP encourages family caregivers to seek available low cost and no cost supports (friends, family, faith communities) and other funding sources (e.g., Medicare, Apple Health, health and long-term care insurance, Veteran's benefits) to supplement state and federal FCSP funding.

TCARE Assessor Wisdom: Many caregivers will need more than one contact before agreeing to engage in the TCARE process. Taking time to build a trusting relationship with the caregiver is very important to the process. When the screener/case manager/Family Caregiver Specialist takes time to develop a trusting relationship with the caregiver, the caregiver will be more willing to share information about sensitive subjects like depression and feelings of guilt. That trust will go a long way in helping the caregiver develop insight into their caregiving experience.

Step 1: Gathering Demographic Information

Step 1 level of services in the FCSP protocol is gathering and entering the demographic information into the GetCare system. (See OAAPS minimum data set in the GetCare Library for guidance on required demographic elements.)

When a family caregiver is identified as needing FCSP's Information & Assistance services, the caregiver and care receiver should be entered into the GetCare system. Washington needs the data about the people we serve for planning, reporting and requesting additional state and federal funding. Use progress notes in GetCare to document one time only funding.

Step 2: TCARE Screen

Step 2 level of services begins with the TCARE® Screen. The screen provides a triaging tool compiling questions answered by the unpaid caregiver to assess risk factors for burnout from caregiving task(s). TCARE® screenings can be conducted in a variety of settings: in person, by telephone, or through a self-screen form, called the Family Caregiver Survey. The scores from the TCARE® screen determine unpaid caregiver eligibility for Step 3 Level Benefits.

What screen scores make a caregiver eligible for an assessment?

When using the screen for purposes of assessment eligibility, a caregiver must have a score of **One High or Three Mediums** in any of the following components to advance to an assessment, which is the next step in this process.

1 high score in any of the following components:

OR

3 medium scores in any of the following:



Stress Measure		Stress Measure
Relationship Measure		Relationship Measure
Objective Measure		Objective Measure
Inner Struggle		Inner Struggle
Family Role		Family Role

Before finalizing a TCARE® Caregiver Personal Survey that has been sent to the local AAA/contractor's office, it is best practice that a TCARE® Screener or Assessor contact the caregiver to discuss their answers and respond to any questions they may have had in filling out the survey. This is especially true for caregivers who speak English as a second language, or don't speak English. The process of contacting the caregiver and entering the screening scores in the GetCare system must be completed within **10 business days**.

TCARE ASSESSMENT AND CARE PLANNING

Step 3: TCARE® Assessment

The full TCARE® Assessment process includes all of the screening questions, as well as assessment questions focused on both the caregiver's experience regarding the kinds and amount of care tasks they provide for the care receiver and the care receiver's health condition. Some of the major areas covered in the assessment: care receiver behaviors, memory issues, Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), cognitive performance questions and diagnoses/conditions.

One home visit at any time during the TCARE® assessment process; (Full Assessment, including all Screen and Assessment questions, consultation, care plan and verbal approval by the unpaid family caregiver) is required before services can be authorized during the initial assessment process as well as during subsequent annual TCARE® reassessment processes (Step 3).

- If the caregiver and care receiver reside together, at least one annual home visit must occur in the home with both caregiver and care receiver present. This home visit allows the assessor to evaluate the care receiver's living situation.
- When caregiver and care receiver don't live together, a home visit in the care receiver's home is strongly encouraged.
- If the care receiver is unwilling to have a home visit take place, consult with your supervisor, and enter a progress note in GetCare.

Step 3 Eligibility

Verify FCSP Caregiver eligibility parameters with your local AAA as they may be different than state policy.

- In order for an unpaid family caregiver to be eligible to access the full TCARE® system (screening, assessment, consultation/care plan and services as recommended by the TCARE® algorithm) a family caregiver must have either:



- One high score in any of the three caregiver measures (relationship, objective, stress) or in inner struggle or identity discrepancy; or
- A total of three medium scores in the caregiver measure scales, inner struggle or family role as indicated in the TCARE® screen.

Statewide eligibility thresholds may be changed in the future depending on available funding and/or demand.

NOTE: If a AAA needs to vary its Step 3 eligibility criteria from that which is stated above, ALTSA FCSP staff must be notified in writing of the reason for this change and approve it prior to the eligibility change being implemented.

NOTE: If a AAA needs to vary its Step 3 eligibility criteria from that which is stated above, ALTSA FCSP staff must be notified in writing of the reason for this change and approve it prior to the eligibility change being implemented.

TCARE Assessor Wisdom: Some AAAs complete an assessment even if a caregiver doesn't qualify for an assessment. These AAAs believe that an assessment is an opportunity for caregivers to take a look at their journey. If they don't have the score levels to make them eligible by state standards, the AAA doesn't have to choose to support them with respite or other expensive services. Or AAAs can use an ETP if the assessor believes the caregiver will benefit from respite. The thinking behind this is that many caregivers won't understand that they are a caregiver until they answer those questions. The conversations and insight that comes with a TCARE assessment can help the assessor build a trusting relationship. Over time, the caregiver may feel more comfortable in sharing.

The caregiver can remain active in the FCSP if their care receiver does not want to participate in the program. However, for the caregiver to receive respite care or other ongoing services, the care receiver needs to be willing to receive care from a respite provider agency that provides in- or out-of-home respite services.

FCSP Policy Reminder: To be eligible for Respite Services paid through FCSP, a caregiver must provide a minimum of 40 hours of care per week (including supervision) or live with the care receiver who needs ongoing help. See WAC 388-106-1210

Available Resources: After completion of an assessment, a caregiver is eligible to receive services associated with the TCARE algorithm selected strategies identified in TCARE® and/or any service the caregiver desires if it is available at the local AAA.

FCSP Policy Reminder: TCARE® Assessors employed by a community FCSP TCARE® subcontractor through an AAA are required to inform caregivers of all the relevant, available services in their community, including all FCSP services contracted by the local AAA. This is to ensure that caregivers have sufficient information to make well informed choices on services that may best suit them.

CONSULTATION/CARE PLAN DRAFT

After an assessment is completed, the TCARE® assessor consults with the caregiver to facilitate service planning. The consultation with a caregiver helps to determine which services will comprise the final care plan and helps to explain the potential benefits of the services to the caregiver. It is important that the caregiver understand why the assessor is recommending the services. Helping the caregiver see WHY certain services are being recommended is important and will assist the caregiver to make decisions about what services they will accept.

A draft version of the care plan is developed by the TCARE® assessor after a TCARE assessment is completed. The consultation with a caregiver is a person- centered conversation, that reflects

- The information the caregiver gave during the assessment
- The caregiver's beliefs, preferences and wishes
- The goals, strategies and the algorithm determine which services will be recommended in the draft care plan.
- Only the services accepted by the caregiver will be included on the final care plan.

TCARE Assessor Wisdom: During consultation, it is best practice to talk about wellness and the importance of finding time for respite and other forms of self care. Including a wellness activity in the care plan will help to remind the caregiver of the importance in managing their own mental and physical health.

Health Goal

It is important to talk with caregivers about a health goal regardless of depression score. Health Goal is to be addressed during the TCARE® Consultation process. Our data reports at least 40% of caregivers in Washington have some signs of clinical depression. Caregiver stresses and other components, including caregiver's inner struggle can affect both mental and physical health in caregivers.

What is the Timeframe for Staff to Complete a TCARE® care plan for a family caregiver?

FCSP Policy Reminder: TCARE® Assessment process within CLC/GetCare: For an assessment to be complete, FCSP staff needs to move the assessment from draft to locked status and send the



assessment to TCARE Inc. for the TCARE® algorithm to run. In the TCARE® assessment process within GetCare a screen must be moved from draft to locked within 30 calendar days to avoid repeating the screening process with the caregiver. A copy to review function is built into the GetCare/TCARE® system so that responses in the screening can be populated into a new assessment. All questions need to be asked during each screen or assessment process.

The Final Caregiver Care Plan is developed from the draft version of the Caregiver Care Plan. The plan will include the agreed upon services and expected outcomes.

Outcomes need to be measurable and specific. For example, instead of stating that a caregiver will learn how to transfer the care receiver from the bed to wheelchair, the assessor might include a statement in the Care Plan that says, “Caregiver will report having less back strain after receiving instruction on safe transfer skills.” This will promote conversation at next rescreen and teach the caregiver about the importance of self care.

Care Plan Approval

Since the family caregiver is the client for the TCARE assessment process and care plan, the TCARE® Assessor will request the caregiver’s signature on the Caregiver’s Care Plan.

- The caregiver’s signature signifies acknowledgment of services and receipt of the Caregiver Care Plan.
- Do not delay services if caregiver’s signature has not been obtained. Only the caregiver’s verbal approval is needed to begin services.
- The care receiver’s signature or verbal approval is never required in FCSP.
- The TCARE® Assessor signature is required to acknowledge the agreement between the two parties.

Available Resources: After completion of an assessment, a caregiver is eligible to receive services associated with strategies identified in TCARE® and/or services the family caregiver has requested that are available in the AAA area. **See strategies and services in the appendices at the end of the chapter.**

FOLLOW-UP AND TCARE® RESCREENING (CHECK LOCAL AAA RULES)

Step	Rescreen every 6 months	Next Steps	Assessment
Caregivers at Step 1 Up to \$250. One time funding. If caregivers require further	(No screen at Step 1) Best Practice - Follow up with phone call to caregiver	Discuss benefits of TCARE screen and assessment with caregiver. Encourage	



services, a screen will need to be completed.	to ask if other services are needed.	screen (caregiver personal survey)	
Caregivers at Step 2 Up to \$500 annually.	Complete screen over the phone or if caregiver has prior screen, send Caregiver Survey and response card to caregiver and follow up with a call to ensure caregiver understood questions.	If screen scores meet assessment eligibility talk with caregiver about benefits of assessment and care plan	Complete Assessment if caregiver is eligible and agrees to an assessment. (see Step 3)
		If scores are too low for to advance to Step 3, talk with caregiver about services available at step 2 and authorize services,	Rescreen in <u>6 months.</u>
Caregivers at Step 3 Full range of services depending on AAA contracted services, policy, community resources and offerings. Once a caregiver is eligible for Step 3, they will remain eligible for Step 3 even if their scores fall below eligibility levels. The family caregiver can move back to step 2 if and when they wish to.	Send Family Caregiver Survey and response card to caregiver and follow up with a call to answer questions (best practice), or complete over the phone. If caregiver or care receiver have a significant change in health or disability, complete full assessment process (screen, assessment consultation and care plan)	If there are no changes, document in progress notes. If scores are higher because of a significant change, or if caregiver requests a new assessment, complete a new assessment process.	Annual Reassessment: Complete full assessment (screen, assessment, consultation and care plan)

For caregivers at Step 1 or Step 2

When caregivers are not requesting additional FCSP services, a rescreen (or the Family Caregiver Survey) at the six-month follow-up should still be encouraged. The rescreening responses will enable the local and state FCSP staff to learn about the effectiveness of the program and caregivers will be able to see how they are doing as compared to prior screening (e.g., have different score ranges in areas such as family role, caregiver measures, inner struggle, etc.) Those who choose not to be rescreened are to be encouraged to call back if their situation or needs change.

When caregivers wish to continue receiving FCSP short-term and/or limited services and have not reached the annual Step 1 or Step 2 financial cap, they can undergo a rescreen every six months.

If the caregiver's rescreen results in higher ranges, FCSP staff should consult the AAA's current eligibility threshold to see if the caregiver should be referred for a full TCARE® assessment.

Rescreening for Caregivers at Step 3

All caregivers who have completed a full assessment and wish to continue to receive services must have a completed rescreen at least every **6 months** through a self-screen (Family Caregiver Survey), telephone or in-person interview. It is recommended to contact caregiver and talk through Family Caregiver Survey over the phone to ensure the caregiver fully understood questions if they filled out family caregiver survey alone. This is especially important if the caregiver doesn't speak English or speaks English as a second language.

At time of rescreen, the assessor should consult with the caregiver to determine if the services are still helpful and desired. If so, then the assessor will make a case note and continue to include the service in the care plan. In the case of scores worsening, that is very common as most care receiver's conditions are progressive as the caregiver's stresses may be increasing. There may be cases where, without FCSP intervention, the caregiver's stresses would be even higher; so, while there is an increase in scores, it is likely that stresses would be even higher without intervention, or the care receiver would have likely been placed in a Long-Term Care setting.

If there is a significant change in the health or abilities of the caregiver or care receiver, or if the caregiver asks for a reassessment, a reassessment should be completed.

If no significant change assessment is needed, write a progress note and continue services as needed until annual reassessment.

What is the procedure for the Sixth Month Screen?

PROCESS

- 1. Create a new screen in GetCare **OR** Copy to Review the most current sixth month screen in GetCare.**
- 2. If there are no changes, write a progress note reporting no changes needed.**
- 3. Screens need to be completed every 6 months (by last day of the seventh month)**

If a caregiver has had a significant change in their level of caregiving, or requests to have a new assessment, a new assessment must be conducted and a new care plan must be created that reflects the changing needs of the caregiver.

ANNUAL REASSESSMENT

Caregivers who are at Step 3 and wish to continue services must receive an annual reassessment **within 13 months** of the most recent assessment regardless of the screening levels. (Once a step three, always a step 3 if that is the wish of the family caregiver.)

At least one home visit must take place during the annual reassessment process (screen, assessment, consultation, care plan, home visit). As caregiving can change dramatically over time, it is important to see the caregiver and the care receiver on an annual basis.

At the annual TCARE® reassessment, if a family caregiver is receiving respite care services and wants to continue to receive them and the TCARE® scores indicate that the caregiver has benefitted from the services, the TCARE® Assessor should determine if the family caregiver is still living with or providing **40 hours per week** of care to the care receiver (40 hours includes supervision). If the family caregiver is providing less than 40 hours per week and it looks like the respite services are helping, the **AAA, according to their own local policy**, can decide whether to reduce or provide continued respite services. For example, the AAA may set the required number of unpaid caregiver hours at a lower lid, e.g., 25 hours a week, to still qualify the family caregiver for respite services. If a family caregiver still lives with the care receiver they would automatically still qualify for respite services depending on the outcome of the reassessment and if the TCARE® Assessor and family caregiver determine that respite services are still a benefit to the caregiver.

Caregivers Caring for More than One Care Receiver

When a caregiver cares for more than one care receiver, the TCARE Assessor will complete separate assessment processes regarding each care receiver. The reason is that the caregiver may have different tasks they do for each care receiver, the caregiver may feel different caregiver measures for each care receiver and may benefit from different services regarding each care receiver. For example, a caregiver may feel the need to attend a support group because of the stresses they feel about caring for their care receiver who has Multiple Sclerosis but feels the need for respite services due to caring for someone with Alzheimer's disease.

Check local AAA policy for providing services to caregivers who have multiple care receivers.

If a Step 2 caregiver is caring for two or more care receivers, the caregiver's service package should not exceed a total of \$500.00 annually. And, if eligible, a caregiver should be encouraged to proceed to Step 3 to receive a possibly more robust service package.

RESPITE POLICIES

The purpose of respite care is to provide relief for families or other unpaid caregivers of adults (age 18 and over) who are living with functional disabilities. Where available, in-home and out-of-home respite care options can be provided on an hourly and/or daily basis, including 24-hour care for several consecutive days. Staff providing respite care services provide supervision, companionship and personal care services that are usually provided by the primary caregiver. Services appropriate to the needs of individuals with cognitive impairment are also provided. Medically related services, such as administration of medication or injections, are provided by a licensed health practitioner.



Respite providers require a contract. Check with your AAA FCSP Coordinator for a list of your current contracted respite providers before authorizing respite services.

The Washington Administrative Codes (WACs) that direct respite care services are WAC 388-106-1200 through 1230 and included in **Appendix H** of this Policy and Procedure Manual.

AAA Respite Procedures

The AAAs must have a written procedure for:

- Determining, with the caregiver and care receiver, the amount of respite care services authorized, when it will be provided, and the name of the respite agency provider. This information must be included in the caregiver's TCARE® Care Plan.
- Arranging for one-time or ongoing respite care with the agency provider and providing them with the TCARE® Respite Information form.
- Maintaining contact with caregivers to determine further needs and/or changes to the respite care plan.
- Providing a substitute respite care worker if the scheduled worker has to cancel.
- Attempting to provide respite care when a caregiver has an emergency; and
-

FCSP Policy Reminder: FCSP-funded respite services shall be terminated upon notification of a care receiver participating in COPES or Medicaid Personal Care, MAC/TSOA, a Developmental Disabilities waiver, or living in an assisted living, adult family home or nursing home facility.

Guidelines for Determining Financial Participation for Respite Care Services

The Department requires eligible care receivers to pay part, or all of the cost of respite care services based on their monthly income (above 40% of the State Median Income (SMI)). The FCSP staff will administer the sliding fee scale (Sr. Citizens Services Act (SCSA) schedule) which is updated annually, to determine the share of the cost of these services. The related income question is asked in Question #20 in the TCARE® Assessment.

NOTE: Remember to consider other sources of payment such as Medicare and/or Apple Health/Medicaid, health and long-term care insurance or Veteran's benefits for payment towards respite care and other caregiver/care received services.



How is the Participation Fee Determined?

- 1) There is no charge to the care receiver whose income is at or below 40% of the SMI, based on family size.
- 2) If the care receiver's gross income is above 40% of the SMI, then, utilizing the SCSA sliding fee scale, the TCARE® assessor will determine the percentage rate the participant is required to pay towards the cost of the respite care services; and
- 3) If the care receiver's gross income is 100% or more of the SMI, the participant must pay the full cost of the respite care services.
- 4) If the care receiver is experiencing extreme financial hardship (e.g., high medical expenses) and cannot pay for their share of the cost of the respite care services, the AAA's FCSP Coordinator or Supervisor may grant an ETP and then the Assessor must document this situation in GetCare Progress notes. At the next reassessment, the care receiver's income will be reviewed for financial participation if respite care services are continued.

How is Income Defined?

A general definition for income includes, but is not limited to, all the money received which the participant can use to meet his/her needs, such as cash, pension, wages, Social Security benefits, Veteran's benefits, dividends.

The cost of respite care is determined by the number of hours or days of respite care service authorized and used, and the rate for the service.

Listed below are examples of how FCSP staff shall determine the care receiver's income:

A.1 If the caregiver and eligible care receiver are married to each other, all the monthly income received in either or both names shall be combined and one-half of the total shall be considered the participant's income. Refer to Column One on the current (annual) SCSA sliding fee scale.

A.2 If the caregiver and eligible care receiver are married to each other and there are dependent children in the home, all the monthly income received in either or both parents' names shall be combined and one-half of the total shall be considered the care receiver's income. Refer to the SCSA fee scale column which represents the number of persons in the household less one (ex. for family of 4, use column 3).

Example: One spouse is the care receiver, the other is the caregiver, and they have two children under 18. The couple's combined monthly income is \$3,000. One-half the total is \$1,500. The monthly income for column 3 (total of persons in the household less one because the husband and wife are counted as one) on the fee schedule is less than 40% of the SMI, so the care receiver does not have to pay participation.

A.3 In a case where both members of a married couple are respite care receivers and the unpaid caregiver is a friend or relative, all monthly income received in either or both names of the married



couple shall be combined and then divided in half. Refer to Column One to determine what percentage of cost each spouse would pay.

A.4 If the care receiver is single (not married to caregiver), and the caregiver is a friend or relative, the only monthly income counted toward participation would be that of the care receiver. The only monthly income counted toward participation would be that of the care receiver. Follow the SCSA sliding fee scale by counting the people who are supported by the single care receiver's income to determine the participation amount. The unmarried care receiver is considered head of their own household, even if they live with another relative/caregiver.

A.5 In a case where there are two non-spousal, care receivers living in the same household and are cared for by a relative or friend, each care receiver's income will be considered separately when determining the percentage rate of participation amounts. The cost of the respite service will be prorated among the two care receivers. They will share in paying for a percentage of the service (if their income is above 40% of SMI)

A.6 Refer to the fee schedule, Column One for the appropriate percentage of cost each participant will pay.

NOTE: Under no circumstances is the combined multiple care receiver's participate to exceed the cost of the respite service(s).

A.7 Refer to local AAA policy. In the case of a care receiver who is a veteran receiving Veteran's Aid and Attendance benefits for their long-term care needs, these benefits may be recognized as income and therefore counted. There are many different Aid and Attendance and caregiver programs in the VA with differing rules. It is important to keep in mind that the caregiver cannot be receiving pay through the VA program and also receive FCSP respite care. That caregiver would be considered a paid caregiver and therefore ineligible for FCSP funded respite.



Spectrum of Respite Care Services

AAA Respite Billing Requirements:

1. The AAA's National Family Caregiver Support Program (NFSCP) funding for Respite Care Services is to be used only when the care receiver's income is at or below the 40% SMI or when participation is a financial hardship. All other respite care charges must be billed to the State funded FCSP. For more information go to MB# H12-056 – Procedure, August 9, 2012. Respite Care Services and Other Non-Core Personal Care Services Funding Source Billing Options Related to Participant Contributions.
2. As part of the monthly invoicing to ALTSA, the AAAs must report all funds received from respite care participants by the agencies collecting them. These funds shall only be used within the provider agencies for purposes of the Family Caregiver Support Program.

What Types of Respite Care Providers can be Used in FCSP?

Respite care services are to be contracted with the local AAA. The types of possible respite agency providers that can be contracted include available residential facilities: licensed boarding homes, adult family homes, assisted living, nursing facilities, along with adult day services, home care/home health agencies, and any other providers such as Senior Companion, Volunteer Services, etc. Provider agencies shall be monitored for compliance according to the HCLA/AAA Policy and Procedures. Respite services may also be provided through an unpaid, network of family, friends and community members.

Family caregivers will be able to choose from available contracted agency providers in their service area. Special requests may be made for cultural, ethnic and language considerations. Caregivers may request a change in agency providers at any time. The array of respite care providers (volunteer and/or paid services) should cover all levels of care including:

- A. Companionship, supervision and meal preparation,
- B. Help with activities of daily living (e.g., personal care, lifting, turning, transferring, dressing, eating, walking, medication reminders, etc.),
- C. Tasks such as catheter care, injections, pressure ulcer care, that require licensed medical or health professionals for respite type care such as a Licensed Practical Nurse or Registered Nurse, and

Out of home services: Adult day services where available (socialization, nursing services, rehabilitation, classes and many other activities) or short-term residential facility stays (nursing homes, assisted living, boarding homes and adult family homes).

There may be instances during a respite episode when transportation to a medical appointment or essential shopping* may be provided to the care receiver by the home care agency worker. (This would

apply if the family caregiver would normally be providing transportation but is unavailable during this episode(s) because s/he is taking a respite break.) This service is allowable if the TCARE® Assessor communicates this need in a written form (this could be included in the caregiver's care plan, Respite Care Information Sheet or AAA/Respite Care Authorization form) to the home care agency ahead of time. The home care agency worker will use 1) public transportation (if appropriate) or 2) insured private vehicle, provided the home care agency worker has a valid driver's license/insurance coverage.

*The Medicaid agency home care rate already includes parity for transportation to medical appointments and essential shopping. Because respite care services utilize this same home care rate, it's reasonable to expect transportation to medical appointments or essential shopping can be included in the respite service package.

Transportation for essential shopping would also be permissible under FCSP Supplemental Services when a home care agency is contracted to do housework and errands type services if the TCARE® Assessor communicates this need in a written form and follows the same procedures for the home care agency worker as stated above.

The following WAC pertains to nursing facilities that provide respite care. [WAC 388-97-1880](#).

Respite Care Provider Staffing and Monitoring Standards Licensing and/or certification of any respite staff are the responsibility of the Home Care/Home Health agencies, Adult Day Services and Residential Services. Check with AAA contract staff on the required certification, licensing, training and background checks needed for all contract respite providers.

If an AAA is unable to provide the array of respite services as listed in this section A through D, above, the AAA must contact HCLA Program Manager for technical assistance regarding adequate provider network.

The AAA must ensure they are utilizing the current respite provider rates and the Annual SMI Schedule (SCSA) to determine care receiver cost contribution/participation.

Rates for Respite Provider Agencies

Rates for In-Home Respite Service Providers

In-home respite care workers shall be paid according to the labor standards and applicable legislation (RCW 74.39A.310). Rates for Home Care Respite Provider Agencies are governed by the following legislation:

[RCW 74.39A.310](#) which requires that the contribution rate for caregiver compensation, paid leave, training and AWHI be paid by the department to home care agencies at the same rate as negotiated and funded in the Collective Bargaining Agreement (CBA) for Individual Providers (IPs) of home care services. This contribution rate is connected to the CBA and is communicated in an MB as changes occur.



Respite care services can contract with home care or home health agencies that employ Nursing Assistant Certified (NAC) staff at their established rate. Nurse delegated tasks are not included within the respite care services.

AAA staff will utilize the latest Management Bulletin on home care rates to determine applicable respite care rates.

Rates for Out-of-Home Respite Providers

Each AAA shall negotiate for an hourly and/or a daily rate with providers whenever possible.

- If an agency provider has only an hourly rate, this rate shall be paid for each hour of respite care used, including 24 consecutive hours of respite care.
- If an agency provider (such as an adult day or residential service) has only a daily rate, the rate shall be paid for 24 consecutive hours or less of respite care used.
- If an agency provider has both an hourly and daily rate, the AAA shall reimburse the provider whichever rate (hourly or daily rate) is lowest.

When a respite episode warrants an exceptional rate for a non-Medicaid funded, out-of-home provider, (e.g., only one facility is available in the area, requires a higher rate, and is still more cost effective than some other type of facility), then the AAA may negotiate an exceptional rate and document it with the subcontractor's contract.

The department shall pay Medicaid facilities the Medicaid rate approved for that facility (e.g., nursing homes, etc.). It shall be unlawful for any facility, which has a Medicaid contract with the department to charge any amounts in excess of the Medicaid rate for services covered, except for any supplementation permitted by the department pursuant to RCW 18.51.070. The participant shall pay for services not included in the Medicaid rate.

The agency provider shall not be paid for more service hours than authorized by the FCSP. Annually, HCLA will notify AAAs of the current rates paid by the department to providers offering a same level of service by respite care providers.

How Should Respite Care Episodes be Scheduled for Emergent and Non-Emergent Situations?

TCARE® Assessors shall encourage eligible caregivers to schedule episodes of respite care in advance. Requests for respite care, which are of an emergent nature, shall have first priority. An example of such an emergent need for respite would be when the caregiver becomes ill or injured to the extent that the caregiver's ability to care for the care receiver is impaired. It is understood that emergencies may not be able to be resolved if respite resources, e.g., providers are not available to meet a given caregiver's needs.

In-non emergent situations, respite care is available on a first-come first-served basis provided that sufficient funding resources are available to fill the requests each month. Respite care services are not

part of an entitlement program. The amount of respite allotted is based on funding and/or home care agency direct care worker availability along with the needs of the particular caregiver and can vary from time to time.

If respite care cannot be provided, refer to the Waiting List section criteria. If a cancellation occurs, respite care shall be made available to those on the waiting list according to the service priority categories.

AAA FCSP SPECIAL CIRCUMSTANCES

Caregivers in Crisis

Local AAA policy will determine how best to serve caregivers in crisis. A caregiver should be screened, assessed, and have a completed care plan within 30 calendar days following the crisis if ongoing services exceeding \$500 were authorized.

Exceptions to Policy (ETP) and Documentation

Each AAA must develop an ETP process to be followed when exceptional cases arise within FCSP and the TCARE® process. The process must include a written approval process between the assessor and their supervisor or the AAA FCSP program coordinator before authorizing the ETP. For tracking purposes, staff must enter the demographics on the caregiver and care receiver, use progress notes in GetCare to document an exception to policy (ETP). Staff shall discuss ETPs with a supervisor and/or the FCSP Program Coordinator. In addition, a short description of the exception and what action was taken to address the situation is needed in progress notes. The date and name of authorizing party's approval of the ETP (e.g., supervisor or FCSP Coordinator) must also be included in the progress notes.

Examples of ETPs

- A caregiver who is in a crisis can be served with Step 2 or 3 FCSP services without first going through a screening or assessment. A TCARE® screening and/or assessment/care plan must be completed within 30 calendar days if ongoing services are needed.
- A caregiver who needs some supplies or a piece of equipment within Step 1 (if a TCARE® screen has been completed) or Step 2 that exceeds the dollar amount.
- For a caregiver who has Limited English Proficiency (LEP) and is requesting services, supplies or equipment, FCSP screeners and TCARE® assessors are asked to conduct a TCARE® screening/assessment using interpreter services. If this is not feasible, follow the documentation procedures for an ETP.
- If the screener has a “gut feeling” that an existing caregiver who rescreens at less than the eligibility threshold is truly in need of a higher level of service such as Step 2 or Step 3, discuss with supervisor.

- There may be those instances where a family caregiver who is struggling with the caregiving role provides unpaid care to an adult who is receiving Medicaid long-term care services (e.g., CFC/COPES). An exception can be made if there are no other resources available to help the caregiver. This individual can also be served without an ETP at Step 1 with resources like support group referrals, conferences etc. but if other needs occur (e.g., consultation, counseling) an ETP is needed. Respite care services are not permitted.
- In certain situations (e.g., culturally diverse communities), a primary caregiver may not be distinguishable from another family member/unpaid caregiver providing care to the same care receiver. In these circumstances, the total service package for these multiple caregivers should not exceed (in hours or funding) the AAA's limit for one caregiver.

Funding Related Waiting List Criteria for Respite and Counseling Services

If a AAA needs to implement a waiting list for FCSP funded counseling services, or respite services, please use the criteria below. The TCARE® score ranges (low, medium, and high) will be used to prioritize caregivers on a waiting list. Uplift scores do not count for any of the priorities. Priority one is considered the highest priority.

Priority 1 – All 5 highs

Priority 2 – 4 highs in Inner Struggle, Objective, Stress, and Relationship Caregiver Measures

Priority 3 – 4 highs in Inner Struggle, Relationship, Stress Caregiver Measures, and Family Role **Priority 4**

– 3 highs and 2 mediums. Highs must include Inner Struggle and Relationship Caregiver Measure

Priority 5 – 3 highs and 1 medium. Highs must include Inner Struggle and Relationship Caregiver

Measure

Priority 6 – 3 highs, no mediums. Highs must include Inner Struggle and Relationship Caregiver Measure

Priority 7 – 2 highs to include Inner Struggle and Relationship Caregiver Measure

Priority 8 – 2 highs. One must include Relationship Caregiver Measure

The waiting lists are established only for caregivers who are new to TCARE®. There may be multiple caregivers on a waiting list who are in the same priority category. When an opening becomes available, the caregiver who has been on the list the longest will be served first.

FCSP FREQUENTLY ASKED QUESTIONS

Are There Restrictions on Purchasing Goods or Services Under the FCSP Steps 1-3?

Yes, funding from the FCSP cannot be used to pay for rent, car repairs, computers, entertainment items, vacation expenses, major appliances, gift cards or utility bills. If staff are unsure of allowable items or services, contact HCLA FCSP Program Managers.



Can a Caregiver Receive FCSP Services if the Care Receiver Lives in an Assisted Living Facility, Paid for Privately?

The state and federal funding sources have different viewpoints on this question:

The State FCSP RCW 74.41, states that the program is to “encourage family and other nonpaid individuals to provide care for adults with functional disabilities at home, and thus offer a viable alternative to placement in a long-term care facility”.

For National FSCP (NFCSP), the Older Americans Act defines a caregiver as: An adult family member or another individual, who is an “informal” provider of in-home and community care to an older individual.

Based upon the different definitions, the state FCSP funding should be limited to family caregivers who care for adults at home, whereas the NFSCP can include caregivers who’s loved ones live in an Assisted Living Facility. When applying the NFSCP funding, HCLA staff cautions AAAs about using costly services for caregivers whose care receivers are living in long-term care facilities.

Can an AAA Provide Services to Caregivers who Live in WA State but Care for Family Member Living Outside of the State?

AAAs can provide services to caregivers, on a case-by-case basis, as determined by local FCSP policy.

How Should Caregiver and Care Receiver Privacy and Confidentiality be Protected?

By its nature, the Family Caregiver Support Program involves collecting sensitive, private information from caregivers and care receivers. Such information must be treated with the utmost care. The Family Caregiver Support Program, is considered a Health Care Component under HIPAA and therefore is subject to its rules, oversight and penalties. Screen and assessment information is confidential and subject to RCW 42.56.590 and RCW 19.255.010 if a breach occurs. If the TCARE® Assessment and Care Plan involves the sharing of caregivers’ responses of any health-related information (e.g., results of the depression scale) AAAs shall get signed consent forms (the AAA can choose the DSHS 14-012 form or similar one) from the caregivers so they are aware that the FCSP staff may share the minimum necessary information with contracted partner programs in order to help provide effective caregiver services. The GetCare database is protected under strict security protocols and AAA security contract language. Only those staff with the proper security clearance and documented confidentiality training are eligible to access the system.

For Activities of Daily Living needs and health-related information on the care receivers that will be shared with providers (e.g., respite care providers), a signed consent form (the AAA can choose the DSHS 14-012 form or similar one) should also be utilized and signed by the care receiver or their designated representative.



What Documentation is Needed in the Family Caregiver File When Purchases are Made?

Staff that authorize services under the FCSP are responsible to ensure that, when purchasing goods/services or one-time set-up fees on behalf of an eligible family caregiver, documentation within a family caregiver file (e.g., copies of authorization and billing tracking documents) must include:

- A caregiver's name,
- A description of the goods and services including purchase price,
- Proof (can be verbal verification with caregiver) the goods were purchased, and
- Goods or services were received, the costs verified, and purchase is consistent with needs identified in the TCARE® care plan.
- **No cash or gift cards may be offered to family caregivers.**

It is important to also consult local AAA policies for additional documentation that may be required.

Can a Care Receiver Receive General Case Management at the Same Time Their Family Caregiver Received FCSP?

Yes, and the FCSP staff should coordinate with the General Case Management staff to optimize service delivery and avoid duplication of efforts and resources.

Can a Caregiver Receive Services Through a Kinship Care Program (Kinship Caregivers Support Program or Kinship Navigator Program), and Simultaneously from the Family Caregiver Support Program?

Yes, as these programs serve different primary care receiver populations (adults versus children), the needs of the caregiver can vary based on their role. The FCSP staff should coordinate with the kinship care staff to optimize service delivery.

TCARE Mentor Tip: If caregiver wants to stay connected to FCSP through Step 1, contact with these caregivers, at least every six months is a good way to determine caregiver's desire for more or less involvement with the FCSP.

Can an Area Agency on Aging Change Eligibility Criteria?

If an Area Agency on Aging must change eligibility criteria, email a summary of plan to the HCLA Family Caregiver Support Program Manager.

TCARE/GETCARE

For questions and more in-depth tutorials about using TCARE or GetCare, refer to the Help Library in the CLC/GetCare system.

What is the Process for FCSP Inactivation?

To disenroll (inactivate) a FCSP caregiver in GetCare:

- All incomplete or draft Screenings and Assessments must be completed and locked or struck out for each caregiver.
- To “inactivate” the caregiver and care receiver in GetCare, they must be disenrolled from the system by end dating the service enrollment in the enrollment section and selecting disenrollment reason.
- Write a progress note, reporting the reason for disenrollment.

What if There has not Been Any TCARE® Activity for a Caregiver in Many Months?

If there have been no screenings, assessments, care plans or progress notes provided in the caregiver’s file for the last year, the caregiver should be disenrolled from services. Check with local AAA policy.

FCSP REPORTS IN ADSA REPORTING (LEGACY)

Legacy TCARE Data Request Instructions and Form

The original (legacy) TCARE portal was abandoned when all TCARE operations were integrated into the Washington State GetCare system in September 2021.

The following data from the legacy TCARE portal (ADSA Reporting) remains available and can be requested for data analysis/research and for public information requests.

- TCARE® 1503 – Active Caregiver Summary
- TCARE® 1504 – Care Plan Service Summary
- TCARE® 1505 – Worker Activity AAA
- TCARE® 1506 – Worker Caseload Tickler
- TCARE® 1063 – Inactive Caregivers by AAA

The Data Request Form and instructions can be found on the ALISA Intranet site at the following address: <https://intra.altsa.dshs.wa.gov/CA/>

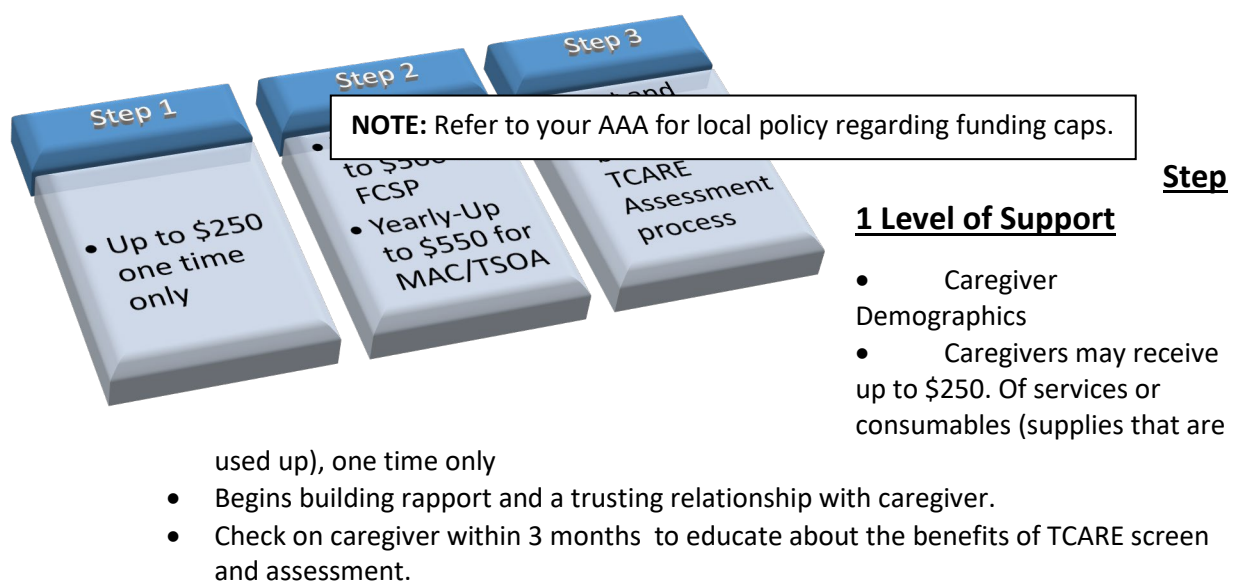
-

FCSP Reports in GetCare

GetCare has a TCARE Manager Tool that keeps track of TCARE screens and Assessments by case manager similar to ADSA Reporting. See the TCARE Manager under the CLC Set button in the top blue ribbon in the CLC/GetCare system.

APPENDICES

Appendix A –Step Levels of Support*



Step 1 Demographics

- Caregiver demographics must be entered into GetCare
- Caregiver may receive up to \$250 of services or consumables (supplies) one time only
- Begins building rapport and a trusting relationship with caregiver.
- Check in with caregiver within three months to educate about benefits of TCARE screen and possible assessment.
- May not receive Respite services or other ongoing services like housework and errands without a AAA approved Exception to Policy(ETP).

Step 2 Level of Support

Step 2 TCARE Screen

Trained TCARE Screener completes a TCARE Screen with caregiver over the phone or in person.

If a personal Caregiver Survey is sent to the family caregiver, it is best practice to contact the caregiver and ensure they understood the questions. This is especially important if the caregiver speaks English as a second language or the TCARE Screen is translated into a language other than English.

Screen must be entered into the GetCare system within 10 days of receiving the Personal Caregiver Survey in the mail or email.

As long as a new screen is completed every 6 months, a caregiver may receive up to \$500. in services or consumables (supplies that are used up) per year. (See AAA rules for local funding CAPS)

May not receive respite services or other ongoing services like housework and errands without a AAA approved Exception to Policy (ETP).

STEP 2 TCARE Screen

- **Trained TCARE Screener completes a TCARE Screen with caregiver over the phone or in person.**

If a Personal Caregiver Survey is sent to the caregiver, it is best practice to contact the caregiver to guide them through the questions especially when the TCARE Screen is translated into a language other than English.

- **Screen must be entered into the GetCare system within 10 days of receiving Personal Caregiver Survey in the mail or email.**
- **As long as a new screen is completed every 6 months, caregiver may receive up to \$500 worth of services or consumables (supplies) per year.**
- **May not receive Respite services or other ongoing services like housework and errands without a AAA approved Exception to Policy(ETP).**



Step 3 Level of Support

Step 3 TCARE Assessment

Eligibility – 1high or 3medium scores in the 5 domains (family role, caregiver measures[stress, relationship, objective], inner struggles) Check with your supervisor or AAA leadership for eligibility requirements in your local AAA.

Caregivers receive one or more services offered by AAA. Check with your supervisor or AAA leadership for a list of contracted services and other supports in your community.

Use TCARE Assessment algorithm developed goals and strategies AND the wishes of the caregiver to determine services and supports that you will recommend to caregiver.

Consult with the caregiver by having person centered conversation with the caregiver and outline WHY you are recommending the services to them. Talk about how the services and supports may reduce the stresses of caregiving.

An in person visit is required in most cases, during the assessment or reassessment process.

Form a care plan with ONLY service and supports the caregiver agreed to during the consultation meeting.

Get verbal agreement from the caregiver (FCSP) and verbal agreement from the caregiver and care receiver (MAC/TSOA only). Send out paper form of care plan with signature page for signature (FCSP) Caregiver only, (MAC/TSOA) Caregiver and Care receiver.

STEP 3 TCARE Assessment

- Eligibility – One high or three medium scores in the 5 domains (identity discrepancy, depression, objective burden, relationship burden, stress burden). Check with your supervisor or AAA leadership for eligibility requirements for your local AAA.
- Caregivers receive one or more services offered by AAA. Check with your supervisor or AAA leadership for list of contracted services and other supports in your community.
- Use TCARE Assessment algorithm developed goals and strategies AND the wishes of the caregiver to determine services and supports that will be offered to caregiver.
- Consult with the caregiver by having a person centered conversation with caregiver and outline WHY you recommend the services to the caregiver. Talk about how the services and supports may reduce the stresses of caregiving.
- An in person visit is required in most cases either during the assessment or the consultation.
- Form a care plan with ONLY the services and supports the caregiver agreed to during the consultation meeting.
- Get verbal agreement from the caregiver (FCSP) or verbal agreement from the care receiver for (MAC/TSOA) as the start services date. Send out paper form of care plan with signature page for signature.

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Washington State Department of Social and Health Services

Appendix B: Service Names, Service Types and Service Categories

Service Category	Service Type Not included in Selection/ Display of Service Name INFORMATION ONLY	Service Name
(0) Other This service category functions as an option for services that do not fit in other service categories.	a) Comfort Therapies (under Health Goal Other), z) Other	Massage
(1) Adult Day Service (Experience time away from care responsibilities)	a) Health model, b) Social model, c) Dementia model, z) Other	Adult Day Care-dementia model Adult Day Health-dementia model Adult Day Health Services Adult Day Care
(2) Assistive technologies (Promote safety and functional abilities of care receiver)	a) Emergency response system (medical alert, in home monitoring), b) Home modifications (e.g. ramps, walk in showers, grab-bars), c) Home safety features (e.g. lighting, locks, exit door alarms), d) Assistive devices and care	Electronic locator bracelet Durable Medical Equipment Home Safety Evaluation Occupational Therapist Evaluation Adaptive Equipment Personal Emergency Response System



Service Category	Service Type Not included in Selection/ Display of Service Name INFORMATION ONLY	Service Name
	supplies (e.g. low beds, mobility devices, commodes, protective garments), z) Other	Care Supplies Physical Therapy Evaluation
(3) Counseling (Develop new perspective and practice skills with feedback)	a) Alternative ways to express anger and frustration, b) Increase level of mastery or confidence, c) Caregiver journey/identity change, d) Develop new way of viewing current situation (Cognitive Reframing), e) Coping Skills, f) Family communication and relationships, g) Understanding and coping with guilt, h) Self-care techniques, i) Stress management techniques, j) Understanding loss and grief, k) Valuing positive aspects of caregiving, l) Problem solving skills, z) Other	Individual counseling Caregiver Counseling
(4.1) Education for caregiver to obtain information about services and assist with planning for the future	a) Available support services and how to obtain them, b) Disease and disease processes (provide basis for accurate assessment of care needs), c) End-of-life planning, decision and care, d) Legal, financial and/or health care planning, e) Safe-guarding care receiver in his/her home (e.g. wander alert services, personal/home safety tips), f) Selecting a suitable living environment, z) Other	Online Caregiver resources Caregiver Advocate Family Caregiver Specialist Dementia Consultation Caregiver Consultation Family Caregiver Training/Education Long Term Care Planning Veteran's Benefits Consultation Caregiver Conference
(4.2) Education for caregiver focused on psycho-social issues and coping skills	a) Alternative ways to express anger and frustration, b) Increase level of mastery or confidence, c) Caregiver journey/identity change, d) Develop new way of viewing current situation (Cognitive Reframing), e) Coping Skills, f) Family communication and relationships, g) Understanding and coping with guilt, h) Self-care techniques, i) Stress management techniques, j) Understanding loss and grief, k) Valuing	Early Memory Loss Support Group Caregiver Consultation Family Caregiver Training Alzheimer's Support Group Powerful Tools For Caregivers Caregiver Conference



Service Category	Service Type Not included in Selection/ Display of Service Name INFORMATION ONLY	Service Name
	positive aspects of caregiving, l) Problem solving skills, z) Other	
(4.3) Education to build caregiving skills (e.g. direct care and communication)	a) Direct care skills (e.g. bathing, dressing, transfer), b) How to ask for help from informal sources (e.g. family, friends, neighbors), c) Skills to communicate with care receiver, d) Skills to communicate with service providers, e) Skills for responding to mood and behavior changes, z) Other	Caregiver Consultation Family Caregiver Training Caregiver Training Caregiver Conference Dietician Consultation
(5) Education for care receiver (Facilitate self-care and/or reduce need for assistance)	a) Improve physical strength, coordination or mobility, b) Skills to increase self-care and independence, c) Reduce expectations for care, z) Other	Falls Prevention Workshop Chronic Disease Self-Management Program Medication Management
(6) Financial and/or Legal Services and Protection (Obtain assistance or counsel)	a) Automatic bill pay (e.g. utility, rent, mortgage), b) Financial assistance or voucher programs (e.g. prescriptions, care supplies, services, housing), c) Legal Services (e.g. estate planning, legal counsel, elder law attorneys), d) Consumer advocacy and protection services (e.g. adult protective services), e) Benefit entitlement programs and/or health insurance plans (e.g. Medicaid, Medicare, LTC Insurance), z) Other	Estate planning/Elder Law Services Benefits Check-up Elder Law Attorney VA Aid and Attendance Advance Medical Directive Information Packet Estate Planning Protective Payee Services
(7) Informal Help Network (Enlist or increase current amount of help)	a) Family and friends (includes family meetings), b) Religious affiliation groups, c) Ethnic/Cultural social club, d) Civic or fraternal organization (e.g. Rotary Club, Lions Club, Jaycees), e) Student group/organizations (e.g. high schools, universities, fraternities), z) Other	Faith based community Religious community In-home respite care (unpaid) Meal Sites Family support Help from Friends Home maintenance/Yard Work Volunteer/Community Service

Service Category	Service Type Not included in Selection/ Display of Service Name INFORMATION ONLY	Service Name
(8) In-home Supports and Services (Reduce responsibility or workload)	a) Chore/Homemaker services, b) Home delivery of meals/groceries, c) Home health care (e.g. nursing, care attendants), d) Personal care, e) Pharmacy delivery, f) Sitter/Companion services, g) Volunteer/Friendly visitor services, z) Other	Housework and Errands In-home Personal Care In-home respite care (paid) Grocery Delivery Service Meals-On-Wheels Bath Aide Home Delivered Meals Volunteer Chore Services Caregiver (private pay)
(9) Living Environments (Introduce alternate source of 24-hour supervision/care)	a) Assisted living or other community-based setting b) Nursing home c) Home of another family member or friend z) Other	
(10) Overnight Respite Services (Experience time away from care responsibilities)	a) Facility-based respite, b) Home-based respite, c) Home of another family member or friend, z) Other	Overnight In home Respite Overnight in home of friend/family Overnight Facility-Based Respite
(11) Palliative and/or Hospice Care (End-of-life supports and services)	a) Facility-based hospice, b) Home-based hospice, c) Palliative care consultation/ services, z) Other	Palliative care Hospice Services
(12) Rehabilitation Services (Identify and promote functional abilities of care receiver)	a) Occupational Therapy, b) Physical Therapy, c) Speech Therapy, d) Respiratory Therapy, z) Other	Occupational Therapist Consultation Physical Therapy Consultation
(13) Support Groups (Expand and sustain networks of support)	a) Condition or disease focused (including early stage groups for care receiver), b) Emotional support/release, c) Friendship/Peer support, d) Skill development, z) Other	Family Caregiver Support Group Support Group for Adult Children Early Memory Loss Support Group Alzheimer's Support Group Online Support Group Disease-based Support Group

Appendix C: TCARE® Strategies and Associated Services

This section illustrates the types of strategies utilized in TCARE® and examples of services that could be offered.

A	Strategies to change personal rules for care
B	Strategies to reduce or minimize workload
B1	Reduce care needs of care receiver
B2	Reduce difficulty of care and tasks
B3	Introduce alternate source for care to provide respite
C	Strategies to support positive self-appraisal (enhance or affirm current identity & behavior)
C1	Reject negative appraisal
C2	Reinforce positive aspects of identity
D	Strategies to reduce generalized stress
E	Strategies to improve overall health

Strategies A, C, and D (Defined Above)

- Caregivers Workshop Series
- Powerful Tools for Caregivers
- Wellness Programs
- Caregiver Education
- Counseling*
- Legal, Financial, Health Care Planning
- Support Groups
- Caregiver Education

Counseling within the FCSP is defined as Individual or Family Counseling that can be provided by the following professionals who hold a current license with the Washington State's Department of Health:

- Psychiatrists
- Psychologists
- Psychiatric advanced registered nurse practitioners (ARNPs)



- Psychiatric mental health nurse practitioners-board certified (PMHNP-BCs)
- Mental health counselors
- Independent clinical social workers
- Advanced social workers
- Marriage and family therapists

Strategy B (Defined Above)

- Equipment and Supplies, PERS (e.g., Assistive Technologies)
- Caregiver Education – Information and Skills (including evidence-based (EB) interventions, e.g., STAR-Caregivers (STAR-C), RDAD (Reducing Disability in Alzheimer’s Disease), Home Care Aide Training
- Care Receiver Education – Improve Health, Strength and Self Care, including Evidence Based interventions (e.g., Chronic Disease Self-Management /Living Well classes, Diabetes Self -Management Program and Chronic Pain Self -Management Programs)
- Financial and Legal Planning, setting up Bill Pay process
- Transportation
- Home Delivered Meals/Grocery Deliveries
- Pharmacy Delivery
- Rehabilitation Services (e.g., OT/PT)

Higher care needs: In TCARE®, services that provide a break from caregiving are identified under the categories of Informal Help Network, In-Home Supports and Services (Personal Care), Adult Day Services, Overnight Respite Services.

Examples of Services:

- Adult Day Services - Adult Day Health, Dementia and Social Day Care
- Chore/Homemaker Services – e.g., housework and errands type service
- Personal Care or Home Health Services
- Out-of-Home and In-Home Respite

Strategy E (Defined Above)

Example of Services:

- Mental and Physical Health Evaluation
- Alcohol and Drug Abuse Evaluation

Wellness Services – Services to keep caregiver healthy that do not include those services related to emotional health. Emotional Health services belong in Strategies A, B, C and

Appendix D: Restrictions for Purchasing Goods and Services

Restrictions for Purchasing Goods and Services under FCSP

- FCSP supplemental service funding CAN'T be used to pay for:
- Gift Cards
- Rent
- Car repairs
- Utility bills
- Major appliances
- Vacation expenses
- Entertainment items

Restrictions for purchasing goods or services under FCSP

- **FCSP supplemental service funding CAN NOT be used to pay for:**
- **Rent**
- **Car repairs**
- **Utility bills**
- **Major appliances**
- **Vacations expenses**
- **Entertainment items**
- **Gift cards**

When in doubt, think of expenses directly related to caregiving services/supplies (refer to RCW 74.41)



Appendix E: FCSP Core Services Definitions for OAAPS Reporting

OAAPS FAMILY CAREGIVER SUPPORT PROGRAM CORE SERVICES	OAAPS SERVICE DEFINITIONS
Information Services (Outreach) Non-Registered Service OAAPS Unit/Bar Code: 1 Activity/.79.51 Information Services (Outreach Activities)	Information Services OAAPS Definition: Access Assistance—Case Management—A public and media activity that conveys information to unpaid caregivers about available services, including in-person interactive presentation, booths/exhibits, or radio, TV, or Web Site Events.
Access Assistance-Information and Assistance Non-Registered Service OAAPS Unit/Bar Code: 1 Contact/.79.2a.2 Access Assistance—Information and Assistance	A service that provides the individuals with current information on opportunities and services available to the individuals within their communities.
Access Assistance – Care Coordination Registered Service OAAPS Unit/Bar Code: 1 Hour/.79.2a.1 Access Assistance— (Screens, Assessments/Coordination of services)	A service provided to an unpaid caregiver, at the direction of the unpaid caregiver, by an individual who is trained or experienced in the coordination skills that are required to deliver services and supports.



Support Services Counseling -- Registered Service Training-- Registered Service Support Groups – Non-registered Service or Registered Service OAAPS Unit/Bar Code: 1 Hour/.79.5c Support Services (Counseling, Support Groups & Trainings)	Counseling—A service designed to support unpaid caregivers and assist them in decision-making and problem solving. This service must be provided by a qualified counselor and includes individual and group sessions Training—A service that provides unpaid caregivers with instruction to improve knowledge and performance of specific skills relating to caregiving. These specific skills may include, but are not limited to, activities related to health, nutrition, and financial management; providing personal care; and communicating with health care providers and other family members. Support Groups -- (nonregistered or registered) —A service led by an individual who meets state/territory policy requirements to facilitate caregiver discussion of their experiences and concerns and develop a mutual support system.
Respite Registered Service OAAPS Unit/Bar Code: 1 Hour/.79.5d.3 Respite Services—Overnight & .79.5d.4 Respite Services—Other	Respite Care—A services which offers temporary, substitute supports or living arrangements for care recipients. It provides a brief period of relief for the unpaid caregiver. There are four types of respite: 1. In-Home Respite 2. Out-of-Home Respite (Day) 3. Out-of-Home Respite (Overnight) 4. Other



Supplemental Services Registered Service OAAPS Unit/Bar Code: 1 Unit/.79.4.a Supplemental Services—Assistive Technology/DME/PERS, .79.4.b Supplemental Services—Consumable Supplies, .79.4.c Supplemental Services--Home Modifications/Repairs, .79.4.d Supplemental Services—Legal/Financial Consultation, .79.4.e Supplemental Services—Homemaker/Chore/Personal Care, .79.4.f Supplemental Services—Transportation, .79.4.g Supplemental Services—Nutrition Services, .79.4.h Supplemental Services--Other	Goods and services provided on a limited basis to complement the care provided by unpaid caregivers <u>“Limited basis” for supplemental Services is equal to the current funding limit of the three FCSP steps. In 2025, the limit is Step 1, \$250 one time only. Step 2, \$500 annually with TCARE screen every 6 months. Step 3, after a full TCARE Assessment and care plan is completed annually and is limited to funding caps determined by each Area Agency on Aging.</u> • Assistive Technology/Durable Medical Equipment/Emergency Response • Consumable Supplies • Home Modifications/Repairs • Legal and/or Financial Consultation • Homemaker/Chore/Personal Care • Transportation • Nutrition Services • Other
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Appendix F: TCARE® Screener, Assessor Training and Assessor Monitor

TCARE® Screener Training

TCARE Screener Training is completed by self-study in the form of power point slides. The recorded Power Point slide deck can be found in the GetCare Help Library under Caregiver Programs. Local AAAs may have additional training and TCARE Inc. may develop new training for Screeners

TCARE® Assessor Online Training

A TCARE® Assessor must complete TCARE® Inc online Assessor training other TCARE Inc. led training and be certified by Tailored Care Inc. before using the TCARE® Assessment Tool in GetCare.

Training Process

AAA Supervisor will enter an Issue Manager Request in GetCare with the following information:

- Name of assessor trainee
- Phone number
- Email address
- AAA and office or network agency
- All other information GetCare needs for access to MAC/TSOA, Provider 1, etc.

Next Steps

1. HCLA FCSP/TCARE Program Manager will provide access to GetCare with requested role permissions.
2. HCLA FCSP/TCARE Program Manager will contact TCARE Inc to register assessor trainee.
3. TCARE Inc will email training process to trainee and provide link to training.
Use Google Chrome, Firefox, Safari or Microsoft Edge to access TCARE Inc. Training site.

NOTE: Assessor trainees cannot use the TCARE assessment in GetCare until they have completed the TCARE Assessor exam and have a training certificate from TCARE Inc.

Our TCARE Assessor Trainees will use the Washington Assessor Training section of TCARE Inc Training. Trainee will:

- Attend TCARE training by TCARE Inc. staff member
 - View all courses
 - Take all quizzes
 - Complete Walk Throughs and Case Studies
 - Complete Hands-on Exercises
 - Pass TCARE Assessor Final Exam
4. Supervisor will assign an experienced, knowledgeable TCARE assessor to mentor new assessor.
 5. Assessor Trainee will assess a caregiver and complete the entire TCARE process; TCARE screen, TCARE assessment, consultation and care plan with assistance as needed from mentor.
 6. AAA will train new TCARE Assessor about local policy, MTD, FCSP, GetCare depending on staff position.

NOTE: Many TCARE Assessor Trainees report that having a mentor while they are working through their first assessment processes is very helpful in learning to become an accomplished Assessor.

Monitoring/Quality Assurance

It is recommended that a supervisor review three TCARE® caregiver cases (which includes entering demographics through the completion of care plan) and provide a mentor who is TCARE certified and provide feedback to each newly certified TCARE® assessor within their first three months. After the first year, it is recommended that a minimum of two TCARE® caregiver cases be reviewed for each assessor to ensure program quality.

Appendix G: TCARE® Assessor Qualification and Recertification

TCARE Assessor Qualifications

Staff administering the full TCARE assessment/consultation and service planning must meet the minimum qualifications of an AAA Case Manager as outlined in Chapter 1 of the Policy and Procedure Manual of AAA Operations. Local AAAs may have additional education/experience requirements for AAA case managers .

NOTE: If a staff member does not meet these minimum requirements, a waiver in form of a letter must be submitted to ALTSA FCSP/TCARE Program Manager that includes an explanation of the qualifications, experience and reasons for recommendation of the staff

Recertification of TCARE® Assessors

If a TCARE assessor has a lapse of more than a year in using the TCARE assessment process, the assessor will visit the TCARE Inc Training site to refresh their knowledge of the philosophy and process of TCARE and complete other updates in training determined by their AAA. If assessor doesn't have access to the TCARE Inc training site, contact the FCSP/TCARE Program manager at HCLA.

Appendix H: WACs and RCWs

FCSP Related Washington Administrative Codes (WACs) and Revised Codes of Washington (RCW)

The following rules apply to clients receiving services in Family Caregiver Support Program. HCS works in partnership with Area Agencies on Aging to provide quality service delivery in all counties.

RCW	
Section 74.41.010	<u>Legislative Findings</u>
RCW 74.41.020	<u>Intent</u>
RCW 74.41.030	<u>Definitions</u>
RCW 74.41.040	<u>Administration – Rules - Program Standards</u>
RCW 74.41.050	<u>Family Caregiver Long-term Care Information and support services—Respite Services, evaluation of need, caregiver abilities</u>
RCW 74.41.060	<u>Respite Care Program - Criteria</u>
RCW 74.41.070	<u>Family caregiver long-term care information and support services - data</u>
RCW 74.41.080	<u>Health care practitioners and families not impaired</u>
RCW 74.41.090	<u>Construction—chapter applicable to state registered domestic partnerships -- 2009</u>
RCW 74.41.900	



WAC	
WAC 388-106-1110	<u>Am I eligible for SCSA-funded services at no cost?</u>
WAC 388-106-1115	<u>What income and resources are exempt when determining eligibility?</u>
WAC 388-106-1120	<u>What if I am not eligible to receive SCSA-funded services at no cost?</u>
WAC 388-106-1200	<u>What definitions apply to respite care services through the family caregiver support program?</u>
WAC 388-106-1205	<u>What are respite care services?</u>
WAC 388-106-1210	<u>Who is eligible to receive respite care services through the family caregiver support program?</u>
WAC 388-106-1215	<u>Who may provide respite care services through the family caregiver support program?</u>

Respite Care Services Washington Administrative Codes (WACs) and Revised Codes of Washington (RCW)

RCW	
Section 74.41.010	<u>Legislative Findings</u>
RCW 74.41.020	<u>Intent</u>
RCW 74.41.030	<u>Definitions</u>
RCW 74.41.040	<u>Administration – Rules - Program Standards</u>
RCW 74.41.050	<u>Family Caregiver Long-term Care Information and support services—Respite Services, evaluation of need, caregiver abilities</u>
RCW 74.41.060	<u>Respite Care Program - Criteria</u>
RCW 74.41.070	<u>Family caregiver long-term care information and support services - data</u>
RCW 74.41.080	<u>Health care practitioners and facilities not impaired</u>
RCW 74.41.090	<u>Construction—chapter applicable to state registered domestic partnerships -- 2009</u>
RCW 74.41.900	
WAC	
WAC 388-106-1110	<u>Am I eligible for SCSA-funded services at no cost?</u>
WAC 388-106-1115	<u>What income and resources are exempt when determining eligibility?</u>
WAC 388-106-1120	<u>What if I am not eligible to receive SCSA-funded services at no cost?</u>
WAC 388-106-1200	<u>What definitions apply to respite care services through the family caregiver support program?</u>
WAC 388-106-1205	<u>What are respite care services?</u>
WAC 388-106-1210	<u>Who is eligible to receive respite care services through the family caregiver support program?</u>
WAC 388-106-1215	
WAC 388-106-1220	<u>How are respite care providers reimbursed for their services through the family caregiver support program?</u>
WAC 388-106-1225	<u>Are participants required to pay for the cost of their respite care services through the family caregiver support program?</u>

WAC [388-106-1230](#)

What determines emergent and non-emergent respite care services through the family caregiver support program?

Appendix I: Commonly Used Acronyms and Abbreviations

AAA Area Agency on Aging

ADL Activities of Daily Living

IADL Instrumental Activities of Daily Living

CFC/COPEs Community Living Connections/Community Options **Program Entry System**

CMS Centers for Medicare and Medicaid

ETP **Exception to Policy**

ETR **Exception to Rule**

FCSP Family Caregiver Support Program

HCLA Home and Community Living Administration

HCS Home and Community Services

IADL Instrumental Activities of Daily Living

NFCSP National Family Caregiver Support Program

MAC/TSOA Medicaid Alternative Care/Tailored Supports for Older Adults

OAA Older Americans Act

RCW **Revised Code of Washington**

SCSA Senior Citizens Services Act

SFCSP State Family Caregiver Support Program

SMI State Median Income

TCARE Tailored Caregiver Assessment and Referral

WAC **Washington Administrative Code**

REVISION HISTORY

<u>Date</u>	<u>Made By</u>	<u>Change(s)</u>	<u>MB #</u>
9/2/2026	Dana Allard-Webb	Moved to new template	N/A
5/11/2021	Dana Allard-Webb	Changes due to GetCare/TCARE Integration Changes for 6-month screen policy TCARE Screener and Assessor Training TCARE Assessor	H21-050
2/28/2022	Dana Allard-Webb	Removed NAPIS language Changed TCARE Assessor and Screener Training Process	H22-
7/15/2025	Dana Allard-Webb	- Updated definitions of OAA family caregiver, greatest economic and social need, and limited basis - Updated annual home visit explanation - Repaired verbal approval language - Updated TCARE Assessor training requirements - Updated TCARE Assessor educational requirements - Updated ALTSA to HCLA - Changed TCARE components identity discrepancy, depression and burdens to new words; family role, inner struggle, and caregiver measures throughout manual.	



Kinship Caregivers Support Program (KCSP) Policies and Procedures

This chapter serves as guidance and information on the provision of Kinship Caregivers Support Program (KCSP) services. The Kinship Caregivers Support Program is intended to provide supportive funding to kinship caregivers who would be at great risk of being unable to maintain the caregiving role without the supports KCSP provides.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Rosalyn Alber Kinship & Lifespan Respite Program Manager
360.584.2450 rosalyn.alber@dshs.wa.gov

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BACKGROUND

The Kinship Caregivers Support Program (KCSP) funds are to support kinship caregivers (grandparents and other relatives) statewide who are at great risk of being unable to maintain the caregiving role without additional financial support at the time a child(ren) come to live with their relatives, as well as after the initial period.

The KCSP funds are provided solely for Area Agencies on Aging (AAAs), or their designated subcontractors to authorize services or items to support children within kinship families.

COLLABORATION AND OUTREACH FOR THE KCSP

- In carrying out the KCSP, each AAA must coordinate the activities of the agencies or the designated subcontractor with the activities of other public and private agencies or organizations providing services for kinship caregivers.
- The AAA and any of its KCSP subcontractor(s), must provide a listing/description of the KCSP for the public to view on the AAA's/subcontractor's website(s), and/or brochure(s) and in the Community Living Connections county resource directory
- The AAA and/or its subcontractor must conduct culturally relevant outreach to kinship caregivers and to possible referral agencies.

KINSHIP CAREGIVER ELIGIBILITY

Persons eligible to receive funding from KCSP include a grandparent (or step grandparent) or other adult relative who is:

- A. raising a child(ren), age 18 or younger child*; and
- B. related by blood or marriage to the child(ren); and
- C. living with the child(ren) in Washington State; and
- D. the primary caregiver of the child(ren) because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child(ren); and
- E. the parent(s) is consistently absent from the home
- F. raising the child(ren) either with a legal relationship, such as legal custody, adoption or informally; and

G. at risk of not being able to continue kinship caregiving without additional financial support services.

*Unless the youth who is older than 18 and attends high school and has documentation to verify school enrollment.

VERIFICATION OF PRIMARY CAREGIVING RELATIONSHIP

The KCSP staff should request that the Kinship caregiver provide current (produced within the last 12 months) verification of his/her primary caregiving relationship to the child(ren) they are raising from a reliable source. For example, if the caregiver has custody paperwork dated more than 12 months from request for KCSP assistance, another current form of documentation must be provided. The verification source must be documented in the client's paper or online GetCare file. And if that is not feasible, this should be noted in the caregiver's file.

Examples include:

- A) legal custody court documents,
- B) medical provider,
- C) parental consent agreement, notarized when possible
- D) school documentation,
- E) tax return,
- F) DSHS award letter for services, e.g., TANF Child Only Grant, Food Assistance,
- G) Social Security information,
- H) lease agreements where a relative child is listed, or Section 8 Housing vouchers which list relative children,
- I) an official letter from the kinship caregiver's Tribal governing body, or social service office,
- J) As a last option, a letter from a faith/religious community leader.
- K) As a last resort signed "Declaration of Health Care Consent"
- L) If the kinship caregiver does not have any documented proof, the KCSP staff must receive permission from the caregiver to contact an appropriate professional or agency, or to make a home visit to verify the primary kinship care relationship.

Verification Documents Relationship

1. If possible, obtain the documents from the client or collateral agency (e.g., other state agencies such as DSHS or DCYF) electronically.



2. If the family has ability to send and respond by email confirming the declaration of relationship, consent and understanding their responsibility of services this may be accepted as their signature.
3. If electronic or in person methods are not feasible, send a copy of screening/intake, consent, and declaration form by mail for signature with a postage-paid return envelope. Do not delay the services because these forms are not signed and returned.
4. We can rely on the documented verbal approval of the client to authorize services.
5. Document the person's name, date the screening took place on the screening/intake form and other necessary information in case notes.

Ineligible Caregivers

Persons who are ineligible to receive funding from the KCSP include kinship caregivers who are:

- A. A licensed foster care parent receiving foster care payments for the relative child; or
- B. A relative who is an unlicensed caregiver and has an assigned Department of Children Youth and Families (DCYF) case worker for the child(ren) in their care. They may be eligible for DCYF funds for concrete goods which are available through the assigned caseworker to support placement.

USES FOR THE KCSP FUNDS

The KCSP funds are to be used to purchase approved items or services which benefit the child(ren)/youth being raised by kinship caregivers to help pay for the cost of meeting one of more of their urgent needs. Alternate payment sources must be exhausted prior to authorizing payments. Those kinship caregivers experiencing the most urgent/ needs have the highest priority. Depending on the needs presented by the kinship caregivers, more than one need may be addressed on a limited bases by the KCSP funds during a three-month period, however, caregivers may utilize the funds for additional needs up to 2 times every 12 months.

Approved items and services for which the KCSP funds can be used, but are not limited to include:

- A. First/last month's rent or utility hook-ups for relatives who must move, in order to take a child into their home.
- B. Rent and/or utility assistance may be available on a case-by-case basis after all other rent/utility supports are accessed and when a family is at risk of eviction and/or utility shut-off (a shut off/eviction notice is not required). *Documentation of the amount owed is required (i.e., lease, bill, statement).



- C. Household items, e.g., child bedding, furniture, cleaning supplies, toilet paper
- D. Child's personal care items, e.g., diapers, hygiene products which meet the need(s) of the child.
- E. Payment for legal packets or mediation services. Facilitation of guardianship or adoption action is an option for relatives when all relevant parties agree upon the action. These services may include payment for court facilitators, court fees, Guardian Ad Litem (GAL) and/or Court Visitor, home study, and attorney fees. AAAs should establish lids for legal fees. For example, \$1,000 for court fees, etc.
- F. Gas and bus vouchers/car repairs needed to transport or provide for the child.
- G. Food**
- H. Children/Youth's clothing (may include adult sizes).
- I. Counseling for the kinship caregiver and child(ren) to address issues such as trauma.
- J. School related supplies and fees, e.g., uniforms, musical instrument rentals, field trips, computers/tablets when these items are unavailable from other sources and required for academic use.
- K. Sports and youth activity registrations, fees, uniforms, and related equipment.
- L. Durable medical equipment or assistive technology devices/equipment to benefit the child not covered by Medicaid or other health insurance.
- M. Medications for the child not covered by Medicaid or other health insurance.
- N. Tutoring.
- O. Safety items, e.g., medication lock boxes, safety locks.
- P. Interpreter services; or
- Q. Supervision for child(ren) during kinship caregiver appointments.
- R. Computer/tablets may be purchased for the kinship caregiver when necessary for tele-med appointments, mental/behavioral health appointments and online support groups for the child and/or caregiver. Expenditures for computers/tablets may not exceed \$800.00 per household. All other resources for obtaining computers/tablets must be exhausted prior to purchase.



* If a caregiver is receiving a child only TANF grant, they may be eligible for the DSHS Economic Services AREN (Additional Requirements for Emergent Needs) program to cover one-time shelter costs.

**Although the KCSP policies do not restrict what types of foods/beverages can be purchased with KCSP funds, ALTSA encourages kinship providers to encourage healthy food/beverage purchases. Policies can be developed at the AAA level to restrict certain food and/or beverage purchases.

INAPPROPRIATE USES OF KCSP FUNDS

KCSP funds cannot be used for ongoing benefits to meet basic needs such as: continued rent or utility payments, or children's medical or dental services.

Other examples of inappropriate uses of these funds include the purchase of:

- A. clothes for household members other than the relative children.
- B. tobacco products.
- C. food/drink items, e.g., alcohol, not appropriate for children's consumption; and
- D. electronic items, e.g., video games, gaming systems.

Computer/tablets may be purchased for the kinship caregiver when necessary for tele-med appointments, mental/behavioral health appointments and online support groups for the child and/or caregiver. Expenditures for computers/tablets may not exceed \$800.00 per household. All other resources for obtaining computers/tablets must be exhausted prior to purchase.

Exceptions can be made by ETPs for items needed for educational purposes, medical, mental health, or support group purposes and not available through other avenues.

SERVICE PROVIDER REQUIREMENTS

Service providers (e.g., legal providers, mental health counselors, interpreters) who receive KCSP payment must be certified or licensed through Washington State, with the exception of persons who only supervise the child(ren) during caregiver appointments or providing tutoring services.

Any person who will provide a service(s) for children without supervision (e.g., counselors, care providers or tutors) must pass and have documentation of a WA State Patrol background check before providing services and before payment can be authorized. The contracted KCSP provider is responsible to ensure background checks are in place.



DETERMINING INDIVIDUAL KINSHIP CAREGIVER FUNDING LEVELS

- A. AAAs or their designated subcontractors will screen kinship caregivers according to standardized procedures developed by the AAA to determine if and how much financial support may be available to meet specific needs of kinship caregivers.
- B. The AAAs are responsible for handling and approving the KCSP Exception to Policy (ETP) cases. The AAAs must send copies (by email) of the approved and denied ETP requests to the ALTA KCSP Program Manager who can also be consulted on individual cases.
- C. Kinship caregivers may apply to the AAA or its subcontractor(s) for financial assistance up to two times per year. More than one need may be addressed by the KCSP funds during a three-month period; however, caregivers may utilize the funds for additional needs up to 2 times every 12 months. The window of time begins when the first service is provided.
- D. If the child(ren's) needs in a kinship care family exceed \$1,500 during a 12-month period, an ETP must be approved by the AAA.

Each AAA will establish limits as to how much financial support may be available to meet specific needs of kinship caregivers.

- E. KCSP funds must be used for eligible expenses incurred after being approved for the program. The only exceptions are eligible expenses incurred prior to approval for things such as rent, utilities or overdue payments.
- F. The AAA or its subcontractor(s) will manage the authorizations and have in place or develop a payment system for approved goods and services, which can include: 1) vouchers 2) purchase orders, and/or 3) credit cards for approved staff; and/or 4) food and gas cards which exclude other items from being purchased. Only a check may be provided to a third-party service provider accompanied by a receipt, invoice, or other valid documentation.
- G. Direct payments to kinship caregivers are not allowed.
- H. AAAs are responsible to ensure that when purchasing goods/services or one-time set-up fees/deposits on behalf of an eligible kinship caregiver, documentation within the client file must include:
 - 1. Kinship caregiver's name.
 - 2. Eligible relative children's first and last names, their birthdates, gender, and last four digits of their social security numbers (if available).
 - 3. A description of the approved goods and/or services including authorized amount.



4. Confirmation that the purchase is consistent with needs identified by the caregiver for the benefit of the kinship child(ren) and is consistent with program requirements; and
 5. Proof (e.g., receipt, invoice, etc.) that the goods or services were purchased, and received by the kinship caregiver and are within the program costs limitations and guidelines.
-
- I. AAAs will decide the process that works best for their service area; however, agencies must be able to produce all back-up documentation upon request, e.g., copies of invoices, receipts, cancelled checks, and client case notes.
 - J. Kinship caregivers must sign an agreement acknowledging that funding may only be used for authorized items and or services and their responsibilities (e.g., returning purchase documentation). Local AAA policies will determine the consequences for purchases over the authorized amount or for any unqualified expenditures.
 - K. The KCSP funds will not affect the TANF grant eligibility for the kinship caregivers.

Telephonic or Video Conferencing Screening Process

Eligibility standards do not change because the screening is occurring by telephone or video conferencing. Staff will complete all screening questions.

1. If possible, obtain the documents from the client or collateral agency (e.g., other state agencies such as DSHS or DCYF etc...) electronically.
2. Send a copy of screening/intake, consent, and declaration form by mail for signature with a postage-paid return envelope. Do not delay the services because these forms are not signed and returned.
3. If the family has ability to send and respond by email confirming the declaration of relationship, consent and understanding their responsibility of services this may be accepted as their signature.
4. A digital picture of signature is also allowed.
5. Document the person's name, and date the screening took place on the screening/intake form and other necessary information in case notes.

REFERRALS TO THE KINSHIP NAVIGATOR PROGRAM

If an AAA operates a separate Kinship Navigator Program (KNP), KCSP recipients must be offered a referral to the local Kinship Navigator to discuss their other needs.

REPORTING REQUIREMENTS FOR THE KCSP

Financial Reporting

To allow for accurate tracking of KCSP funds, ALTSA requires that AAAs account for expenditures separate from other programs.

The KCSP expenditures are reported in three categories:

- Program Administration: (up to 10% of the AAA allocation may be used for general administration). AAAs can choose to pass on their allocation for program administration to their subcontractor,
- Service Delivery: (up to 15% of the AAA allocation may be used for costs associated with outreach, payment authorization, screening, background checks); and,
- Goods and Services: Payment for goods or services needed by the children of eligible kinship caregiver families.

Program Reporting

The AAAs/KCSP subcontractors must utilize the Community Living Connections (CLC) reporting system to enroll caregivers, record KCSP caregiver services and complete the Kinship Intake for each participating kinship caregiver family.

Narrative Reporting

Annually, and no later than October 1st of each year, AAAs are required to submit the following information to the ALTSA Kinship Care Program Manager:

- 1) At least two case examples describing the circumstances and the needs of a participating caregiver, what assistance was provided to the caregiver through KCSP, and the impact the intervention had on the kinship caregiver and their family to help or continue stability for the children in their care. This information is used to explain to the legislature and other interested parties the effectiveness of and need for support for the KCSP.
- 2) Copies of any new public relations material(s) developed for the KCSP (including brochures, newspaper articles, flyers, etc.).



REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
3/24/2020		COVID Temporary Revision	
5/21/2020		COVID Temporary Revision	
12/15/2022		Revised	

Kinship Navigator Program

Chapter 17c describes Kinship Navigator Program available to kinship caregivers. Information collected from caregivers is stored in the GetCare data management system.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Rosalyn Alber Kinship & Lifespan Respite Program Manager
360.584.2450 rosalyn.alber@dshs.wa.gov

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BACKGROUND

Kinship caregivers are resource families that have a prior relationship with a child or youth, either as relatives or suitable persons. Relatives have a relationship through blood, marriage, or custom. Suitable persons, sometimes called “fictive kin” have a preexisting relationship with the child. They can be neighbors, godparents, schoolteachers, coaches, family friends, or non-relative “aunties.”

DEFINITIONS AND EXAMPLES

Caregiver Eligibility

Persons eligible to receive services from KNP may include a kinship caregiver as defined in the Background Section above, raising a child(ren) aged 18 or younger, not theirs by birth, unless the youth who is older than 18 attends high school.

Role of the Kinship Navigator

The role of the Kinship Navigator is to connect kinship caregivers with community resources, such as health, financial, legal services, support groups, training, and emergency funds, federal and state benefits.

HISTORY OF WASHINGTON STATE’S KINSHIP NAVIGATOR PROGRAM

The Kinship Navigator Program began in Washington State in July of 2004 when Casey Family Programs (a member of the Washington State Kinship Oversight Committee/KCOC) funded and piloted two programs. As a result of the pilot, the Legislature funded the program in 2005 and as of 2023 has expanded to all Area Agencies on Aging (AAAs) in WA state covering each county.

In 2016 the Legislature appropriated funding for the Tribal Kinship Navigator Program. As of 2023 there are seven participating Tribes (Lummi, Samish, Port Gamble S’Klallam, Colville, Yakama Nation, Makah, Quileute).

PRINCIPAL DUTIES AND RESPONSIBILITIES FOR THE KINSHIP NAVIGATOR

- The Kinship Navigator will provide information and assistance along with supportive listening to kinship caregivers of all ages who are raising children or



planning to do so. Navigators need to be knowledgeable about relevant federal and state benefits, as well as local resources.

- The Kinship Navigator will provide outreach focusing on serving relatives from geographically isolated and historically marginalized communities.
- The Kinship Navigator will provide follow-up with kinship caregivers as needed.
- The Kinship Navigator must develop strong collaborative working relationships with groups and agencies that work with kinship caregivers.
- The Kinship Navigator will help educate the community about the needs of kinship families and available resources.
- The Kinship Navigator will support the caregivers while mediating with state agency staff and/or service providers to ensure the caregivers receive services for which they are eligible.
- The Kinship Navigator will participate in available training and statewide Kinship Navigator meetings. Attendance in Kinship Care Oversight Committee (KCOC) meetings is encouraged.
- The Kinship Navigator must record and report information as outlined below.

REPORTING REQUIREMENTS FOR THE KNP

Data Collection/Program Reporting

All client data is entered into the GetCare database. (Tribal Navigator Programs will either use GetCare or excel spreadsheet).

Data collection steps include:

- 1:** Demographic data service report (GetCare)
- 2:** Kinship Program Intake Assessment (annually-GetCare)



3: Time spent on client support (Case Coordination units in GetCare)

Program reporting includes:

- Case examples (semi-annually to ALTSA Kinship Program Manager)
- Client satisfaction (conducted annually at the program level)

If Kinship Care Support Program (KCSP) disbursement is applicable, please consult chapter [17b of the Long Term Care Manual \(LCM\)](#) for required support documentation.

BUDGET/ALLOWABLE COSTS

Funds are available starting in FY 2024 to support at least one Kinship Navigator FTE at each Area Agency on Aging (AAA). Allowable costs include staff, travel, translation and interpreter services, data collection support, supplies and administration (not to exceed 10%) and equipment only when directly necessary to provide Kinship Navigator services.

FOR MORE INFORMATION

Please see find the website under related links or contact [Rosalyn Alber](#).

RESOURCES

Related Administrative Policies

- Kinship Navigator Program MB

Related Links and Websites

- <https://www.dshs.wa.gov/altsa/home-and-community-services-kinship-care/kinship-care>



CONTACTS

[Rosalyn Alber, Kinship & Lifespan Respite Program Manager, rosalyn.alber@dshs.wa.gov, Phone # 360-584-2450, Address ALTSA HQ Blake East](#)

ACRONYMS

- ALTSA-Aging and LONG-TERM Support Administration
- KNP-Kinship Navigator Program
- KCOC-Kinship Caregiver oversight committee
- KCSP- Kinship Caregiver Support Program
- AAA- Area Agencies on Aging
- RCW- Revised Code of Washington

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #

Senior Nutrition Program

Chapter 18 provides an overview of Senior Nutrition Program services. This program provides older individuals with nutritious meals and services to fulfill the following purposes:

- 1) Reduce hunger, food insecurity, and malnutrition among older individuals.
- 2) Promote socialization of older individuals.
- 3) Promote the health and well-being of older individuals by assisting such individuals to gain access to nutrition and other disease prevention and health promotion services to delay the onset of adverse health conditions resulting from poor nutrition health or sedentary behavior.

This chapter reflects the revised Senior Nutrition Program Standards which are referenced in full under “Resources”.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Cameron Akita Program Manager
360.725.2466 cameron.akita@dshs.wa.gov

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I. PROGRAM PURPOSE & SERVICE DEFINITIONS

Purpose:

The purpose of the Older Americans Act (OAA) Nutrition Program is to:



1. Reduce hunger, food insecurity, and malnutrition among older individuals.
2. Promote socialization of older individuals.
3. Promote the health and well-being of older individuals by assisting such individuals to gain access to nutrition and other disease prevention and health promotion services to delay the onset of adverse health conditions resulting from poor nutrition health or sedentary behavior.

The OAA Nutrition Programs are authorized under Title III Part C. They fulfill their purpose by providing access to healthy meals, nutrition education and nutrition counseling. These services are targeted to older adults in the greatest economic and social need.

Service Description:

The purpose of Nutrition Services under the OAA is met by providing the following:

1. **Congregate Meals** - OAA authorizes meals and related nutrition services in a variety of congregate settings, which help to keep older adults healthy and prevent the need for more costly medical interventions. In addition to serving healthy meals, the program presents opportunities for social engagement, information on healthy aging and meaningful volunteer roles, all of which contribute to an older individual's overall health and well-being.

The congregate setting is designed to provide a welcoming and pleasant atmosphere where people aged 60 and older (and other eligible persons) can gather for a meal. The balanced meal and the social contact together provide positive motivation for self-care for older individuals who may otherwise lack access to nutritious foods or experience social isolation. The nutrition program is more than just a meal—its purpose is to nourish the whole person.

Congregate nutrition services may also include shelf stable, pick-up, carry-out, drive-through, or similar meals if included in an approved Area Agency on Aging (AAA) Area Plan and under the following conditions:

- a) During disaster or emergency situations affecting the provision of nutrition services;
 - b) To older individuals who have an occasional need for such meal; and/or
 - c) To older individuals who have a regular need for such meal, based on an individualized assessment, when targeting services to those in greatest economic need and greatest social need.
2. **Home-Delivered Meals (HDM)** - OAA authorizes meals and related nutrition services for older individuals in their home who are unable to shop or prepare meals independently and have limited access to assistance with these tasks. Home-delivered meals are often the first in-home service that an older adult receives, and the program is a primary access point for other home and community-based services.

The HDM program serves older individuals who are homebound, including individuals with complex medical needs, individuals experiencing isolation (cultural, social, or geographical), individuals who are age 60 or over, and in some cases, their caregivers, spouses, and/or persons with disabilities. This program provides much more than food; it provides a wholesome meal plus



a safety check, and sometimes the only opportunity for face-to-face contact or conversation for that day.

Home-delivered meal programs may provide services via home delivery, pick-up, carry-out, drive-through, or similar meals.

3. **Nutrition Education** – information provided through Congregate or HDM programs that gives participants the knowledge and skills to make healthy food and beverage choices. Nutrition education is a required component of OAA Nutrition Services.
4. **Nutrition Counseling** – provision of individualized guidance to participants at nutritional risk. This service under Congregate and HDM programs provides one-on-one guidance by a registered dietitian that must align with the Academy of Nutrition and Dietetics.
5. **Other Nutrition Services** – additional services under Congregate and HDM programs that may be provided to meet the nutritional needs or preferences of eligible participants. This may include but is not limited to adaptive dinnerware, supplemental foods, oral nutrition supplements, or groceries.

Nutrition Project – a program or initiative that provides services under this section by entities contracted to achieve the purpose of the OAA.

II. ELIGIBILITY, TARGET POPULATION & SERVICE FREQUENCY

Congregate Meal Services:

1. **Eligibility Criteria:**
 - a. All people 60 years of age and older.
 - b. The primary participant's spouse may dine with the participant regardless of age.
 - c. Individuals with disabilities who are not older individuals but who reside in housing facilities occupied primarily by older individuals at which congregate meals are served.
 - d. A person with a disability, regardless of age, who lives with and accompanies older eligible individuals to the congregate site.
 - e. Individuals, regardless of age, providing volunteer services during the meal hours.
 - f. An eligible participant's unpaid caregiver aged 18-59 whose meal is paid for through Title IIIIE Family Caregiver Support Program or other funds.

*Non-eligible individuals may, in accordance with the Area Agency on Aging (AAA) and nutrition services provider (herein referred to as provider) policy when funding is available, be served a congregate meal once the needs of the eligible populations (parts a-f above) have been met:

 - i. Staff of the nutrition program under 60 years of age.
 - ii. Anyone who pays the full cost of the meal (this is considered program income).



Meals served to non-eligible individuals are not NSIP eligible and must not interfere with participation of the eligible populations.

2. Target Population:

- a. Effort should be made to target services to people 60 and over who are unable to prepare meals for themselves because of:
 - i. A disabling condition, such as limited physical mobility, cognitive or psychological impairment, sight impairment, or
 - ii. Lack of knowledge or skills to select and prepare well balanced meals, or
 - iii. Lack of means to obtain or prepare nourishing meals, or
 - iv. Lack of incentive to prepare and eat a meal alone.
 - v. To the degree feasible, the provider shall ensure that preference is given to those individuals aged 60 and over who meet the vulnerability criteria in [RCW 74.34.020\(21\)](#).
 - vi. Waiting list policies shall be developed collaboratively by the provider and AAA, with final approval by the AAA.
- b. Services are targeted to those in greatest social and economic need with particular attention to:
 - i. Older individuals whose income is at or below the Federal poverty level.
 - ii. Older individuals with physical and mental disabilities.
 - iii. Older individuals with non-English language preference or those who experience language barriers.
 - iv. Older adults who experience cultural, social, or geographical isolation, as outlined in 45 CFR 1321.3 "Greatest social need".
 - v. Older individuals at risk of institutional placement (unable to perform at least 2 activities of daily living without substantial assistance (including verbal reminding, physical cuing, or supervision) and determined to be in need of placement in a long-term care facility).
 - vi. Older individuals in greatest social or economic needs as defined in state and area plans.

3. Service Frequency:

Providers shall serve at least one hot, cold, or other appropriate meal in a congregate setting at least once a day, five or more days per week. When funding permits, providers should consider serving additional meals and/or providing shelf stable meals for emergencies.

If a provider operates both Congregate and HDM programs, the five days per week frequency requirements must be met for congregate and home-delivered meals independently, e.g., if the provider delivers 7 meals to HDM participants, congregate meal sites must still be served on 5 or more days per week.

Exceptions to meal frequency requests must be approved and kept on file with the AAA. Data on exception to meal frequency must be documented in the Area Plan.



4. Nutrition Risk Screening:

Congregate meal programs under the OAA must screen participants for nutritional risk. At a minimum, programs must screen participants for nutritional risk within three weeks of their first meal (longer timeframes may be established and must be documented by AAA policy & procedure) and annually thereafter. The DETERMINE Your Nutritional Health checklist, also known as the Nutrition Screening Initiative (NSI) shall be used to report required data to the ACL, though other nutrition screening tools may be used to supplement a nutrition project.

5. Congregate Meal Services for Adult Day Care Providers

In order to provide Congregate Meals Services at an Adult Day Care or Adult Day Health service, the provider must be contracted in accordance with these Senior Nutrition Program (SNP) Standards and the meals must meet the following criteria:

- a)** The individual served the meal is eligible for this service according to subsection 2(a) and is at the Adult Day Care or Health services site for the purpose of receiving congregate meals rather than Adult Day Care or Health services; or
- b)** The cost of the Adult Day Services for the individual is covered by a source other than COPES, Medicaid, SCSA or Respite or any other means-tested program, and OAA funds are allocated specifically for meals for these individuals; and
- c)** The individual is given the opportunity to donate toward the cost of the meal.

Home-Delivered Meal (HDM) Services:

1. Eligibility Criteria:

- a)** To be eligible for HDM services, individuals must be age 60 and older and homebound*.
*Homebound is defined as typically unable to leave home unassisted, and for whom leaving home takes considerable and taxing effort. The homebound person may leave home for medical treatment or short, infrequent absences for non-medical reasons.

AND

- b)** Unable to prepare meals for themselves because of at least one of the following:
 - i.** A disabling condition, such as limited physical mobility, cognitive or psychological impairment, sight impairment, or
 - ii.** Lack of knowledge or skills to select and prepare nourishing and well-balanced meals, or
 - iii.** Lack of means (such as financial, transportation, lack of access to food, etc.) to obtain or prepare nourishing meals, or
 - iv.** Lack of incentive to prepare and eat a meal alone.

AAAs may establish additional criteria based on local targeting factors and greatest needs as defined in respective AAA Area Plan and may include the following:



- c) Meet the vulnerability criteria. A person is considered vulnerable if they are unable to perform one or more of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs) listed below without assistance due to physical, cognitive, emotional, psychological, or social impairment.
 - i. Activities of daily living are eating, dressing, bathing, toileting, transferring in and out of bed/chair, walking.
 - ii. Instrumental activities of daily living are preparing meals, shopping, medication management, managing money, using the telephone, doing housework, transportation; or
 - iii. Has a behavioral or mental health condition that could result in premature institutionalization; or is unable to provide for their own health and safety, due to cognitive, behavioral, psychological/emotional conditions which inhibit decision-making and threaten the ability to remain independent.

AND/OR

- d) Lacks a consistent informal support system, i.e., has no family, friends, neighbors, or others who are both willing and able to perform the service(s) needed, or the informal support system needs to be temporarily or permanently supplemented.

AND/OR

- e) Other people who are under 60 years old AND meet at least one of the following criteria, if resources are available
 - i. The spouse, regardless of age, of a participant receiving HDM funded through OAA or the Medicaid Waiver for HDM (COPES).
 - ii. Individuals with disabilities, regardless of age, who reside in the same home with other individuals eligible for the service.
 - iii. Individuals, regardless of age, providing volunteer services for the HDM program during meal delivery and meal hours.
 - iv. An eligible participant's unpaid caregiver aged 18-59 whose meal is paid for through Title IIIIE Family Caregiver Support Program or other funds.

*Non-eligible individuals may, in accordance with the AAA and provider policy when funding is available, be served a home-delivered meal once the needs of the eligible population have been met:

- i. Staff of the nutrition program under 60 years of age.
 - ii. Anyone who pays the full cost of the meal (this is considered program income).
- Meals served to non-eligible individuals are not NSIP eligible and must not interfere with participation of the eligible populations.

****Per 45 CFR 1321.87(a)(2)(ii), "HDM service providers may encourage meal participants to attend congregate meal sites and other health and wellness activities, as feasible, based on a person-centered approach and local service availability."**

2. HDM Target Population:



To the degree feasible, the provider shall target services to older individuals in greatest economic and social need with particular attention given to:

- a) Older individuals whose income is at or below the Federal Poverty Level (FPL).
- b) Older individuals with physical and mental disabilities.
- c) Older individuals that communicate in a language other than English, or those who experience language barriers.
- d) Older adults who experience cultural, social, or geographical isolation, as outlined in 45 CFR 1321.3.
- e) Older individuals at risk of institutional placement.

3. Waiting List Policy:

If resources are limited, waiting list policies shall be developed collaboratively by the provider and AAA, with final approval by the AAA.

4. Service Frequency:

Home-delivered meal providers must offer five or more HDM per week, unless an exception to service frequency is approved and documented by the AAA as described in subsection II(A)(3). Exceptions to meal frequency requests must be approved and kept on file with the AAA. Data on exception to meal frequency must be documented in the Area Plan.

When funding permits, providers should consider serving additional meals and/or providing shelf stable meals for emergencies.

Home-delivered meals may be hot, cold, frozen, dried, or shelf-stable with a satisfactory storage life.

5. Assessment of Eligibility

Each HDM provider must assess individuals requesting HDM services for eligibility according to criteria in Section II(B).

The HDM provider may conduct the assessment or have a formal written agreement with another agency to conduct the assessment. The formal agreement will include assessor qualifications.

Initial determination of eligibility can be made via phone screening; however, an in-home assessment must be performed within three weeks of the participant's first meal (longer timeframes may be established and must be documented by AAA policy & procedure).



Reassessments shall be completed annually, or sooner for participants who are assessed to need meals on a temporary basis, for example if the participant is recovering from surgery or illness. HDM participants must first be provided the opportunity for an in-home reassessment. With AAA approval, telephonic assessments may be used as an alternative if an in-person option is not available (i.e., due to health & safety issues, inclement weather, or critical staffing issues). The HDM assessment must document the following:

- a) Confirmation that client meets all eligibility criteria as outlined in Section II(B)(1).
- b) Screening for the client's nutritional risk.
- c) Evaluation of the client's alternative means of obtaining consistent and adequate meals, including an assessment of their strengths and their formal and informal support systems.
- d) Referral to other services within the continuum of care as appropriate.
- e) Questions to obtain the data required by the AAA and HCLA for reporting purposes.

***Note:** HDM provider staff/volunteer drivers play a critical role for nutrition programs. Programs should consider developing strategies and procedures to leverage this role in ways to support the ongoing participant assessment process.

6. Subcontracting Requirements:

All HDM providers must establish specific written procedures on how in-home assessments will be conducted. HDM providers who subcontract assessments must have a written agreement for doing the assessments.

The written agreement should include the following information:

- a) Responsibilities and obligations of each program.
- b) Specific programmatic procedures to be followed by each program.
- c) Assessment form to be used.
- d) Minimum qualifications for persons conducting assessments.
- e) Orientation and/or training regarding the HDM and the assessment process.

III. PROGRAM SERVICES AND OAAPS REPORTING

Program service requirements are specified in the OAA. The OAA also requires data to be collected by State agencies, AAAs, and service providers through the Older Americans Act Performance System (OAAPS) for various purposes.



In Washington State, GetCare is the system of record for all OAAPS reporting (GetCare is also known as Community Living Connections, or CLC). The SNP Standards provide brief descriptions of OAAPS reporting requirements for related services. More detailed information on OAAPS reporting can be found in the CLC Help Library.

Nutritious Meals:

Meals must be high quality, nutritionally complete and comply with the most recent Dietary Guidelines for Americans (meal pattern vs. each meal) published collaboratively by the United States Departments of Agriculture (USDA) and Health and Human Services (HHS) to provide to each participating older individual:

- 1) A minimum of 33 1/3 percent of the dietary reference intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, if the project provides one meal per day.
- 2) A minimum of 66 2/3 percent of the allowances if the project provides two meals per day.
- 3) 100 percent of the allowances if the project provides three meals per day.

To the maximum extent practicable meals are adjusted to meet any special dietary needs of program participants. The standards are intended to provide flexibility to local nutrition programs to design meals that are appealing to program participants and meet dietary guidelines.

OAAPS Reporting Requirements/Definitions for Meals:

Congregate Meal (one unit = one meal) a meal provided to a qualified individual in a congregate/group setting, or other setting as established in Section I(B)(1) and included in the approved AAA Area Plan. The meal as served meets all of the requirements of the Older Americans Act and state and local laws.

NSIP Congregate Meal (one unit = one meal) A Nutrition Services Incentive Program (NSIP) Meal is a meal served that meets all the requirements of the OAA, which means at a minimum that: it has been served to a participant who is eligible under the OAA, has NOT been means-tested for participation, and has been provided the opportunity to provide a voluntary contribution to the cost of service.

Home Delivered Meal (one unit = one meal) a meal provided to a qualified individual in their place of residence, or by other approved means as established under Section I(B)(2) and in the approved AAA Area Plan. The meal as served meets all of the requirements of the Older Americans Act and state and local laws.

NSIP Home-Delivered Meal (one unit = one meal) A Nutrition Services Incentive Program (NSIP) Meal is a meal served in compliance with all the requirements of the OAA, which means at a minimum that it has been served to a participant who is eligible under the OAA and has NOT been means-tested for participation; includes all OAA eligible meals including those served to persons under age 60 where authorized by the OAA. NSIP Meals also include home delivered meals provided as Supplemental Services under the National Family Caregiver Support Program (Title III-E) to persons aged 60 and over who are either care recipients (as well as their spouses of any age) or caregivers.



Nutrition Risk Screening:

Nutrition screening is a first step in identifying individuals at nutritional risk or with malnutrition. The OAA requires nutrition programs for both Congregate and HDM services to provide nutrition risk screening.

At a minimum, nutrition program providers must administer the **DETERMINE Your Nutritional Health** checklist published by the Nutrition Screening Initiative (NSI) to participants and find out their nutrition risk scores.

HDM providers may administer the NSI checklist alone or incorporate the questions into the participant assessments. Other tools that exceed the scope of **DETERMINE**, e.g. **Mini-Nutrition Assessment**, may be used to ascertain risk.

For participants whose screening indicates nutritional risk, providers should provide a copy of the Nutrition Risk Screening to the participant and suggest they ask their doctor, dietitian or other qualified health or social service professional for help to improve their nutritional health.

At a minimum, when a participant is at high nutritional risk, providers shall also screen participants for malnutrition using an approved malnutrition screening tool. For participants whose screening indicates that they are at risk of malnutrition, providers should refer to appropriate services and interventions. It is recommended that all participants be screened for malnutrition, however AAAs may establish individualized procedures based on local factors, using a person-centered approach.

OAAPS Reporting Requirements for Nutrition Risk Screening

The number of participants determined to be at high risk must be included in the data submitted to the AAA and HCLA for the federally required State Performance Report. A participant is defined as high risk if they score comparable to six (6) or higher on the DETERMINE Your Nutritional Risk checklist.

Nutrition Education:

Nutrition Education is a required component of Older Americans Act (OAA) funded senior nutrition programs. Nutrition Education intended to promote better health by providing accurate and culturally appropriate nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers, or participants and caregivers in a group or individual setting.

Nutrition Education must be reviewed by a Registered Dietitian Nutritionist (RDN) and provided to individuals through training resources and other planned activities. Teaching methods and instructional materials must accommodate the older adult learners (i.e. large print handouts or demonstrations) and should be culturally affirming and presented in a way that participants understand.

1. Nutrition Education Goals

- a)** To promote positive nutrition and physical activity messages so individuals are motivated to attain and maintain optimal health and wellness.
- b)** To provide information and skills so individuals can make healthy food choices.

c) To help individuals understand and access healthy food and nutrition information.

2. Nutrition Education Content

Content must be tailored to SNP participants and inform them about current facts and information that can promote improved food selection, eating habits, nutrition, health and wellness promotion and disease prevention practices.

Some examples of nutrition education activities include:

- presentations
- cooking classes
- food preparation demonstrations
- distribution of RDN/ICE prepared educational content and instructional materials
- field trips
- plays
- panel discussions
- planning and/or evaluating menus
- food tasting sessions
- question and answer sessions
- gardening
- physical fitness programs
- videos & other visual presentations
- mobile applications that support healthy eating, food access, and other nutrition education topics
- other resources provided through the Nutrition and Aging Resource Center.

For HDM participants, activities can include the distribution of educational materials.

3. Documentation

Documentation will include the following:

- date of presentation or distribution of materials
- name and title of presenter or title of materials distributed
- topic discussed (if applicable)
- number of persons in attendance

If materials are delivered to HDM participants, documentation will include date of distribution, copy of distributed material, and number of participants receiving the information.

OAAPS Reporting Requirements for Nutrition Education:

Nutrition Education is a Cluster 3 Non-registered Service and if reported requires reporting service units. A unit is defined as one session per participant:

1 (one) unit = 1 (one) session X # of participants

For example, a program provides a presentation on healthy meal preparation at a meal site. There are 20 OAA eligible participants in attendance.



1 session x 20 eligible participants= 20 units

The program will report 20 Nutrition Education units.

Note: *Federal reporting requirements do not include reporting time for RDN/ICE preparation of tailored content and instruction in various mediums.*

Nutrition Counseling:

Nutrition counseling is the provision of individualized advice and guidance to individuals at nutritional risk because of their health or nutritional history, dietary intake, medications use or chronic illnesses, about options and methods for improving their nutritional status, working with the individual's physician as appropriate. Nutrition Counseling may be a component of medical nutrition therapy, which includes assessment of nutritional status, nutrition diagnosis, nutrition interventions, and nutrition monitoring/evaluation. Nutrition therapy must be provided by an RDN. The service includes:

1. Nutrition Assessment: Assessing present food intake habits, client history, and other related factors.
2. Nutrition Diagnosis: Data collected in step 1 informs appropriate nutrition diagnosis.
3. Nutrition Intervention: Developing a written plan to assist the individual to address the root cause of the issue.
4. Nutrition Monitoring/Evaluation: Planning follow-up care to evaluate achievement of objectives and progress of planned goals.

OAAPS Reporting Requirements for Nutrition Counseling:

Nutrition Counseling requires unduplicated client and unit counts.

Reporting of nutrition counseling: one unit = one hour per participant (partial hours may be reported to as .25 for each 15 minutes).

Outreach:

Outreach is an activity designed to seek out and identify, on an ongoing basis, the hard-to-reach, isolated, and vulnerable target group of eligible individuals in the program service area. Outreach is an individual, one-on-one contact between a service provider and a potential OOA-eligible participant or caregiver. Nutrition program outreach should be provided as necessary to reach the target population. It may be provided by the AAA, provider, or by another contracted provider on behalf of one or more nutrition services providers. The provider must include all costs associated with the delivery of nutrition outreach services in their program budget.

OAAPS Reporting Requirements for Outreach

1 (one) unit = 1 (one) contact. One-on-one outreach to individuals initiated by an agency or organization for the purpose of identifying potential clients (or their care givers) and encouraging their use of existing services and benefits.



Referral to Community Living Connections/Aging & Disability Resource Centers (Information and Assistance):

Subject to participant consent, all participants who appear to have a need for other services should be referred to Information and Assistance or directly to the appropriate service.

Referral to Basic Food:

The nutrition program provider must provide information to participants about benefits available to them under the Supplemental Nutrition Assistance Program (SNAP), which is called Basic Food in Washington State. Basic Food benefits help low-income individuals and families obtain a more nutritious diet by supplementing their income. Participants will receive information at time of initial assessment and a minimum of one time a year afterwards.

Participants can apply for Basic Food at a local Community Services Office or [online](#). Providers must coordinate their activities with local agencies that conduct outreach for Basic Food to facilitate participation of eligible older persons in the program.

IV. MENU PLANNING & FOOD SERVICE STANDARDS

Menu Planning:

The special dietary needs of older adults must be considered in menu planning, food selection, meal preparation and meal presentation. Participants should be involved in the menu planning process, and participant food preferences (e.g., likes and dislikes, cultural preferences) must be solicited in the development of menus.

Menus may be evaluated for nutritional adequacy using either **nutrient analysis** or a **food group-based meal pattern**. All menus and meals must be certified by the signature of a Registered Dietitian Nutritionist (RDN) or Individual with Comparable Expertise (ICE) to meet nutrition requirements.

AAAs may require providers to submit documentation or review documentation during annual monitoring visits or using a comparable method to ensure compliance. All records of approved menus should be kept consistent with contract requirements.

Regardless of how the menus are evaluated, all menus will incorporate the current Dietary Guidelines for Americans as appropriate for older adults.

A healthy eating pattern includes:

- A variety of vegetables from all subgroups – dark green, red and orange, legumes (beans and peas), starchy and other
- Fruits, especially whole fruits
- Grains, at least half of which are whole grains
- Fat-free or low-fat dairy, including milk, yogurt, cheese, and/or fortified plant-based calcium equivalent beverages.



- A variety of protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), and nuts, seeds and other plant-based protein sources.
- Oils, including those from plants: canola, corn, olive, peanut, safflower, soybean and sunflower. Oils are naturally present in nuts, seeds, seafood, olives and avocados.

A healthy eating pattern limits:

- Saturated fats, added sugars, and sodium

Key recommendations that are quantitative are provided for several components of the diet that should be limited. These components are of particular public health concern in the United States, and the specified limits can help individuals achieve healthy eating patterns within calorie limits:

- Consume less than 10 percent of calories per day from added sugars.
- Consume less than 10 percent of calories per day from saturated fats.
- Consume less than 2,300 milligrams (mg) per day of sodium.

Sodium Guidelines: The recommendation for adults and children ages 14 years and older to limit sodium intake to less than 2,300 mg per day is based on evidence showing a linear dose-response relationship between increased sodium intake and increased blood pressure in adults. Adults with prehypertension and hypertension would particularly benefit from blood pressure lowering. For these individuals, further reduction to 1,500 mg per day can result in even greater blood pressure reduction.

In tandem with the recommendations above, Americans of all ages should meet the *Physical Activity Guidelines for Americans* to help promote health and reduce the risk of chronic disease.

Nutrient Analysis:

Meals planned using a nutrient-based planning approach are considered to meet nutrient intake recommendations when menus are appropriate in calorie content and meet one-third of the current Dietary Reference Intake (DRI) for key macro- and micronutrients in each meal.

The goal is to meet the requirements for a >70 old man, as these DRIs represent the highest values for people ≥60 years of age. To allow for menu flexibility and client satisfaction, nutrients may be averaged over 1 week and up to 1 month as determined collaboratively between the AAA and provider. See [Appendix D](#) for DRI values.

When a change in dietary standards has been published, the new value for key nutrients should be used as a basis for meal planning. The new value should be adopted within a reasonable amount of time, not to exceed one year after publication.

Food Group-Based Meal Pattern:

Meals planned using the food group-based meal pattern approach is considered to meet nutrient intake recommendations when the serving sizes and guidelines regarding food components are followed.

Food groups may be combined in a mixed meal and meet meal pattern requirements (i.e., a casserole or stew using appropriate serving sizes for protein, grains, and vegetables).



When using a food group-based menu pattern planning approach, computerized nutrient analysis may be helpful, but is not required, as long as nutrition providers use an accepted method to control the calorie content, saturated fat, added sugars, and sodium content of the meals. See [Appendix E](#) for a food group-based menu pattern.

Food Substitutions:

All meals and menus must be served as written. If the meal cannot be served or is not acceptable to the participants, the Program Director or their designee, ICE, or RDN must be informed and approve all proposed changes.

All meal or menu deviations must be documented and initialed in the provider's official paper or paperless file system for review by the AAA.

Food substitutions may not reduce or significantly alter the nutritional content of the meal. Food substitutions at the time of food preparation and serving should be infrequent.

Therapeutic Diets and Medical Nutrition Therapy:

SNP providers may, but are not required to, offer meals and menus to accommodate therapeutic/modified diets. A therapeutic diet is designed to meet the requirements of a given situation and may be modified in individual nutrients, caloric values, consistency, flavor, techniques of food preparation, content of specific foods, or combinations of the preceding.

A current therapeutic diet prescription (no older than six months) should be signed by the participant's physician, RDN, or ICE and filed in the provider's official files. Therapeutic diets must be planned, prepared and served by trained staff under monthly supervision and/or consultation of an RDN or ICE.

Additionally, SNP providers may, but are not required to, offer meals and menus to accommodate medical foods and foods for special dietary use. Nutrition interventions, including in some cases liquid supplements, can provide essential support to individuals at high risk. The OAA, including NSIP will pay for medical foods and foods for special dietary uses when all the following requirements are met:

1. When indicated for participants who are malnourished, at risk of malnutrition, or with disease-related special nutritional needs. These include older participants who, because of anatomical, physiological, or behavioral health challenges, cannot meet their nutritional needs by eating a nutritionally balanced diet of solid or textured modified foods, or for those who have increased or altered metabolic needs due to illness, surgery, or other special conditions. This may include individuals screened for and at risk of malnutrition through OAA nutrition programs or individuals referred to programs from outside entities.
2. There is a recommendation by an appropriate health professional, i.e., physician or RDN, as part of an assessment-based nutrition plan for the individual, and the plan is re-evaluated and updated at least every six months.



3. The participant must be provided with a minimum of 33 1/3% of the DRI except in cases where the individual's specific medical nutrition therapy plan dictates otherwise; and if the medical food or food for special dietary uses is used as:
 - a) a substitution for part of the conventional meal components, the combination of the medical food or foods for special dietary uses and conventional foods must meet the criteria in Section IV. Note: Use of conventional foods in combination with medical food or food for special dietary uses are viewed as one meal.
 - b) replacement of a conventional meal, the medical food or food for special dietary uses must meet the criteria in Section IV and be used as a replacement because a conventional meal, even with modifications, is inadvisable. Note: Meals in this category are viewed as one meal.
 - c) vitamins, minerals and / or food supplements, with exception to liquid meals that meet the criteria above may not be provided with SNP funds.

Food Service Standards:

1. Standardization of Recipes and Portion Control:

Recipes used by the nutrition program provider should be adapted and standardized for use by carefully testing each recipe in its own kitchens with its particular equipment, available ingredients, and skills and abilities of its personnel.

The recipes should then be adjusted for yield (number of servings) based on the number of people to be served and the portion size necessary to comply with nutrient requirements. Meals offered to participants must comply with nutrient requirements. What is served to SNP participants (what a participant selects) may vary from the planned meal offering as participants can choose the food items they wish to eat.

Except when food comes from a food service vendor/caterer, a file of standardized recipes which are acceptable to program participants should be kept and used for the purposes of:

- a) Production Control - Eliminates guesswork, food waste and recipe failure; and reduces supervision time of inexperienced or new personnel.
- b) Portion Control - Helps reduce leftovers and eliminate waste; and ensures that the food prepared for HDM services is adequate; assures that Congregate participants feel fairly treated; helps the program stay within budget; and provide examples of sensible portion sizes to help participants achieve or maintain healthy weights.
- c) Quality Control - Helps ensure that an acceptable finished product is produced that meets one-third DRI when proper portion sizes are served.



- d) **Cost Control** - Simplifies purchasing by establishing proper amounts of food ingredients to purchase and use and minimizes leftover food.

All food service workers should be trained to follow standardized portions and provided with necessary equipment and utensils to serve standardized portions. A visual standard of reference for portion size should be provided.

The nutrition program provider should develop procedures for determining how many people will eat at each Congregate site each serving day or how many HDMs must be prepared, so food production staff can adjust their standardized recipes to yield the proper number of portions.

2. Leftover or excess food policy:

The provider should develop, and have approved by the AAA, a written policy describing the procedures the nutrition provider will follow regarding the use and handling of excess food not needed to serve Congregate participants or prepare home-delivered meals.

In developing these procedures, particular attention should be accorded to the sanitation and safety of the foods and the economic consequences that leftovers have on the provider's food costs and budget.

Use of leftovers is strongly discouraged in the preparation of home-delivered meals. Leftovers (from meals served in the same day) may be offered to Congregate participants as second helpings at those congregate settings that do not have on-site cooking facilities or methods to preserve leftover food to meet the nutritional standards for later consumption.

Meals must meet 1/3 DRI and all other OAA requirements to be counted as an additional meal/unit of service for reporting purposes. If the meal is taken from a meal site to be consumed at the participant's home, the unit of service may be counted under Congregate Meal services if included as a part of the approved AAA Area Plan, and if it complements the program as referenced in Section I(B)(1)(a-c).

If leftover meals are provided at a congregate site, a set of written instructions should be included with each meal. The instructions should include:

- the date the meal was prepared,
- the discard date (two days following),
- refrigeration instructions,
- a statement about proper hand washing,
- instructions to reheat to 165 degrees,
- and a disclaimer that states:

"For your safety: food removed from this site must be kept hot or refrigerated promptly. We are not responsible for illness or problems caused by improperly handled food. When food has been removed from the premises its safety is the sole responsibility of the participant".

3. Food Quality:



All foods used in the nutrition program must meet standards of quality, sanitation and safety applying to foods that are processed commercially and purchased by the program. All foods used in the nutrition program must be:

- a) From approved sources. (per WA Retail Food Code)
- b) Comply with applicable state and local laws, ordinances and regulations; and be clean, wholesome, and free from spoilage; free from adulteration and mislabeling, and safe for human consumption.
- c) Hermetically sealed food which has been processed in an approved commercial food processing establishment may be used.
- d) Home-canned foods may not be used.
- e) All foods contributed to the nutrition program must meet the same standards of quality, sanitation and safety that apply to foods processed commercially and purchased by the nutrition program.
- f) Fresh or frozen meat and poultry used in the meals provided by the provider must be USDA inspected. Wild game cannot be used in the nutrition program because it is not inspected by USDA and is considered "adulterated" and would not be approved for use according to the Washington State Health Code.
- g) Dried meat or dried fish may be used in meals only if it has been commercially processed at a government (including tribal) approved processing plant.
- h) The provider assumes the responsibility for determining the condition, quality and safety of fresh or frozen fish used in its food service since federal or state inspection of fresh or frozen fish is not required.
- i) The provider assumes responsibility for determining the condition, quality and safety of fresh produce used in its food service.
- j) Purchasing procedures should assure availability of food, supplies and equipment in the quantity and quality consistent with established standards and at the most favorable prices consistent with set standards.

Service providers are encouraged to use with locally produced foods whenever possible and to collaborate with local food producers and other food assistance programs to maximize access to and use of high quality, nutritious, affordable foods.

4. Additional requirements



- a) Meal service should be offered for a period of time adequate for all participants to eat a leisurely meal. Flexible service time may be offered as long as food safety procedures are followed.
- b) Menus should be posted in an easily accessed location in each congregate nutrition site and must be provided to home delivered meal participants upon request.
- c) Service providers at congregate meal sites are not required to post common food allergen information but should be able to provide a list of all ingredients used in the meal.
- d) Providers must have a Certified Food Protection Manager or access to a CFPM and identified a Person in Charge (PIC) to ensure safe food handling practices and procedures are followed, per WAC 246-215-02107.
- e) Food should be prepared using production and presentation methods that enhance the palatability, hence acceptability, of the food served. Acceptability of the food served will depend upon appearance (color, consistency, shape or form, arrangement, size portion) and flavor (seasoning, texture, odor, temperature, degree of doneness).
- f) In purchasing food and preparing and delivering meals, providers should follow appropriate procedures to preserve nutritional value and food safety. Foods should be selected, stored, prepared, and served in a manner to assure maximum nutrient content or food value.

V. FACILITY & FOOD SAFETY STANDARDS

Location of Congregate Meal Sites:

The location for the congregate meal program is essential to its success. In order to create a gathering place that offers opportunities for good nutritious meals and social interaction, an ideal facility will:

- 1) Be conveniently located to the target population.
- 2) Have convenient, accessible and affordable transportation.
- 3) Be in a safe, well-lit, well-maintained location.
- 4) Be easily visible and open to the public.
- 5) Have adequate space to support programming.
- 6) Have clear, inviting and culturally appropriate exterior and interior signage.
- 7) Have a welcoming interior space that is culturally appropriate, safe & accessible, and supportive of high-quality meal service.



Examples of location include community centers in low-income areas, subsidized housing complexes, senior centers, schools, Adult Day Services, and religious facilities.

In no way may a nutrition program operated by specific groups, such as churches, social organizations, senior centers or senior housing developments restrict participation in the program to their own membership or otherwise show discriminating preference for such membership.

Congregate Physical Facilities and Equipment:

Compliance with federal, state, and local fire, health, sanitation, safety and building codes, regulations, licensure requirements, and other provisions relating to the public health, safety, and welfare applicable to each congregate nutrition site, food preparation site, and food service vendor/caterer used in the nutrition program is required in all stages of food service operations. Congregate facilities and equipment must meet the following requirements:

1. Comply with federal, state and local fire and building codes. Programs must have the local or state fire marshal or equivalent conduct a fire and life safety inspection of each site prior to opening and annually thereafter.
 - a) A copy of the most recent annual inspection report must be kept on file at the nutrition site.
 - b) If the provider experiences difficulty obtaining timely inspection, the provider will notify the AAA.
 - c) The AAA will work with the provider and local entity to obtain an inspection
 - d) If the AAA is unable to resolve the issue at the local level, the State Unit on Aging SNP Program Manager will be notified and provided with documentation of the AAA's efforts to get resolution at the local level in order to determine next steps including notification of the State Marshal where applicable
 - e) A provider shall not be cited for failure to obtain an inspection as long as there is documentation of efforts to get the inspection in a timely manner *

***Note:** *Standards require the annual inspection; the intent of (e) is to ensure the provider is not cited when monitored by AAA if they have taken appropriate steps to obtain the inspection. The standard intends to promote cooperative resolution at the local level. Repeat instances of failure to obtain inspection are not acceptable and should not occur if the provider and AAA complies with the requirements in this section.*

2. **Compliance with the Americans with Disabilities Act (ADA).** At a minimum:
 - a) Be free of architectural barriers that limit the participation of people with disabilities.
 - b) Make special provisions as necessary for the service of meals to persons with disabilities.



- c) Have available for use upon request adaptive food containers and utensils for individuals with disabilities. Provide tableware and flatware, including plates, glasses, cups, forks, spoons, and knives, which are appropriate for older persons. The provider may not ask or require participants to bring their own tableware and flatware for use at the congregate nutrition site. This may include weighted, bent, or other adaptive utensils, lidded cups/mugs, lipped/high-sided dishes, and other adaptive tableware to support independence.
- d) Provide for a permanent or temporary separation between the dining area and the food preparation area when food is prepared and served in the same facility.
- e) Have equipment, including tables and chairs that are sturdy and appropriate for older persons. Tables should be arranged to ensure a pleasant atmosphere for dining and encourage maximum socialization among participants. Adequate aisle space should be provided between tables to allow persons with canes, walkers or crutches to walk with ease and to accommodate wheelchairs.

Note: *It is recommended that a self-assessment for ADA compliance be conducted at each site annually or after remodeling, and for new facilities, prior to opening. A link to the ADA checklist is footnoted below.*

Food Safety Guidelines:

Preparation of food for Congregate and HDM services must comply with Food and Drug Administration (FDA) Food Code and Washington State Retail Food Code, and Chapter 246-215 of the Washington Administrative Code (WAC).

1. **Health Inspection Reports:** providers must have in their official files a copy of all current Food Service Inspection Reports (or their equivalents), which have been completed by state or local health authority for each congregate nutrition site, food preparation site, and food service vendor/caterer used in the nutrition program.

For the purposes of these standards, a food service vendor/caterer is defined as an entity contracted by the provider to prepare meals for HDM or Congregate programs.

To be current, the date on the report must not exceed one year elapsed. If for any reason a congregate nutrition site, food preparation site, or food service vendor/caterer does not have a current Food Service Inspection Report, the AAA and the provider must take immediate action and work together to achieve compliance.

Additionally, HDM and Congregate providers that operate food establishments must have at least one Certified Food Protection Manager (CFPM) on staff as evidenced by a valid certificate. This requirement applies to providers considered "Food Establishments" as defined by WAC 246-215-01115. The CFPM ensures proper training for persons in charge, procedures are developed, and food safety practices are achieved. (Find a list of accredited programs for the CFPM here: [ANAB - ANSI National Accreditation Board](#)).

2. **Food Worker Cards:** All food service employees and volunteers who are involved with unwrapped or unpackaged food products must hold a current Food Worker Card and/or obtain one within 14 calendar days from their first day of work. Providers may pay the permit fees for their volunteers and paid staff. All Food Worker Cards must be maintained in the provider's official files.
3. **Temperature Control Guidelines:** Foods should be prepared, displayed, served and transported with the least possible manual contact, with suitable equipment and utensils, and on surfaces that, prior to use, have been cleaned, rinsed, and sanitized to prevent cross contamination. Effective procedures for sanitizing dishware, cleaning equipment, and work areas should be written and followed consistently.

On a daily basis, temperature checks should be taken with a food thermometer at the time all food leaves the production area (including the food service vendor/caterer's kitchen) and at the time of serving.

Records of these temperature checks must be maintained in the nutrition program provider's official files. Depending upon procedures involved in food preparation and delivery (e.g., transportation, receiving, storing and serving), additional temperature checks may be required.

Certain foods, called Time/Temperature Control for Safety (or TCS for short) food can support more rapid growth of bacteria if not held at the proper temperature. The following table references various time and temperature controls required by FDA and WA Food Codes:

Process	Temperature Requirement	Time Requirement
Cold Holding TCS Foods	<41°F (5°C)	-
Hot Holding TCS Foods	>135°F (57°C)	-
Cooling TCS Foods	Within 2 hours: 135°F to 70°F (57°C to 21°C) Within 4 hours: 70°F to 41°F (21°C to 5°C)	Within a total of 6 hours from 135°F to 41°F (57°C to 5°C) or less
Reheating TCS Foods	At least 165°F (74°C) for 15 seconds (internal temperature)	Rapidly reheat and hot hold less than 2 hours
Thawing TCS Foods	<41°F (5°C) or other method specified in WAC 246-215-03510	-



Frozen Storage	At or below 0°F (-18°C)	-
Time as Temperature Control for TCS Foods	Between 41°F and 135°F (5°C to 57°C)	Within 4 hours (discard after 4 hours)

Table 1. Time/Temperature Control for Safety

Home delivered meals shall be prepared, individually plated, packaged and delivered in accordance with current FDA and WA Retail Food Code and as per the following guidelines:

- a) The meal will be delivered directly to the participant or the participant's designee in accordance with food safety guidelines.
- b) Thermal carrying bags, hard-sided coolers and appropriate heating or cooling pads and devices will be used to help keep hot meals hot and cold meals cold during the entire delivery process.
- c) Frozen foods and meals shall be packaged for delivery in clean cardboard boxes, paper bags or thermal containers and delivered frozen. Cooling pads should be added if there is a risk of thawing. Any thawed meals, i.e., meals that no longer contain ice crystals, must be discarded.
- d) Frozen foods and meals shall be stored at the meal site at 0° F or below. Provision of frozen foods or meals should be based upon the ability of the provider and homebound participant to provide safe conditions for the storage, thawing, and reheating of the frozen foods.
- e) The goal is to keep cold foods cold at all times during delivery, ideally below 41° F. Cold food items can be held at above 41° F for up to four hours provided the meal is temperature checked at 41° F or lower upon removing it from refrigeration and does not reach 70° F or higher at any time from the point of removal from refrigeration to the time of delivery to the participant.

Food items must be discarded if not delivered within the four hours from the time of removal from temperature control. Cold food with a temperature above 70° F at any time must be discarded.

- f) The goal is to keep hot meals hot at all times during delivery, ideally between 135° Fahrenheit (F) and 165° F. However, food items prepared the same day can be held outside of the temperature control range, i.e., at less than 135° F, for up to four hours.

This is only when the temperature is checked to be at 135° F or higher directly upon removing it from temperature control, e.g., from a commercial warmer, oven, stove or microwave, followed by immediate plating, packaging and placement into a thermal holding container for delivery.



Food items must be discarded if not delivered within four hours from the time of removal from temperature control. See [Appendix F](#) for sample temperature logs.

- g) Hot food items, prepared the day prior, properly chilled and placed in refrigeration overnight to be reheated the next day for delivery, including chilled or frozen prepackaged meals, can be held outside of temperature control range, i.e., at less than 135° F, for up to four hours.

This is only when temperature is checked to be at 165° F or higher directly upon removing it from temperature control followed by immediate plating, repackaging (if needed), and placement into a thermal container with appropriate heating pads for delivery.

Food items must be discarded if not delivered within the four hours from the time of removal from temperature control.

- h) On a daily basis, the provider shall document:

- the temperature and time of each batch of hot and cold food items at the time it is removed from temperature control and placed into the thermal holding containers, and
- the time of the final delivery shall also be documented for each route.

- i) Records of delivery temperatures and time must be maintained in the home-delivered nutrition program (and congregate program, as appropriate) provider's official files.

4. Meal Packaging Supplies and Carriers

- a) Meal packaging supplies and carriers will be used to ensure that hot foods are packaged and transported in separate carriers from cold foods.
- b) Meal carriers used to transport food will be enclosed and equipped with insulation and supplemental hot or cold sources as needed to support hot and/or cold food temperatures. Meal carriers will be cleaned and sanitized daily. Food and meals being transported to the home for use of the homebound participant should be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, and unnecessary handling. The holding time, with appropriate temperature control, between food preparation and the consumption of the meal should be minimal to reduce opportunities for contamination and to maintain nutritional quality, food acceptability, and food safety. Providers are encouraged to enter contracts that limit the amount of time meals must spend in transit before being consumed.



VI. PROGRAM ADMINISTRATION

Service Guidelines:

The provider must develop written program objectives that are specific, verifiable, and achievable for the frequency of meals to be served, service level of nutrition education and, if provided, nutrition outreach.

Participant Information & Record Keeping:

Providers must record and report the names and number of meals each participant receives on a monthly basis during the program year. In addition, the provider must collect the following information by their fifth meal:

- 1) Name, home address, and phone number of participant.
- 2) Emergency contact information (name, phone number, relationship to participant, physician if applicable/available).
- 3) Special dietary requirements, restrictions, or nutritional concerns or conditions shared by the participant.

The provider must also collect other reporting data required by the AAA and HCLA (i.e., the nutrition risk screening data as outlined in Sections II(A)(4) and II(B)(5)).

Note: *Obtaining participant birthdate is recommended. If a participant refuses to provide their date of birth, please note of this in the client file (GetCare).*

Participants may not be denied service if they refuse to provide the required information, with the exception of HDM applicants who refuse to allow an in-home assessment (or telephonic assessment, as applicable) to determine eligibility for home-delivered meals.

This in no way relieves the provider of the responsibility to make reasonable attempts to get the information from the participant and to explain the reasoning behind the request.

Adult Protective Services/Mandatory Reporting:

According to RCW 74.34.020(13) mandatory reporters include employees of social service agencies. By law, mandated reporters must immediately report the abuse, abandonment, neglect and financial exploitation of a vulnerable adult to DSHS Adult Protective Services (APS).

If you suspect a vulnerable adult is being harmed, call Adult Protective Services to report it. You can report by phone or online through the following webpage:

[ADULT PROTECTIVE SERVICES CONTACT INFORMATION](#)



If the person is in immediate danger, call 911. You do not need proof to report suspected abuse, and you do not need to give your name when you call.

SNP providers must include mandatory reporting and permissive reporting (RCW 74.34.020(16)) requirements in staff and volunteer training.

When providing a report to APS, please be ready to provide:

- 1) Your name and contact information (in case follow up is needed; your name is optional).
- 2) Names and contact information for the vulnerable adult and the person you think is causing harm.
- 3) Description of the situation.
- 4) Any known safety concerns.

Organizational Structure:

Congregate and HDM services may be provided independently or by the same provider. They may also be provided under the sponsorship of a parent agency including, but not limited to, a Community Action Agency, Council on Aging, senior center, public or private school, hospital, housing authority, county health department, parks and recreation department, city or county government, Indian Tribal Council, or by an agency that is independent and not part of a larger organization. HDM providers may also contract to provide Medicaid funded home delivered meals, e.g. Community Options Program Entry System (COPES) and must account for related program revenue and expenditures separately.

Service Agreements:

All Congregate or HDM providers shall develop a written agreement or contract with each outside agency or organization where nutrition services are provided, which addresses the following issues:

- 1) Responsibilities and obligations of each party, including compliance with SNP standards.
- 2) Staffing interrelationships.
- 3) Costs or payments, if any, to be paid or incurred by either party.
- 4) Days and hours the congregate nutrition site will operate and provide services in the agency's or organization's facility, or for HDM, days meals will be delivered.
- 5) Procedures to get food service equipment repair and maintenance
- 6) Other matters as necessary to operate the nutrition program according to these standards.



Staffing Requirements:

The provider should employ an adequate number of qualified personnel to ensure the success of the program. When hiring, preference should be given to persons age 60 or older and individuals that reflects the communities served when other qualifications are equal. The staffing pattern should include:

1. **Nutrition Program Director:** The program director should be empowered with the necessary authority to conduct the day-to-day management and administrative functions of the program. At the discretion of the AAA (in collaboration with the provider) the director may be hired on a full-time basis or part-time, as long as the staff time allocated is adequate to fulfill the responsibilities of the position.

Program directors should have management or supervisory experience and a background in food, nutrition, or food service management.

2. **Certified Food Protection Manager (CFPM):** providers that operate food establishments (WAC 246-215 01115(50)) must have at least one CFPM on staff (WAC 246-215-02107). A CFPM is not required to be on site but plays a key role in ensuring food safety. CFPMs may support food safety across more than one site and help to train persons in charge to maintain proper food safety standards
3. **RDN or ICE:** The OAA requires Congregate and HDM services to be carried out with the advice of "a dietitian or individual with comparable expertise (ICE)." For the purpose of these standards, a dietitian is referred to as a registered dietitian nutritionist (RDN) and must be registered by the Commission on Dietetic Registration.

An ICE is defined as a certified nutritionist who meets the qualifications stated in [RCW 18.138.030 \(4\)](#) and has current State certification.

An RDN or ICE must be available to the provider for the planning and provision of nutrition services, either on staff, under contract, or in a volunteer capacity. The required responsibilities of the RDN or ICE are:

- a) Assist in the development of menus.
- b) Certify that all meals meet the nutrient requirements as defined in the section on menu planning.
- c) Provide consultation on food quality, safety, and service (in collaboration with CFPM).
- d) Plan menus or meals to meet special dietary or therapeutic needs, if provided by the program.
- e) Assist with the development of program objectives related to nutrition education.
- f) Provide nutrition education directly or oversee the provision of nutrition education.



- g) Assist with the development of program objectives related to nutrition therapy services, and provide nutrition therapy, where the nutrition program has allocated the resources to provide the service.

Additional responsibilities may include staff training and other activities based upon the needs and priorities established for the program. These needs and priorities should be jointly established by the AAA and the provider.

- 4. **Other Personnel:** The method used to provide meals, nutrition education, and nutrition outreach will determine the number and type of permanent, consultant, or volunteer personnel required to manage the nutrition program and provide fiscal, administrative and clerical support.

5. **Criminal Background Checks (Minimum Requirement):**

Background checks are required every two years for all SNP employees and volunteers who will have unsupervised contact with SNP participants. This applies to individual contractors as well as employees and/or volunteers of a contracted entity.

"Unsupervised" means not in the presence of: another employee or volunteer from the same business or organization as defined in [RCW.43.43.830](#)

AAAs will include background check requirements in SNP provider contracts and will review compliance during required desk and on-site monitoring.

Minimum Training Requirements:

1. **Safe Food Handling Practices**

All staff and volunteers involved in the handling of food must have training on safe food handling practices prior to beginning food handling duties if the worker does not hold a valid food worker card. (Reminder – all food service workers must obtain a food worker card within 14 calendar days from the beginning of employment).

Staff and volunteers preparing food or handling unwrapped or unpackaged food must receive the required food worker training and obtain a food worker card, according to local health department requirements and Washington Administrative Code [WAC 246-217](#).

On site procedures for safe food handling practices must be accessible to staff and volunteers.

2. **Orientation and In-Service Training**

All staff, both paid and volunteer, should receive orientation before providing nutrition program services. The provider should provide in-service training on a regular basis for all staff, paid or volunteer, engaged in implementing the program.



Such training should be designed to enhance each staff member's performance of their specific job responsibilities, consider requests for training from staff, and be designed to resolve problems identified during the AAA monitoring of program performance.

Each provider should have a written training plan describing the content of orientation and the subject matter expected to be covered during in-service training. The dates and content of training actually provided should be documented. As allowed by the funding source, nutrition program funds may be used to pay for costs to local, statewide or out-of-state training in accordance with AAA policies.

3. Emergencies, Weather Related Conditions and Natural Disasters

Staff shall also be trained in emergency and evacuation procedures. A written plan describing procedures to be followed in case a Congregate or HDM participant becomes ill or is injured will be reviewed in depth with staff, volunteers and participants, and should also be posted in a visible location if possible. If posting is not allowed staff shall have easy access to the information

The provider shall have written procedures to be followed in the event of weather-related or other emergencies, disasters, or situations that may interrupt Congregate services, HDM, or the transportation of participants to the nutrition site. Sample plans are included in [Appendix G](#).

Program Budget & Meal Costs:

The provider must account for the program costs identified in this section. From these costs, the provider must determine an average per meal complete cost on an annual basis that includes all costs from all categories listed below. Cost will be determined for a congregate meal and for a home delivered meal if applicable, and grab-and-go meals (as allowable per local planning).

The complete per meal cost is the amount that must be charged to non-eligible individuals and outside fund sources, such as Medicaid funded HDM or an Adult Day Services provider. Revenue and expenditures for home-delivered, congregate, and non-OAA funded meals must be accounted for separately.

The per meal cost for Medicaid-funded meals must not be more than the cost charged to other funds sources.

The cost categories include:

1. **Salaries and wages** - labor costs for food preparation, cooking, and serving; cleaning of the dining facility, meal preparation areas, and food service equipment; transporting meals to nutrition sites or participants' homes; direct food service supervision.
2. **Personnel benefits** - costs for health insurance, pension, unemployment, OASI, workers' compensation, etc.



3. **Supplies** - costs of food raw food and food purchased with NSIP funds; all non-capital supplies and equipment such as serving supplies, disposables, cleaning materials, and computers.
4. **Other Services and Charges** - space rental/leases; professional services; communications such as phone, Internet, postage; travel; advertising; insurance; utilities; repairs and maintenance; miscellaneous.
5. **Capital Outlays** - costs of capital items such as land and buildings, capital improvements, and equipment such as stoves, dishwashers, trucks and vans, steam tables, freezers, etc.
6. **Nutrition education** and outreach costs should be accounted for as required by the AAA.

Surplus Property:

Nutrition program providers are eligible to receive property which is declared surplus by the federal government in accordance with laws applicable to surplus property.

Sales and Use Tax:

The provider is exempt from paying sales or use tax for:

1. Food or meals purchased at the wholesale or retail level and utilized by the nutrition program.
2. Contributions for meals received from individuals participating in the nutrition program.

The provider will not violate its tax-exempt status if it develops printed material suggesting a contribution amount as a guide for participants to use when they make their contribution.

VII. PROGRAM FUNDING

Funding Sources:

The Senior Nutrition Program may be funded by OAA Titles IIIB, C and E, the Nutrition Services Incentive Program (NSIP), state funded Senior Citizens Services Act (SCSA), SB5736, Senior Nutrition Services state funds; local public and private funds; and income generated by the program, including voluntary contributions from participants and program fundraising. See [Appendix B-Table 1](#) for more information.

1. **Nutrition Services Incentive Program (NSIP):** AAAs and their nutrition program providers are eligible to participate in NSIP. The purpose of NSIP is to provide incentives to encourage and reward effective performance in the efficient delivery of nutritious meals to older individuals.

The NSIP provides an allotment of cash or commodities to states and Indian Tribal Organizations (ITO) for their nutrition programs based on the number of meals served in the previous year in proportion to the total number of Title IIIC meals served by all states and ITOs that year, as reported in the State Program Reports (OAAPS).



Washington State has elected to receive cash in lieu of commodities. NSIP cash is allocated to AAAs based on the number of NSIP-eligible meals served in the previous year in proportion to the total number of NSIP-eligible meals served by all AAAs as reported through OAAPS. NSIP cash may only be used for meals served to individuals eligible for Congregate or HDM according to these standards. Food purchased with NSIP cash must be United States (U.S.) agricultural commodities or other foods of U.S. origin.

Meals counted for purposes of NSIP reporting are those served to individuals listed in Section III, Target Population and Eligibility. Meals that **cannot** be included in counts used to determine NSIP funding are:

- a) Any meal that is served to a participant who is required to meet income eligibility criteria to receive the service through which the meal is served. This includes:
 - i. Medicaid Waiver home-delivered meals.
 - ii. Medicaid Adult Day Care meals.
 - iii. Medicaid Adult Day Health meals.
 - iv. Adult Day Care or Health meals for which Child and Adult Care Food Program (7CFR Part 226) funds have been claimed.
 - v. SCSA- or Respite-funded Adult Day Care or Health meals.
 - vi. Meals funded by Title III E served to caregivers under age 60.
 - vii. Meals served to individuals under 60 who pay the full cost of the meal.
- b) Meals served at Adult Day Care or Health services that can be included in counts used to determine NSIP funding are those that meet the following criteria:

The Adult Day Care or Health service is a contracted congregate nutrition site, in compliance with the SNP Standards, and the individual served the meal is aged 60 or over, and attending the Adult Day Care or Health service for the purpose of receiving congregate nutrition services rather than Adult Day Care or Health services, or the cost of the Adult Day Services for the individual is covered by a source other than COPES, Medicaid, SCSA or Respite or any other means-tested program, and OAA funds are allocated specifically for meals for these individuals; and the individual is given the opportunity to donate toward the cost of the meal.
- c) Service providers must maintain separate records to document that NSIP cash was used to purchase:
 - i. United States Agriculture commodities and other foods used in their food service;



- ii. Food in the meals furnished to them under contractual arrangements with food service management companies, caterers, restaurants or institutions, provided that each such meal contains United States produced commodities or other foods at least equal in value to the NSIP funding

NSIP cash may be carried over into the next consecutive contract year at the AAA's discretion. NSIP cash which is carried over into the next contract period must be included in the provider's budget for the next contract period and must be considered as a resource when projecting the total number of meals to be served in the next contract year.

NSIP meal reporting guide is located in [Appendix A](#).

- 2. **Participant Contributions** - Nutrition program providers must provide each eligible participant served a meal funded by Title III or SCSA with the opportunity to make a voluntary and confidential contribution (*donation*) to the cost of the meal. The AAA shall consult with the providers and older individuals to determine the best method for accepting voluntary contributions and to ensure that any method used is not coercive.

- a) **Privacy and Confidentiality:** The provider must protect the privacy of each older person with respect to their contribution or lack of contribution. The provider must arrange for methods of receiving contributions from individuals in such a manner as not to publicly differentiate among individual contributions.

The provider should periodically assess the nutrition program's methods of receiving contributions to ensure that the confidentiality of each individual contribution is not compromised.

- b) **Collection of Contributions:** Each provider may develop a suggested contribution schedule for services received. In developing a contribution schedule, the provider should consider the income ranges of older individuals in the community and the provider's other sources of income.
- c) **According to Ability to Donate:** Suggested contribution schedules must in no case be used as a means test to determine the eligibility of individuals to participate in the nutrition program. The amount of contribution, if any, should be determined by each participant according to their ability to donate.
- d) **Voluntary:** Providers must clearly inform participants that there is no obligation to contribute, and that the contribution is purely voluntary. The provider may not deny any older person a meal because the older person will not or cannot contribute to the cost of the meal.
- e) **Use and Handling of Contributions:** Contributions made by eligible participants are nutrition services contributions must be used to increase the number of meals served by a program, to facilitate access to such meals, and to provide other supportive services directly related to nutrition services.



- f) **Procedures:** The provider should develop, and the AAA should approve and monitor, specific written guidelines and procedures for the collection of contributions for meals served at nutrition sites. The provider should develop, and the AAA should approve and monitor, specific written procedures for collecting, handling, counting, and depositing cash contributions or their equivalents. These procedures must follow generally accepted accounting principles (***Please refer to Home and Community Living Administration's AAA Policies and Procedures Manual – Chapter 9, Fiscal Procedures for more information.***
- g) **Contributions Using Basic Food Program Benefits:** Basic Food Benefits, in the form of the Quest Card, may be accepted from participants as contributions toward the cost of the meal. As noted in Section III *Program Service and Reporting*, SNPs must provide participants with information about how to access the benefits available

Because benefits are available through the Quest Card, an electronic benefits transfer (EBT) system, the provider must inform participants that these contributions cannot be completely confidential. In order to accept contributions through the Quest Card, the provider must be certified by the USDA Food and Nutrition Service (FNS) and have a contract with the State's EBT vendor, the financial institution that administers the EBT system. If the provider receives over \$100/month in basic food contributions, a point of sale (POS) machine will be provided by the Basic Food Program. If the provider receives less than \$100/month per meal site or delivery route, manual vouchers will be provided by the Basic Food Program.

To contribute with vouchers, a participant would have to request a voucher(s) from a staff person and sign it. The staff person must call a toll-free number to verify that the participant has the contribution amount in his account. The provider must then redeem the voucher through the State's EBT vendor within 30 days. The provider must assure that all provisions relating to the use and handling of basic food benefits as prescribed by federal, state and local agencies responsible for administering the Basic Food Program are met. **Providers must contact the USDA Food and Nutrition Service to become a Basic Food vendor.**

RESOURCES

<https://www.dshs.wa.gov/altsa/home-and-community-services/senior-nutrition-program-standards/administration>

<https://www.ecfr.gov/current/title-45/part-1321>

[Senior Nutrition | ACL Administration for Community Living](#)

Related WACs and RCWs

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
9/30/2025	Cameron Akita	Combined Chapters 18 and 19 (HDM and Congregate Nutrition Services), inclusion of revised Senior Nutrition Program Standards, compliance with OAA Final Rule (2024)	



Congregate Nutrition

The congregate nutrition services program helps meet the complex nutritional needs of older persons who do not have adequate nutrition by providing sound and satisfying meals and other services such as nutrition outreach and education, in a group setting. Federal Standards require each meal served to contain at least one-third of the current Recommended Dietary Allowances as established by the Food and Nutrition Board of the National Academy of Sciences - National Research Council.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Cameron Akita Program Manager
360.867.8861 cameron.akita@dshs.wa.gov

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PROCEDURES

Target Population

A. The target population for the congregate nutrition services program is persons age 60 and over who:

1. Are unable to prepare meals for themselves because of:
 - a. Limited physical mobility; or
 - b. psychological or mental impairment; or
 - c. Lack of knowledge or skills to select and prepare nourishing and well balanced meals; or
 - d. Lack of incentive to prepare and eat a meal alone.

2. All persons served should be members of the target population.

B. To the degree feasible, persons served should meet the following vulnerability criteria:

1. Is unable to perform one or more of the activities of daily listed below without assistance due to physical, cognitive, emotional, psychological or social impairment.
 - a. Ambulation
 - b. Bathing
 - c. Cooking
 - d. Dressing or undressing
 - e. Eating
 - f. Housework
 - g. Laundry
 - h. Manage medical treatments (prescribed exercises, change of dressings, injections, etc.)
 - i. Manage medications (what to take, when to take, how to store properly, etc.)
 - j. Manage money (budgeting, check writing, etc.)
 - k. Personal hygiene and grooming
 - l. Shopping
 - m. Telephoning
 - n. Toileting
 - o. Transfer (getting in and out of bed/wheelchair)

p. Transportation

OR

2. Has behavioral or mental health problems that could result in premature institutionalization, or is unable to perform the activities of daily living listed in #1, or is unable to provide for his/her own health and safety primarily due to cognitive, behavioral, psychological/emotional conditions which inhibit decision-making and threaten the ability to remain independent.

AND

3. Lacks an informal support system: Has no family, friends, neighbors or others who are both willing and able to perform the service(s) needed or the informal support system needs to be temporarily or permanently supplemented.

Eligibility

- A. SCSA Eligibility requirements: Age 60 or over.
- B. OAA Eligibility requirements: Age 60 or over OR spouse of person age 60 or over.
- C. Individuals providing volunteer services during meal hours.

NUTRITION PROVIDERS

Congregate nutrition sites located in communities where there are significant numbers of minorities should make special efforts to serve these minorities.

In no way may a program operated by specific groups, such as churches, social organizations, senior centers or senior housing developments, restrict participation in the program to their own membership or otherwise show discriminating preference for such membership.

SERVICE PROVISION

- A. Referral to Information and Assistance/Case Management (I&A/CM). Subject to participant consent, all participants who appear to meet the vulnerability criteria listed above should be referred to the I&A component of the I&A/CM program for screening to determine the need for case management services.
- B. The service provider should document or have immediate access to the following information about each participant no later than his/her fifth meal at the congregate nutrition site:
 - 1. Name, home address, and phone number of participant.
 - 2. Name and phone number of participant's physician and/or person to contact in case of an emergency.

3. Special diet requirements, restrictions, or nutritional problems and concerns expressed by the participant.
- C. Each congregate nutrition program service provider must provide each older person with the opportunity to make a voluntary and confidential donation to the cost of the meal.
- D. Each congregate nutrition site must seek to be authorized to accept food coupons (food stamps) in lieu of cash from participants who are eligible to purchase food coupons and who wish to use the coupons for congregate meals. Food coupons can be accepted by the congregate nutrition site for meals served at congregate nutrition sites in accordance with the Food Stamp Act.
- E. The service provider must provide special menus, where feasible and appropriate, to meet the particular dietary needs arising from the health requirements, religious requirements, or ethnic backgrounds of eligible persons.
- F. Each day's menu must meet one-third of the current Recommended Dietary Allowances.

RESOURCES



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Related WACs and RCWs

WAC 388-17-100(F)	Nutrition Services are not Means Tested
OAA Title III C Sec. 331	Hot Meals to be Provided in Congregate Settings, Nutrition Education and Other Nutritional Services May be Included

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #



Transportation

Chapter 20 explains the types of transportation services available to ALTSA clients under the Older American's Act, Senior Citizens Services Act, Waiver programs, Medicaid Personal Care (MPC), Assistive Technology, Adult Day Services, Adult Day Health, and Medicaid Transportation Broker Services administered through the Health Care Authority.

ALTSA will coordinate services with other agencies that are safe, efficient, cost effective, and appropriate to our clients.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Linda Garcia Language & Disability Access Program Manager
360.968.9745 linda.garcia1@dshs.wa.gov

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WHAT ARE TRANSPORTATION SERVICES?

Transportation services assist eligible clients with getting to and from social services, medical services and health care services, meal programs, senior centers, essential shopping, and some recreational activities. Personal assistance for those with limited physical mobility is provided during transport. Always look first to local public transportation services and demand-responsive public transportation service for individuals with disabilities who, because of their disability, cannot use accessible, regular fixed-route bus service.

*Funding may be limited for some transportation services. For 1099 Providers refer to MB 14-075.

PROVIDING TRANSPORTATION SERVICES FOR WAIVER CLIENTS AND ROADS TO COMMUNITY LIVING CLIENTS

Clients may be eligible for waiver-funded (e.g. COPES, Medicaid Transformation Project (MTP), and New Freedom transportation services) and RCL transportation services when the service:

- Provides client access to community services and resources to meet their therapeutic goal, as determined in their care plan;
- Cannot be provided by the client's family, friends, neighbors, or community agencies;
- Is not diversional in nature; and
- Is in addition to and does not replace the Medicaid-brokered transportation (available through use of the Medical ID card) or transportation services available in the community.

Additional Considerations:

- Do not authorize this service for essential shopping scored in CARE.
- The client's personal care attendant can accompany the client at no extra cost if the client needs assistance during the trip or at the destination.
- This service is limited to two round trips per week to a destination within a fifteen-mile radius from the client's residence and provided by the lowest cost and most appropriate mode of transportation. Compensation for automobile transportation shall be limited to 120 miles per month. These limits do not apply to transportation services available under MTPD program.
- Use the AAA contractor list to identify contracted, qualified service providers and service rates. Qualified providers include volunteers, taxis, and public transit.
- Payment of this service will generate a 1099 document if the provider's 1099 earnings are \$600 or more for the tax year.

If the client is eligible, you may authorize this service with 1099 vendors in ProviderOne, using these codes:

COPES	S0215 - U2
RCL	S0215 – U2

New Freedom	S0215 – U2
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COMMUNITY CHOICE GUIDES (CCG) WHO PROVIDE TRANSPORTATION SERVICES FOR ROADS TO COMMUNITY LIVING (RCL) AND WASHINGTON ROADS CLIENTS

Not every CCG can provide transportation to eligible RCL and WA Roads clients. CCGs who provide transportation services must meet specific transportation requirements in their Community Transition and Training Specialist contract. This service does not replace nor be a substitute to the Medicaid Transportation Broker available to the eligible client. This service is in addition to the Medicaid Transportation Broker.

CCGs meeting all requirements to provide transportation may provide clients with transportation to essential community services and resources in accordance with the client's care plan.

Examples include, but are not limited to

- Visiting community settings to help a client locate and arrange accessible housing.
- Taking a client to various offices necessary to facilitate community living (e.g. to change address with SSA and US Postal Service or obtain an ID card from the Dept. of Licensing).
- Showing a client where community resources are located (pharmacy, local grocery store, etc.) and how to access them (bus stops, etc.).
- Taking a client to shop for transitional household goods (not for essential shopping scored in CARE).
- Transporting the client from the skilled nursing facility to their new community setting. The CCG may transport small personal items (e.g. a suitcase or walker) along with the client but they are not to provide "moving" services.

CCGs providing transportation must:

- Allow the client's personal care attendant to accompany the client with no additional payment if the client requires assistance during the trip or at the destination.
- Be responsible for the entire performance of the transportation services in accordance with federal, state, and local ordinances, statutes, and regulations.
- Maintain transportation records to document the dates, times, destinations, and distances of each client's transportation service.
- Only be compensated for the time they are with the client.

To authorize a CCG to provide transportation for an eligible RCL and WA Roads client:

- For Washington Roads, obtain prior approval from supervisor, assign WA Roads RAC. (*See LTC Manual [Chapter 5a.docx](#) for additional information*).
- For RCL, send an email to DSHSALTSARCLReferrals@dshs.wa.gov to verify client is eligible for RCL and to request RCL RAC. (*see LTC Manual [Chapter 29](#) for additional information*).
- Document the need by selecting Community Integration on the Treatment Screen in CARE. Use the Sustainability Goals screen to communicate authorization for the specific transportation



service. Assign the transportation task to a CCG who meets all transportation requirements in their contract.

- Authorize the transportation rate at the regular CCG rate using service code SA263.

FUNDING TRANSPORTATION SERVICES FOR ADULT DAY SERVICE CLIENTS

Individuals may receive services through an adult day care or adult day health program.

Adult Day Care:

WAC 388-71-0724 (15) "Transportation to and from the program site is not reimbursed under the adult day care rate. Transportation arrangements are made with locally available transportation companies or informal resources."

Transportation for Adult Day Care (as Respite or Social Day Care) may be financed with Older American's Act or Senior Citizens Services Act (SCSA) funding. Refer to AAA Policies and Procedures Manual, Chapter 3, for criteria.

Adult Day Health:

WAC 388-71-0724 (16)" Transportation to and from the program site is reimbursed under adult day health daily rate. Adult day health is required to assist clients in arranging or providing transportation to and from the program sites".

In referring the client to an adult day health center, the case manager may consider: the frailty and endurance of the client, the clients skilled nursing or rehabilitative needs, and a reasonable round-trip travel time that may not exceed two hours, unless there is a no closer center that can meet the clients skilled care needs.

USING THE ASSISTIVE TECHNOLOGY (AT) PROJECT TO MEET TRANSPORTATION NEEDS

If a client has access to a vehicle, consider using the Assistive Technology Project to solve the client's special transportation need. AT devices refer to any item, piece of equipment, or product system, whether acquired commercially off-the-shelf, modified, or customized, that help to increase, maintain, or improve the functional capabilities of individuals with disabilities.

Examples of transportation devices include automatic or manual lifts for vans or other vehicles; hand controls; etc. The client must own the vehicle to receive modifications. Check into other resources for vehicle modifications such as:

- The Division of Vocational Rehabilitation (DVR) (individual must be in a vocational plan);
- The Veteran's Administration (VA) for a service-connected disability;
- New Freedom Waiver (if there are denials from other sources);
- Other waivers in DDA or HCS that may offer assistive technology;
- CFC program offered by DDA and HCS that offers assistive technology;
- The Northwest Access Fund offers a low-interest loan program for vehicle modification or vehicle purchase. NW Access Fund website: <http://www.nwaccessfund.org/>



This is state funded only program with limited funds and services will not be paid out of ProviderOne.
Refer to LTC Manual, Chapter 16, for additional information on Assistive Technology.

Roads to Community Living (RCL) Assistive Technology and Vehicle Adaptations

Purchase of assistive technology or vehicle modifications that help to increase, maintain, or improve the functional capabilities of participants.

RCL	SA 390
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NOTE: The purchase or lease of vehicles is not covered by any State or Federal program administered through ALTSA.

FUNDING TRANSPORTATION SERVICES FOR DDCS CLIENTS

For more information on transportation funding through DDCS programs please refer to the [DDA Policy Manual](#) regarding Waiver Services, CFC, Community Residential Services, Community Protection Program, and Family Support Services.

MEDICAL MILEAGE REIMBURSEMENT FOR ADULT FAMILY HOME PROVIDERS

Reimbursement is available to an Adult Family Home Provider who transports a resident to medical providers as outlined in the Department's service plan generated by CARE. Reimbursement is available for up to 50 miles per month when brokerage transportation will not meet the residents' needs.

The AFH resident must have an assessed need for medical transportation as documented in the CARE service plan. Compensation will be on a per-mile-driven basis at the standard IRS mileage rate, up to a maximum of fifty (50) miles per month per resident.

Mileage reimbursement for travel to medical appointments is not available to AFH providers in the PACE program.

Mileage reimbursement for travel to medical appointments is different from Mileage reimbursement for community integration. Authorization for one does not preclude authorization for the other. When authorizing medical transportation, use the comment section on the Transportation screen in CARE, to document why Medicaid brokerage transportation will not meet the client's needs.

Authorize up to 50 miles per month using service code:

S0215	U4
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USING NON-EMERGENCY MEDICAL TRANSPORTATION BROKER SERVICES – WAC 182-546

The Washington State Health Care Authority (HCA) may pay for transportation services to get clients to and from needed non-emergency healthcare appointments. These appointments must be for services allowed by the client's current Medicaid enrolled program.

Non-emergency medical transportation is provided through businesses called Regional Brokers. Clients may use Medicaid Transportation Broker Services for medical appointments regardless of what program or waiver service they are receiving. This service is covered under the client's ProviderOne services card



To receive this service:

1. The medical destination must be covered by the client's medical program;
2. The medical provider must be the closest provider of that type. Documentation of language barriers may be considered on an exception to rule basis by the case manager;
3. It must be pre-authorized by a Regional Broker. The Broker:
 - Will screen to look at prior transport resources;
 - Will choose the mode (bus/transit, reimbursement, etc.) and the company/provider;
 - May need private information to make a decision. This is covered and allowed by HIPAA. If client refuses to provide information, the Broker will deny transportation.

Regional Broker List – Non-Emergency Medicaid Transportation –
<https://www.hca.wa.gov/assets/billers-and-providers/ContractedBrokers.pdf>

If the client already has a way to get to their healthcare appointment, HCA may be able to help client by paying for gas or paying for client's mileage.

USING STATE FUNDED ALTERNATIVE BENEFIT PLAN (ABP) SERVICES

Transportation can be provided under ABP services when the non-emergency medical transportation service cannot. This program will convert individuals who were on the previous MCS/GAU/GAX programs. This program can include transportation to assessment centers for chemical dependency evaluations to determine treatment requirements or to establish the need for a protective payee.

ABP	Service code T2003
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ABP In-home	Service code T1019
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PROVIDING TRANSPORTATION SERVICE THROUGH OLDER AMERICANS ACT, TITLE III (B), AND SENIOR CITIZENS SERVICES ACT (SCSA) FUNDING

The target population for transportation services is persons aged 60 and over who need transportation to medical and health services, social services, meal programs or for shopping assistance and cannot:

- Manage their own transportation because they do not have a car;
- Drive;
- Afford to drive; or
- Use public transportation or public transportation is not available or accessible.

Prioritize clients for transportation funded through the Older Americans Act, using the following criteria:

4. Clients:

a) Are unable to perform one or more of the activities of daily living listed below without assistance due to physical, cognitive, emotional, psychological, or social impairment:

- Ambulation;
- Bathing;
- Meal Preparation;
- Dressing;
- Eating;
- Housework (e.g. laundry);
- Personal Hygiene;
- Shopping;
- Using the telephone;
- Toileting;
- Transportation;
- Transfer (getting in and out of bed/wheelchair);
- Managing money (budgeting, check writing, etc.); and/or
- Managing medical treatments (prescribed exercises, change of dressing, injections, etc.)

OR

b) Have cognitive, behavioral, or mental health problems that could:

- Result in premature institutionalization;
- Keep them from performing the activities of daily living listed above;
- Prevent them from providing for their own health and safety.

c) Lack an informal support system (i.e. have no family, friends, neighbors, or others who are both willing and able to perform the service(s) needed.)

Transportation may be provided through Regular Specialized Transportation or Volunteer Transportation. Please refer to the Transportation Guidelines: <https://www.dshs.wa.gov/altsa/home->

[and-community-services/transportation-program-guidance](#) in the [Information for AAA and AAA Contracts](#) (for programs such as COPES, CFC, MAC, TSOA, etc.)

If you identify a client who meets the above criteria, refer them to the Senior Information and Assistance (I&A) case management program for intake into transportation programs. Consult with the local Area Agency on Aging (AAA) for additional referral information.

NOTE: Clients receiving funds through Title III of the Older Americans Act and non-means tested SCSA services must be given a free and voluntary opportunity to contribute to the cost of the services provided. Transportation providers may develop a suggested contribution schedule. If a schedule is developed, providers must consider the income ranges of older adults in the community. No eligible person may be denied service because he or she is unable or unwilling to contribute to the cost of service. The service provider must protect the person's privacy with respect to contributions, establish procedures to safeguard and account for all contributions made by users and use all such contributions to expand the service.

RESOURCES

Related WACs and RCWs

WAC 388-71-0724 (15) How do I apply for an adult day program state contract (adult day care)
WAC 388-71-0724 (16) How do I apply for an adult day program state contract (adult day health)
WAC [182-546](#) Transportation Services

Acronyms

AAA	Area Agency on Aging
ABP	Alternative Benefit Plan
ADC	Adult Day Care
ADH	Adult Day Health
AFH	Adult Family Home
APS	Adult Protective Services
AT	Assistive Technology
CARE	Comprehensive Assessment Reporting Evaluation
CCG	Community Choice Guide
CFC	Community First Choice
COPES	Community Options Program Entry System
DDCS	Developmental Disability Community Services
DVR	Department of Vocational Rehabilitation
GA-U	General Assistance - Unemployable
GA-X	General Assistance – Expedited Medicaid
HCA	Health Care Authority



HCS	Home and Community Services
MAC	Medicaid Alternative Care
MCS	Medical Care Services
MPC	Medicaid Personal Care
MTP	Medicaid Transformation Program
RCL	Roads to Community Living
SCSA	Senior Citizens Service Act
TSOA	Tailored Supports for Older Adults
VA	Veterans Administration
WAC	Washington Administrative Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/10/2025	Linda Garcia	- Moved chapter info to template with new DSHS logo and made general formatting changes - Updated table of contents - Changed MTPD to MTP - Updated language re: WA Roads, added link to WA Rds LTC manual chapter 5a. - Updated language re: RCL, added RCL Referral email address, added link to Chapter 29. - Under “Funding Transportation Services for DDA Client”, added link to DDA Policy Manual - Made correction to service code for medical mileage - Under Non-Emergency Medical Transportation Broker section - replaced link to Regional Broker list and added clarifying language. - Added Resource section - Added WACs section and acronyms section	H25-010
7/15/2025		Added Home and Community Living Administration to header.	



		• Updated Table of Contents • Changed references to DDA to DDCS • Clarified language regarding addition of RCL RAC • Updated Revision History to include date & MB number for previously released updates. • Updated Glossary	
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Volunteer Chore Service

Through the use of volunteers, this program provides assistance with housework, laundry, shopping, cooking, moving, minor home repair, yard care, limited personal care, and transportation to eligible elderly and disabled persons. The program does not provide assistance with bill paying or to people living in residential care facilities, with the exception of assistance to persons moving back to the community from residential care.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Cameron Akita Program Manager
360.867.8861 cameron.akita@dshs.wa.gov

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PROCEDURES

Eligibility

A person is eligible for Volunteer Chore Services (VCS) if he or she is:

1. Eighteen years of age or older; and,
2. Living at home, unless the person is moving from a residential facility to home and needs assistance moving; and,
3. Unable to perform certain household or personal care tasks due to functional or cognitive impairment; and,
4. Financially unable to purchase services from a private provider or to have his or her needs met using other resources.

Referral Process

- A. VCS is required to give priority to referrals from HCS, DDD, I&A and case management staff. Make referrals to VCS when an applicant or client:
 1. Does not meet the eligibility requirements for department paid services; or
 2. Is on the waiting list for Chore Personal Care Services; or
 3. Is eligible for five or less hours of Chore Personal Care Services per month; or
 4. Declines Medicaid Personal Care, COPES or Chore Personal Care Services because of income participation or estate recovery; or
 5. Needs assistance with tasks not available in the Medicaid Personal Care, COPES or Chore Personal Care Services Program.
- B. Complete Section I of the DSHS form 15-184, Referral to Volunteer Chore Service Program, following the instructions on the back of the form. If services are needed on an emergency basis (within 7 days), make a referral to VCS by telephone and send a completed DSHS form 15-184 by mail.
- C. Tear out the goldenrod copy of the form and place it in the client's service record. Mail the rest of the form to the local VCS office with a self-addressed envelope. For the phone number or mailing address of the local VCS office refer to the VCS directory, or call the VCS administrative office at (206) 467-5344 for all counties but Whatcom, Skagit, Island, San Juan, and Snohomish. For these counties, call the local Area Agency on Aging.

- D. The VCS staff will search for a volunteer and complete Section II on the referral form. VCS will retain the pink copy and return the completed original to the referring office. This will serve as notice of whether a volunteer has been found for the client.
- E. If more than two weeks are needed to find a volunteer, VCS will send a photocopy of the form back to the referring office marked “pending”. Follow up with VCS directly if you have not heard within two weeks whether a volunteer was found.
- F. After VCS has completed Section II and returned the form to the referring office, file the white original form 15-184 in the service record, replacing the incomplete goldenrod copy, and send the yellow copy to Attn: Volunteer Chore, AASA, PO Box 45600, Olympia, WA 98504-5600.

RESOURCES



H:\data\Manual\
Chapter 21\TQ Ch 21

Related WACs and RCWs

- WAC 388-15-206 Volunteer Chore Services
- RCW 74.38.050 Availability of Services for Persons Other Than Those of Low Income—Utilization of Volunteers and Public Assistance Recipients-Private Agencies—Well Adult Clinics—Fee Schedule, Exceptions
- RCW 74.08.541(4)(c) Definitions—Chore Services--Eligibility

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #

Chapter 22a: Apple Health Managed Care (MCO) and Apple Health Medicare Connect (DSNP)

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Kelli Emans	Senior Strategic Integration Advisor (360)725-3213 Kelli.emans@dshs.wa.gov
Brendy Visintainer	Duals Integration Unit Manager (360)725-2640 Brendy.Visintainer@dshs.wa.gov
Ethan Leon	Managed Care Data and Policy Analyst (360)725-3566 Ethan.Leon@dshs.wa.gov
Vanessa Sherrill	Advancing Medicare-Medicaid Integration (AMMI) Program Manager (360)725-3477 Vanessa.Sherrill@dshs.wa.gov

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OVERVIEW OF MANAGED CARE

The purpose of the managed care service delivery model is to integrate services an individual may need in one delivery system with one payment called a capitated payment. The managed care plan must furnish all of an individual's services included in the managed care contract using this capitated payment. This puts the managed care plan at risk for high cost services as well as creates incentives to use prevention and pro-active techniques to keep a person well.

The Health Care Authority (HCA), the Department of Social and Health Services (DSHS), and the Centers for Medicare and Medicaid Services (CMS) have contracts with managed care entities. The contract between HCA, DSHS and/or CMS and the Managed Care entity details what services are covered in the contract and what the Managed Care Organization (MCO) is responsible for. Contract examples include:

- Apple Health (Medicaid)
- Program for all Inclusive Care for the Elderly (PACE) (DSHS & CMS)
- Medicare Advantage and Dual eligible – Special Needs Plan (DSNP) (CMS)

APPLE HEALTH (AH) MANAGED CARE AND APPLE HEALTH MEDICARE CONNECT (AHMC)

Apple Health (AH) Managed Care

See [WAC 182-538](#) Washington State Health Care Authority Managed Care for full details.

HCA is the single state Medicaid agency and is responsible for managing Medicaid medical benefits for eligible recipients. HCA also manages the medical benefits of state employees known as the Public Employees Benefits Board (PEBB) program.

HCA has transitioned to mostly contracting with plans to administer the Medicaid benefits, some of the most relevant programs for our clients are:

1. Fully Integrated Managed Care (FIMC)

HCA contracts with MCOs who are responsible for the full scope of Medicaid physical, mental and substance use disorder services. For more information, please see the HCA publication: ["Welcome to Washington Apple Health: Managed Care" benefits book.](#)

2. Behavioral Health Services Only (BHSO)

HCA contracts with MCOs who are responsible for mental and substance use disorder services. Clients who are eligible for BHSO benefits are not eligible for FIMC due to having another Third Party Liability (TPL) for their physical health benefits. This is most commonly Medicare and are referred to as Dual Eligible clients. For more information, please see the HCA publication: ["Welcome to Washington Apple Health: Behavioral Health Services Only" benefits book.](#)



3. Fee for Service (FFS) (See [Special Populations](#) for more information)

Provider is paid directly by HCA for services provided. All dual eligible (those on both Medicare & Medicaid) are FFS for their medical but enrolled in managed care for behavioral health services only. For more information, please see the HCA publication: [“Welcome to Washington Apple Health: Coverage without a managed care plan” benefits book](#).

4. Apple Health Managed Foster Care (AHFC) (See [Special Populations](#) for more information)

HCA contracts with Coordinated Care (an MCO) to provide medical services and coordination to foster children, foster care alumni and individuals who receive adoption support services.

5. Primary Care Case Management (PCCM) (See [Special Populations](#) for more information)

Mostly tribal clinics. Providers are paid FFS, clinic is given a monthly per member per month payment to fund care coordination activities.

Apple Health Medicare Connect (AHMC), seen as a D-SNP segment in CARE and ProviderOne, is not an Apple Health (Medicaid) service. For more information see the section [“What is a D-SNP”](#).

Identifying clients who are enrolled in managed care via ACES Online, Provider One, and CARE:

Staff may need to explore further with a client to determine the client’s actual coverage. Here are the ways staff can find a client’s managed care plan and eligibility:

ACES Online:

First pull up a client by entering name or ACES ID. Hover over the Details drop down and select Medical Information.

ProviderOne:

First hover over the Client dropdown and select Benefit Inquiry. Search the client by their ProviderOne ID number. Click the Ok button. You will now be on the screen that shows Managed Care information.

CARE:

First open the client’s file in CARE. Expand the Client Details section. Click on the ProviderOne option. Click the View ProviderOne Details. This will open a web browser and click on the Managed Care hyperlink. This will display their managed care plan.

If the client is enrolled in managed care, the health plan name, program and start and end dates will be visible. You can view managed care information, Primary Care Case Management, Health Home, and PACE enrollments on this screen. Clients who are Fee-For-Service (FFS) will not show any managed care enrollment plan but will be active on a Medicaid program in ACES.

Please see the [Resources section](#) for screenshots.

Integrated Managed Care

Additional web resources for benefits and eligibility can be found in the [Resources section](#) at the end of this manual.

Benefits:

Please see the [HCA Benefit Matrix](#) for more detail. Coverage includes:

- Outpatient care such as: Wellness exams, immunizations, maternity care
- Pharmacy, including over the counter (OTC) and prescription medications
- Laboratory services
- Inpatient Hospital/Emergency Room
- Nursing facility for rehab/skilled nursing services
- Outpatient Mental Health

Eligibility:

Eligibility for Apple Health Medical coverage is handled through:

- The Health Benefit Exchange www.WAHealthPlanFinder.org
- The local DSHS community service office for SSI-eligible aged, blind, and disabled clients.
- www.washingtonconnection.org

Mandatory AH Integrated Managed Care enrollees include:

- Parents, children & pregnant women
- SSI Categorically Needy Blind and Disabled
- CFC, CFC+COPES & institutional clients
- Medicaid Expansion adults without children ([MAGI](#))
- Foster Care (if they do not elect Fee-For-Service [FFS] coverage)
- Clients with Third Party Liability

Enrollment

Medicaid clients will be enrolled into an MCO in the month they are determined eligible for Medicaid. This means they will be enrolled back to the first of the month in which they are determined eligible. This reduces gaps in managed care coverage and increases care coordination for individuals who are newly eligible or have lost eligibility and are reestablishing their Medicaid eligibility.

Fully Integrated Managed Care (AH-FIMC)



FIMC for Medicaid Only includes the full scope of Medicaid physical plus mental health and substance use disorder services. Clients with physical health and pharmacy coverage will be enrolled in FIMC Apple Health.

- Apple Health Family (Healthy Options)
- Apple Health Blind Disabled
- Apple Health Adult Coverage
- State Children's Health Insurance Program

Dual eligible clients will
not be enrolled in FIMC.

Benefits:

- Medicaid clients have a choice of at least two managed care organizations in an IMC region.
- Medicaid State Plan services will remain the same and clients will continue to have access to block grant or state-funded behavioral health services that complement the Medicaid benefits.
- Clients will now have one point of contact for medical and behavioral health services instead of navigating up to three systems.

Services covered include:

- Outpatient care such as: Wellness exams, immunizations, maternity care
- Pharmacy, including OTC and prescription medications
- Laboratory services
- Inpatient Hospital/Emergency Room
- Nursing facility for rehab/skilled nursing services
- Mental Health services with the exception of crisis services
- Substance Use Disorder treatment

Behavioral Health Services Only (BHSO)

The **BHSO** program for **Dual Eligible clients** provides specialty mental health and substance use disorder services **ONLY** and is a separate product than FIMC that is offered by the same MCOs.

Clients who are typical FFS populations can access behavioral health services through the BHSO program (For example: Medicare coverage or someone exempt from managed care). They will get physical health services through the FFS system.

Apple Health – BHSO = FFS Medical and Managed Care for behavioral health services.

- Medicare/Medicaid duals
- PCCM
- Foster Care clients that elect to have FFS benefits

Exceptions

- Dually eligible and otherwise managed care exempt individuals will not be enrolled in FIMC but will be required to be enrolled in a managed care plan for BHSO
- An undocumented person (as defined by WAC [182-503-0535 \(1\)\(e\)](#)) will not be enrolled in either program and will remain in FFS medical except undocumented pregnant women, during their pregnancy will be enrolled in BHSO.

Special Populations

There are clients who can be enrolled in programs outside of the five managed care programs or may not be enrolled in a managed care plan at all, known as Fee-For-Service (FFS). These special populations are:

- American Indian/Alaskan Native (AI/AN)
 - Eligible for Primary Care Case Management (PCCM)
 - Eligible for FFS
- Foster Care
 - Eligible for Apple Health Foster Care
 - Eligible for FFS
- Non-Citizen Clients, specifically:
 - Qualified aliens who have not met the five-year bar
 - Only eligible for FFS
 - Non-Qualified aliens
 - Only eligible for FFS
 - Undocumented person
 - Only eligible for FFS

American Indian/Alaskan Native and Foster Care clients may elect to be part of the FFS program.

Per WAC [182-503-0535](#) Non-Citizen Clients as defined in the above section are not eligible for Managed Care Plans and are only eligible for FFS benefits if found eligible for a State Funded Medicaid Program.

Click to return to [Apple Health Managed Care](#)

My client should be enrolled in managed care but isn't?

There are several reasons a client should be enrolled in a managed care plan but they are not. For example, the exemptions section shows groups of clients that are eligible Fee-For-Service (FFS) program. However, there are clients that can be approved on a program in ACES, but not be eligible for FIMC or BHSO. These programs are:

- Unmet Spenddowns (Any program that ends in 95 or 99)
- QMB (S03)
- SLMB (S05)
- QI-1 (S06)



Also there can be situations when a client has been determined functionally and financially eligible for a LTSS program (L-Program in ACES) but due to being in an Acute or State Hospital setting they are still pending in ACES due to the client's residence needing to be in a Long-Term Care facility before the program can be made active in ACES.

Finally, per WAC 182-503-0535, there are clients that may have State-Funded FFS Medicaid eligibility due to their Citizenship or Immigration status. Those individuals are:

- Qualified aliens who have not met the five-year bar
- Non-Qualified aliens
- Undocumented person

Health Plan Service Areas & Network

For the most up to date service area map detailing what plans are available in each county and RSA please visit [HCA's website](#).

Regional Service Areas (RSA):

RSAs are the new geographical boundaries or service areas for Medicaid purchasing of physical and behavioral health care through managed care contracts.

- Authorized by legislation in 2014
- Regions on a map, not an organization that oversees services

Apple Health managed care

Service area map - January 2026



Integrated managed care regions

Greater Columbia	Pierce	Salish	North Central
King	Spokane	Great Rivers	
North Sound	Thurston-Mason	Southwest Washington	

Apple Health Foster Care (statewide)[†]

[†] Apple Health Foster Care is a statewide program. Integrated managed care is provided through Apple Health Core Connections (Coordinated Care of Washington - CC).

Health plans offered

CC	– Coordinated Care
CHPW	– Community Health Plan of Washington
MHW	– Molina Healthcare of Washington
UHC	– UnitedHealthcare Community Plan of Washington
WLP	– Wellpoint Washington (previously Amerigroup)

Health Plan Contact Information (for Clients/Providers)

	Customer Service Website Provider Line Provider Website	1-800-600-4441 www.wellpoint.com 1-800-454-9790 https://www.provider.wellpoint.com/washington-provider/home
	Customer Service Website Provider Line Provider Website	1-800-440-1561 www.chpw.org 1-800-440-1561 www.chpw.org/for-providers
	Customer Service Website Provider Line Provider Website	1-877-644-4613 www.coordinatedcarehealth.com 1-877-644-4613 https://www.coordinatedcarehealth.com/providers.html
	Customer Service Website Provider Line Provider Website	1-800-869-7165 www.molinahealthcare.com 1-800-869-7165 https://www.molinahealthcare.com/providers/wa/medicaid/pages/home.aspx
	Customer Service Website Provider Line Provider Website	1-877-542-8997 www.uhccommunityplan.com 1-877-542-9231 www.uhcprovider.com/en/health-plans-by-state/washington-health-plans/wa-comm-plan-home.html

Changing Plans

Apple Health enrollees may change plans every month (effective the 1st of the following month):

- Via telephone at 1-800-562-3022 ext. 16131. Clients may either wait for a customer services representative or use automated telephone Individual Voice Recognition (IVR)
- Online at www.waproviderone.org/client
- Via paper enrollment form mailed to HCA

- The Health Benefit Exchange www.WAHealthPlanFinder.org (MAGI and Family medical-not SSI [S-programs] or Long-Term Care [L-programs])

Community Behavioral Health Support (CBHS) Services formerly Behavioral Health Personal Care (BHPC) Residential Moved to [Chapter 22d](#)

MCO Funded Behavioral Health Wraparound Support previously Behavioral Health Personal Care (BHPC) In-Home

Beginning July 1st, 2024, a Managed Care Organization (MCO) will only fund the following Behavioral Health Wraparound Support (BHWS) formerly, Behavioral Health Personal Care (BHPC) for additional personal care hours reflected in an increase beyond the CARE generated hours.

To be eligible for BHWS funding, a client must meet the criteria outlined in all three boxes.

If a client does not meet the three criteria boxes, do **NOT** submit a BHWS request.

Criteria for BHWS funding

The client must meet criteria below for a request of BHWS funding to be made:

Box #1 – Psychiatric Disability Criteria:

1. The client has a primary diagnosis of a serious mental illness (schizophrenia, bi-polar disorder, major depressive disorder); and that psychiatric diagnosis is the primary reason for client's need for assistance with personal care.

Please note: If the client has the following diagnoses: intellectual disabilities, Alzheimer's/dementia, traumatic brain injury, substance use disorder, and these are the primary reason the client requires assistance with personal care, do not submit this form.

However, if the client has these **diagnoses** but the mental health diagnosis/behaviors are the primary reason the client needs personal care, still submit the request.

OR

2. The client has behaviors or symptoms of a mental illness that cause impairment and functional limitations in self-care/self-management activities; and it is these behaviors or symptoms of mental illness that are the primary reason for client's need for assistance with personal care.

AND

Box #2 – Involvement with Mental Health Services Criteria:

In addition to the above criteria being met, the client should also engage with mental health services in one of the three ways below:

1. The client is currently receiving mental health services;
- OR**
2. The client is transitioning from an inpatient setting and will be receiving mental health services in the community;

AND

Box #3 – Needs wraparound support beyond the CARE generated hours:

The client meets the criteria in both Box #1 and Box #2, **AND** needs wraparound support (additional personal care hours) beyond the CARE generated hours. Follow the instructions below for requesting MCO funding for wraparound support.

Are you unsure if your client meets the criteria above?

If so, request a care conference with your supervisor and the designated Care Coordination Contact listed on the [Medicaid and Medicare Managed Care Coordination Contacts Lists](#). Review the client's care plan, including diagnoses, treatments, behaviors, etc., and why you think this client's need for BHWS funding is because of behaviors or symptoms of a mental illness.

Is this a new request for BHWS funding?

If so, and the client is currently receiving mental health services covered under their medical benefit (i.e. Apple Health), please contact the client's local mental health professional/case manager to coordinate the care plan and ensure the CARE assessment has accurate information (diagnoses, treatments, behaviors, etc.). If the client is receiving behavior support services through an ALTSA paid provider, and is not currently receiving mental health services through their medical benefit, then coordinate with the ALTSA paid behavior support provider to ensure accuracy of the assessment.

1. Fax client's signed/completed Consent form ([DSHS 14-012](#)) to the client's local mental health professional/agency or ALTSA paid behavior support provider.

2. Call the client's local mental health professional/agency (or ALTSA paid behavior support provider) and discuss the following information:
 - a. An assessment has been completed and you are calling to discuss the case, review the care plan, and client's need for BHWS support.
 - b. Inform them of client's planned living setting
 - c. Review client's mental health diagnoses and treatment plan for accuracy.
 - d. Review what services are being provided by the local mental health professional/agency (or ALTSA paid behavior support provider) as well as what services are being provided through long-term care services. At this time, discuss if there are any service(s) missing in the client's care plan and what types of services or supports may be available to address these gaps. The goal of this conversation is to develop a coordinated care plan to meet the client's needs.
 - e. Incorporate any information from the local mental health professional/agency (or ALTSA paid behavior support provider) into the CARE assessment.
3. Add the contact information for the local mental health professional/agency or ALTSA paid behavior support provider on the BHWS Request to the MCO ([DSHS form 13-712](#)).

Request BHWS funding from the MCO

Within 2-5 days of completing a CARE assessment (moving it to current) in which the criteria in the boxes above are reflected and described, a BHWS request for funding should be submitted to the MCO. A timely request for funding is vital to ensure care plan coordination is achieved. In addition, this process ensures the social services authorization and ETR (if needed) are done timely.

1. Complete the BHWS request form (DSHS form 13-712) to the MCO and include the CARE Assessment Details, CARE Service Summary.

Detail the behaviors and caregiver interventions on this form, and what BHWS support is needed. This information helps the MCO quickly determine how the client's mental health is impacting their need for the BHWS request.

Please note: if the additional support hours requested is unusually high, prior to submitting the request for funding, staff the case with your supervisor, your regional Managed Care Systems Consultant (MCSC), and consider a care conference with the designated Care Coordination Contact listed on the [Medicaid and Medicare Managed Care Coordination Contacts Lists](#). This step allows the MCO to ask clarifying questions and ensures collaboration of the care plan.

2. Send [DSHS form 13-712](#), CARE Assessment Details, and CARE Service Summary (also known as the packet) to the Funding Request Contact listed on the [Medicaid and Medicare Managed Care Coordination Contacts Lists](#) via secure email using the **template emails and subject line language provided**.



Behavioral Health
Wraparound Suppo



3. The MCO will review the packet and determine if the established criteria listed above has been met.
 - i. The MCO should confirm receipt of request within 2 business days of receiving, and must respond with a decision to approve, counter-offer, or deny the request within 5 business days of receiving a complete packet. If decision will exceed 5 business days, the MCO representative will contact the Case Manager (CM). If you do not receive a response within 5 business days you should escalate the communication through the assigned escalation contact listed on the [Medicaid and Medicare Managed Care Coordination Contacts Lists](#).

The MCO may review additional information, as necessary, in deciding whether the above criteria are met, reviewing PRISM, conversation with the provider, conversation with the HCS/AAA worker, conversation with the Enrollee's Mental Health Provider and other involved providers.

- ii. If the request is denied, a clear rationale for why the request did not meet criteria and/or what services will be provided to the client by the MCO to meet the client's need should be written on the form by the MCO representative.

When the MCO denies BHWS funding based on the provision of other services, a plan (e.g., Individual Service Plan) must be developed by the MCO and implemented to meet the service needs identified.

4. Once the MCO signs, completes and returns the [DSHS form 13-712](#):
 - i. Document the approval or denial from the MCO in a SER.
 1. Approvals,
 - a. notify the provider of the BHWS approval and document this conversation in a SER, including the name of the person you spoke with. Explain that this approved BHWS rate is a wraparound rate above the CARE generated rate/hours. Language to be used when notifying the client's provider:

<CLIENT'S MCO> has approved a Behavioral Health Wraparound Support of <MCO APPROVED HOURS> for the dates of <Approved Funding Dates on 13-712>. This is only a portion of the client's funding and is in addition to the CARE generated hours. The Managed Care Organization (MCO) is the sole decision maker for ongoing funding beyond the approved funding dates. Future requests to the MCO for ongoing funding beyond the approval dates must include documentation supporting the need for ongoing services.

 - b. In CARE Web, include the following approval information on the Comments screen, under the General Comments.

<CLIENT'S MCO> has approved a BHWS for the dates of <Approved Funding Dates on 13-712>. The following supports will be provided: COPY (Ctrl + C) and PASTE (Ctrl + V) the comments from the section that states what the caregiver does (or will do) as an intervention.

2. Denials,
 - a. notify the provider of the BHWS denial. Document this conversation in a SER, including the name of the person you spoke with. Language to be used when notifying the client's provider:

<CLIENT'S MCO> has denied the Behavioral Health Wraparound Support of <REQUESTED HOURS FROM MCO>. The Managed Care Organization (MCO) is the sole decision maker for determinations on these requests. Continue to staff any changes in the client's condition with the client's assigned case manager.

- ii. Scan and email a copy of the completed DSHS form 13-712 (approved or denied) to: MCOBHOforms@dshs.wa.gov. Please scan/email only ONE client's form per email.
- iii. Submit completed DSHS form 13-712 to the Document Management Systems (DMS) via HOTMAIL to be included in client's electronic case record (ECR).

- i. **For In-home clients,**
 1. The wraparound support hours approved by the MCO will be incorporated into the personal care service code T1019.
 2. Select reason code "MCO_BHO Client/ MCO_BHO Funded" for that service line.
 3. The start and end date of the service code should be the same dates approved on [DSHS form 13-712](#).

Example of in-home personal care with wraparound support:

DSHS form 13-712 – approved amount by MCO:

For In-Home Clients

CARE generated hours per month:	92
Wraparound Support additional hours:	45
Total hours per month requested:	137
Monthly estimated cost of care:	\$ 4,816.92

Authorization to in-home care provider (137 hours = 548 units):

**CHAPTER 22a: Apple Health Managed Care (MCO) and
Apple Health Medicare Connect (DSNP)**
Long-Term Care Manual



#	Status	Service code	Service name	Start date	End date	# Units	Unit type	Rate
1.10	Approved	T1019,U6	Personal Care In-Home	11/01/2023	08/31/2024	548	1/4 Hour	\$8.79

Service line details Edit

Service code	Service name	
T1019,U6	Personal Care In-Home	
Start	End	# of Units
11/01/2023	08/31/2024	548
Unit type	Rate	Total
1/4 Hour	\$8.79	\$4,816.92
Business status	Reason code	
Approved	MCO_BHO Client/ MCO_BHO Funded	

5. On the Behavior screen select the following options:
 - i. To the question, “Was a referral sent to the MCO or HCA?” Select “No”
 - ii. Select “other” for the reason no referral was made.
 - i. Document the reason the CBHS referral was not made in the required comment box.
 1. Case manager will type “Client’s Care Plan is for in-home.”
6. On the Care Plan screen in the In-home section for the personal care adjustments enter the Reason “BHWS approved hours”.

In-home

Monthly hours	Monthly ¼ hrs	Mileage can be authorized for...
115	460	Individual Provider
Personal care adjustments		Adj. monthly hrs.
+	Reason	Hour adj. +/-
	BHWS approved	25 +
	BHWS approved hours	
	Client voluntary hour reduction	
	Home Delivered Meals	
	HQ Approved Limitation Extension	
	HQ Approved Personal Care ETR	
	Private Duty Nursing	



7. Set a reminder for at least a week before the end of the MCO funded approval period (or CARE plan period) so that another request for BHWS support can be made to the MCO if the client continues to meet the criteria listed above.
8. If the client's case is transferred to another office/agency, ensure the next CM/agency is aware of the MCO's approval of BHWS support and when another BHWS request will be due if necessary.
9. At next assessment, if client meets the criteria in the boxes above, request funding from the MCO for BHWS support services following the same process noted above.

Another BHWS request to the MCO for funding is necessary when:

- An annual assessment is completed
- A significant change assessment is completed
- An interim assessment is completed and there is a change in client's in-home care hours (e.g. informal support change, QA correction)
- Client changes from one MCO (for example Wellpoint) to another MCO (for example Molina)

Behavioral Health Administrative Services Organization (BH-ASO)

Some services, such as response services for individuals experiencing a mental health crisis, must be available to all individuals regardless of their insurance status or income level. For this reason, the HCA will have a contract with an organization known as a Behavioral Health Administrative Service Organization (BH-ASO) to provide these services in integrated regions.

BH-ASO

The BH-ASO is only responsible for a subset of crisis-related services for Medicaid clients in integrated region and is responsible for providing limited services to individuals who are not eligible for Medicaid, as well as managing certain administrative functions.

Services Provided – Regardless Insurance Status or Income

The following services may be provided by the BH-ASO to anyone in an integrated region who is experiencing a mental health or substance use disorder crisis:

- A 24/7/365 regional crisis hotline to triage, refer and dispatch calls for mental health and substance use disorder crises;
- Mental health crisis services, including the dispatch of mobile crisis outreach teams staffed by mental health professionals and certified peer counselors;



- Short-term substance use disorder crisis services for people intoxicated or incapacitated in public;
- Designated Mental Health Professionals (DMHPs) who can apply the Mental Health Involuntary Treatment Act, available 24/7 to conduct Involuntary Treatment Act assessments and file detention petitions;
- Chemical dependency specialist who can apply the substance use disorder involuntary commitment statute, including services to identify and evaluate alcohol and drug involved individuals who may need protective custody, detention, etc. The chemical dependency specialist will also manage case findings and legal proceedings for substance use disorder involuntary commitment cases.

Services Provided – Uninsured and Low-Income

The BH-ASO may provide certain mental health and substance use disorder services to people who are not enrolled in or otherwise eligible for Medicaid. For some services, like those funded through the federal Substance Abuse Prevention and Treatment (SAPT) block grant, individuals may need to meet other priority population requirements to be considered eligible.

The BH-ASO may provide the following services to individuals who are not eligible for Medicaid:

- Mental health evaluation and treatment services for individuals who are involuntarily detained or agree to a voluntary commitment;
- Residential substance use disorder treatment services for individuals involuntarily detained as described in state law;
- Outpatient mental health or substance use disorder treatment services, in accordance with a Less Restrictive Alternative court order;
- Within available resources, the BH-ASO may provide non-crisis behavioral health services, such as outpatient substance use disorder and/or mental health services or residential substance use disorder and/or mental health services, to low-income individuals who are not eligible for Medicaid and meet other eligibility criteria.

What is a D-SNP

A Dual-Eligible Special Needs Plan (D-SNP) is a special kind of Medicare Advantage plan for dual-eligible individuals. A D-SNP combines Medicare and Apple Health (Medicaid) services under one managed care plan. In Washington, D-SNPs have been branded as Apple Health Medicare Connect (AHMC) to better communicate that AHMC is only available who are enrolled in Apple Health (Medicaid) and Medicare.

Who is a dual-eligible individual

A dual-eligible individual has both Medicare coverage and Apple Health coverage. This includes physical and behavioral health care coverage. If a client is a dual-eligible client, Medicare is the primary coverage

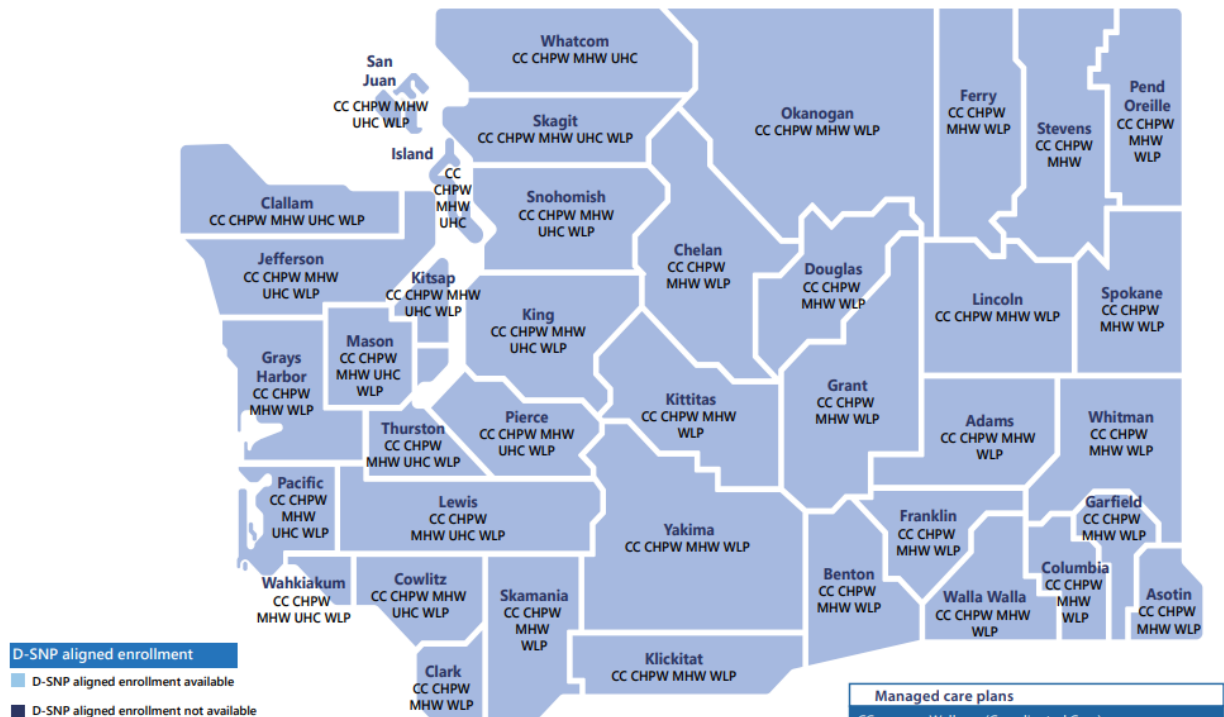
for their physical health care needs. They also have Apple Health as secondary coverage. Dual-eligible clients also have behavioral health coverage through an Apple Health managed care plan. This is a Behavioral Health Services Only (BHSO) plan. Behavioral health includes mental health and substance use disorder treatment.

AHMC Health Plan Service Areas & Network

For the most up to date service area map detailing what plans are available in each county please visit [HCA's website](#) or use the [service area guide](#) found in the attachments.

Apple Health Medicare Connect Aligned Enrollment map - January 2026

Washington State
Health Care Authority



Dual-Eligible Special Needs Plan (D-SNP) is known as Apple Health Medicare Connect. Use this map to choose a managed care plan that aligns your D-SNP and Behavioral Health Services Only (BHSO) coverage. **D-SNP aligned enrollment is now available in every county.**

Visit hca.wa.gov/ah-medicare-connect for more information on enrollment, D-SNP, and what plans are available in each county.

HCA 19-0071 11/25

Care Coordination

Apple Health Managed Care & Nursing Facilities

Managed care, like Medicare, covers a rehabilitative/skilled nursing benefit if the authorization criteria is met. When a managed care enrollee is hospitalized and needs to be discharged to a nursing facility, the plan must be contacted for nursing facility authorization.

MCOs have transitional care requirements for moves from the hospital to the nursing facility and home. Once it has been determined that the rehab/skilled stay will end or an enrollee does not meet authorization criteria, that enrollee should be referred to Home and Community Services (HCS) for a nursing facility level of care (NFLOC) assessment. HCS should also review available options with the client.

Contacted Regarding Discharges:

- If contacted by a hospital/facility for the NFLOC assessment or for discharge options
 - Staff must ask if the hospital stay is covered by an MCO **and** if the client is enrolled in Medicaid managed care.
- If the client is enrolled in Medicaid managed care (Apple Health):
 - The facility must have a denial from the MCO before the stay can be covered by HCS.

Assisting with Coordination (Case Managers)

- If you receive billing questions, refer the provider to the health plan the client is enrolled in.
- Assist clients who have Apple Health medical coverage by knowing the health plan contact phone numbers.
- Find out which plan(s) contract with doctors and specialists in their area. This will help you assist the client in choosing the right Apple Health managed care plan. It will also help when the client has a provider/plan coordination issue.
- If you need assistance with acute hospital or skilled nursing facility transitional care activities, please use the plan contacts in the [Medicaid and Medicare Managed Care Coordination Contacts](#) list.
- Report issues to the plan, the HCS HQ Managed Care Data and Policy Analyst Ethan Leon at Ethan.Leon@dshs.wa.gov
- For additional information regarding Nursing Facility coordination, see the [Nursing Facility Case Management Chapter, Chapter 10](#).

For additional information on Nursing Facility billing see the [HCA Nursing Facility Provider billing Guide](#)

Managed Care Organization (MCO) Assistance with Transition of Care

MCOs, who are responsible for physical health benefits, should offer the following support to clients, HCS and/or the hospital when clients are discharging from inpatient hospital settings:

- Coordinate medically necessary services, supplies, and resources. For example:
 - Transition planning:
 - Arranging for DME (Durable Medical Equipment) approval and delivery
 - Assigning a PCP (Primary Care Provider) for the client to see post discharge
 - Assisting in community transition setting searches
 - Negotiating contracts with SNFs and paying for Enrollees' SNF stays that meet rehabilitative or skilled criteria
 - Completing a written discharge plan, including scheduled follow-up appointments, provided to the Enrollee and all treating providers; Formal or informal caregivers shall be included in this process when requested by the Enrollee to ensure timely access to follow-up care post discharge and to identify and re-engage Enrollees who do not receive post discharge care
 - Post Discharge care:
 - Organized post-discharge skilled and rehabilitative services, such as home health care services, after-treatment services, and occupational and physical therapy service
 - Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following discharge
 - For Enrollees at high risk of re-hospitalization, the Contractor shall ensure the Enrollee has an in-person assessment by the Enrollee's PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge. The assessment must include follow-up of: discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage to appropriate referrals
 - Scheduled outpatient Behavioral Health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge
 - Follow-up to ensure the Enrollee saw his/her provider
 - Planning that actively includes the patient and family caregivers and support network in assessing needs.
- Assist with facilitating authorizations for covered medical services and behavioral health services.
- Ensure continuity of care for enrollees transitioning to the MCO during an active course of treatment for an acute or chronic health condition

MCOs should offer the following care coordination to enrollees who meet criteria:



- Individual needs support coordinating access to service with their primary/private insurance provider
- Individual encounters difficulty accessing prescribed treatment, services, or supplies
- Individual has complex healthcare needs and could otherwise benefit from assistance in coordinating care. For example:
 - An individual receives a new diagnosis and they or their guardian feel like they “don’t know where to start”
 - An individual has had frequent or long-term hospitalizations
 - An individual has had frequent emergency department use

All HCS and AAA case managers should use the MCO Transitions of Care Contact List found at <http://intra.altsa.dshs.wa.gov/hcs/> on the right side of the webpage, under Contractors for the most current Transitions of Care contacts. When corresponding please use the Transitions of Care (discharge) email attachment found at the end of this chapter to frame HCS and AAA emails to the MCO for Initial Contacts, Follow Up, and Day of Discharge coordination.

If you experience any issues with this process, please contact to HQ Managed Care Data and Policy Analyst.

Managed Care Assistance with Care Coordination

When an HCS/AAA client enrolled in managed care needs assistance to coordinate their health care services and access to appropriate treatment, the CM must assist the client and their guardian, if applicable, to request “care coordination” from the client’s Apple Health MCO or Medicare Advantage (MA) Health Plan (including clients who have managed care only for behavioral health services).

We have a document in the [Apple Health & Managed Care](#) section titled MCO Care Coordination at a Glance which will help answer questions about the role of Managed Care Organizations in Care Coordination, why it can be helpful to coordinate with the MCOs and how to coordinate with the MCOs. We also have a Care Coordination contact list can be found on the HCS/AAA intranet website at <http://intra.altsa.dshs.wa.gov/hcs/> on the right side of the webpage, under Contractors. For D-SNP Coordination please use the [Medicaid and Medicare Managed Care Coordination Contacts Lists](#) on the D-SNP CM-TOC tab. Finally we also have a decision tree that will help you determine what program a client is on titled Managed Care Coordination Decision Tree 5.14.25. (Please see the Attachment section at the end of this chapter.)

1. To request care coordination, the CM may send a secure email* to the client’s MCO to request care coordination and assistance to address barriers the client is experiencing to access medically necessary care covered by Apple Health. Email addresses for the five Apple Health plans are:
 - a. Molina Healthcare of Washington, Inc. (MHW)
 - b. Community Health Plan of Washington (CHPW)
 - c. Coordinated Care of Washington (CCW)
 - d. Wellcare (for Dual Special Needs Population [D-SNP] operated by CCW)
 - e. United Healthcare Community Plan (UHC)



- f. Wellpoint (WLP) (for Dual Special Needs Population [D-SNP])
- g. Humana/Arcadian Health Plan (for Dual Special Needs Population [D-SNP])

*Emails from the DSHS URL (@dshs.wa.gov) identifies the requestor as a DSHS employee and meets HIPAA requirements to request care coordination on behalf of an HCS/AAA client.

2. When making a care coordination request include the following in your email:
 - a. In the Email "Subject" line, provide the reason for care coordination request. For example:
 - i. Mental health treatment
 - ii. Durable medical equipment
 - iii. Needs Primary Care Provider
 - b. In the body of the email, provide the following information:
 - i. Client Name
 - ii. Client ProviderOne ID: (9-digit number ending in WA)
 - iii. Date of Birth
 - iv. Residence Type
 - v. CM Name and Contact Information
 - vi. Summary of client barrier/issue/need
3. If you do not receive a response or assistance with your request timely, the CM should discuss the case with their supervisor to determine if escalation is needed. Sent a second email to the MCO with 'escalation' in the title of the email.
4. If the CM and supervisor do not receive a response, they may determine escalation to HCS HQ is needed when issues are not resolved.
 - a. If the CM supervisor determines that escalation to HQ is appropriate, the CM supervisor will submit the original email communication and escalation with the MCO to Ethan.Leon@dshs.wa.gov

Once the request for escalation is received, HCS HQ will outreach with HCA to discuss the identified barrier to access. Based upon the type of request, the case manager and supervisor will be notified regarding next steps.

If you experience any issues with this process, please contact the HQ Managed Care Data and Policy Analyst Ethan.Leon@dshs.wa.gov.

RESOURCES

Related WACs & eCFRs

WAC 182-526-0155	HCA & Appellant's Representation
WAC 182-538	Washington State Health Care Authority Managed Care
WAC 182-538-130	Exemption

[CFR 42-438](#) Managed Care

Acronyms

AAA	Area Agency on Aging
ACES	Automated Client Eligibility System
AH	Apple Health
AHFC	Apple Health Foster Care
AHMC	Apple Health Medicare Connect
AI/AN	American Indian/Alaskan Native
BH-ASO	Behavioral Health Administrative Services Organization
BHSO	Behavioral Health Services Only
CARE	Comprehensive Assessment Reporting & Evaluation
CCC/CCW	Coordinated Care of Washington
CFC	Community First Choice
CFR	Code of Federal Regulations
CHP/CHPW	Community Health Plan of Washington
CM	Case Manager
CMS	Centers for Medicare and Medicaid Services
COPES	Community Options Program Entry System
DME	Durable Medical Equipment
DMHP	Designated Mental Health Professionals
DSHS	Department of Social and Health Services
D-SNP/DSNP	Dual-Eligible Special Needs Plan
eCFR	Electronic Code of Federal Regulations
FFS	Fee For Service
FIMC	Fully Integrated Managed Care
HCA	Health Care Authority
HCS	Home and Community Services
HUM	Humana
IVR	Individual Voice Recognition
LTSS	Long Term Services and Supports
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MHC/MHW	Molina Health Care of Washington
NFLOC	Nursing Facility Level of Care
OTC	Over the Counter

PACE	Program for all Inclusive Care for the Elderly
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PEBB	Public Employees Benefits Board
QI-1	Qualified Individual Program
QMB	Qualified Medicare Beneficiary
RSA	Regional Service Area
SAPT	Substance Abuse Prevention and Treatment
SLMB	Specified Low-Income Medicare Beneficiary
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TPL	Third Party Liability
UHC	United Health Care
WAC	Washington Administrative Code
WLC	Wellcare
WLP	Wellpoint

Glossary

Care Coordination	An approach to healthcare in which all of a patient's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the patient and the patient's caregivers and works with the patient to make sure that the patient gets the most appropriate treatment, while ensuring that health care is not duplicated.
Disenrollment	The process by which an enrollee's participation in a managed care program is terminated. Reasons for disenrollment include death, loss of eligibility, or choice not to participate, if applicable.
Fee-For-Service	A service delivery system where health care providers are paid for each service separately (e.g. an office visit, test, or procedure).
Long-Term Services and Supports	A wide variety of services and supports that help people with functional impairments meet their daily needs for assistance in qualified settings and attain the highest level of independence possible. LTSS includes both Home and Community-Based Waiver Services and Medicaid Personal Care Services.
Managed Care	A prepaid, comprehensive system of medical and health care delivery. - <i>Medical</i> : Includes preventive, primary, specialty care and ancillary health services - <i>Integrated</i> : Includes Medical services PLUS behavioral health and long term services and supports.
Third Party Liability	Refers to the legal obligation of third parties (e.g., entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a state plan. By law, all other available third party resources must meet their legal

	obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state plan.
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REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
8/2/19	Integration Unit	Updated into new template	
5/9/23	Office of Policy and Integration	Split Chapter 22 into three parts: Chapter 22a, 22b, and 22c	

Web Resources

Return to [Identifying clients who are enrolled in managed care via ACES Online, Provider One, and CARE](#)

Return to [Integrated Managed Care](#)

Return to [AHMC Health Plan Service Areas & Network](#)

Apple Health & Managed Care



How to identify
Managed Care Plans



MCO care



Behavioral Health



Managed Care
Coordination Decisi

[Medicaid and Medicare Managed Care Coordination Contacts](#)

[HCA Managed Care webpage](#)

[Regional Information Spreadsheet](#)

[Fee-For-Service \(FFS\)/Apple Health Coverage without managed care](#)

[ProviderOne Find a Provider List for FFS](#)

[Washington Healthplanfinder](#)

[“Welcome to Washington Apple Health: Managed Care” benefits book](#)

[“Welcome to Washington Apple Health: Behavioral Health Services Only” benefits book](#)

[“Welcome to Washington Apple Health: Coverage without a managed care plan” benefits book](#)

[Apple Health Enrollment Form](#)

[HCA Apple Health Medicare Connect \(Dual-Eligible Special Needs Plan \[D-SNP\]\) Website](#)



[D-SNP Service Area Guide](#)

[Chapter 22d CBHS Community Behavioral Health Support](#)

[HCA Community Behavioral Health Support website](#)

Health Homes

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Anthony Foster	Health Home Training Specialist 360.725.2640 Anthony.foster@dshs.wa.gov
Kerri Hummel	Health Home Quality Assurance Specialist 360.725.2278 Kerri.Hummel@dshs.wa.gov

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HEALTH HOME PROGRAM

Overview

The Health Home (HH) program was created out of the Affordable Care Act, section 2703, which allowed states to provide specific services to Medicaid and Medicare/Medicaid (Duals) eligible clients. This program is a collaboration between [HCLA](#) and [HCA](#).

Integrated Care Coordination

The HH program promotes person-centered health action planning to empower clients to take charge of their own health care. This is accomplished through better coordination between the client and all their health care providers.

HH services are a set of optional Medicaid benefits available to eligible clients. Participation is voluntary, at no cost to clients, and does not change or duplicate services currently being delivered. A Care Coordinator (CC) steps in when a service is needed and is not already being provided, to bridge gaps in care. The HH program is designed to:

- Ensure cross systems coordination and care transition;
- Increase confidence and skills for self-management of health goals; and
- Create a single point of contact responsible for bridging all systems of care.

Client Advocacy

Clients receiving HH services will be assigned a CC who will partner with them, their families, caregivers, representatives, doctors, and other agencies providing services to ensure coordination across these systems of care. The CC will:

- Work with their client to develop a Health Action Plan (HAP) that is person-centered;
- Make in-person visits and provide support by telephone to help the client, their families and service providers;
- Assist the client in accessing the right care at the right time, at right place and with the right provider; and
- Provide at least one of the HH services each month.

The client and CC meet at a location of the client's choice: their home, clinic, or other community location to receive services. Care Coordinators, sometimes work with a team for the delivery of HH services.

Health Action Plan (HAP)

The HH program emphasizes person-centered care with the development of the HAP. The HAP includes routine screenings such as the Patient Activation Measure (PAM®), an assessment that gauges the knowledge, skills, and confidence level essential to managing one's own health and healthcare.



Other tools CCs use include screenings for body mass index, depression, level of independence in accomplishing activities of daily living, fall risk, anxiety, substance use, and pain. The HAP and the assessment screens are updated periodically. The centerpiece of the HAP is identifying the client's self-identified short and long-term health related goals, including action steps that the client and others plan to do to improve their health.

HAP Form DSHS 10-481 and Instructions

[Form 10-481: Health Action Plan \(HAP\)](#)

[Form 10-481: Health Action Plan \(HAP\) Instructions](#)

Structure – who provides these services?

HCA contracts with both community-based organizations and managed care plans to provide HH services. These designated "Health Home Leads" contract with Care Coordination Organizations (CCOs) to provide the services. Some HH Leads hire internal CCs as well. The HH program is structured as a community-based delivery system and focuses on matching clients with a CCO that has a preexisting relationship or has expertise that would enhance their ability to provide HH services to that particular client.

Enrollment

Clients are passively enrolled into the HH program by HCA. Enrollment into the HH program is voluntary and clients may disenroll at any time by their CC or by signing an Opt Out form.

Eligibility

To be eligible for Health Home Services clients must:

- Be on Medicaid or have both Medicaid and Medicare (Dual Eligible); and
- Have an identified chronic condition; and
- Be at risk for a second chronic condition
 - Predictive Risk Intelligence System (PRISM) score of 1.5 or higher (indicates risk for a second chronic condition).

PRISM is used to determine which clients are eligible. Specifically, the client must have a chronic condition and be at risk of another as determined by a PRISM risk score of 1.5 or more. A risk score of 1.5 means a client's expected future medical expenditures to be 50% greater than the average for Washington's Supplemental Security Income disabled population.

Not all clients are eligible. For example, clients on spend down or enrolled in PACE, are not eligible.



For those with limited PRISM data, there is a Clinical Eligibility Tool that may be used to determine a risk score and can be found at [Health Home | Washington State Health Care Authority](#)

Payment – how do Leads get paid?

Health Home services are Medicaid covered benefits and paid for by the state through its contracts with managed care organizations providing HH services to their members and community based HH Lead entities. HCA pays the HH Leads through ProviderOne. Case Managers never authorize HH services.

Dual Special Needs Plan (DSNP)

In January 2023, the Health Home program was extended as a Medicare benefit to Dual Special Needs Plan (DSNP) enrollees who were actively receiving Health Home services at the time of DSNP enrollment.

The program expanded further in January 2025, when each Medicare Advantage (MA) Health Plan began offering a Health Home program to all full-dual DSNP enrollees who meet Health Home eligibility criteria.

The service delivery structure remains unchanged. Health Home Leads and Care Coordination Organizations (CCOs) continue to provide Health Home services to DSNP beneficiaries. After a client transitions to Health Home services through a DSNP, the Medicare Advantage Plan reimburses the Health Home Lead directly.

Services Provided

As defined by CMS, the HH program provides the following six services beyond the traditional Medicaid or Medicare benefits.

Comprehensive Care Management

The initial and ongoing assessment and care management services aimed at the integration of primary, specialty, behavioral health, long-term services and supports, and community support services, using a comprehensive person-centered HAP which addresses all clinical and non-clinical needs. Examples include:

- Conduct outreach and engagement activities
- Complete required and optional screenings
- Develop the HAP
- Develop goals and action steps to achieve those goals
- Prepare crisis intervention and resiliency plans



Care Coordination

Facilitating access to, and the monitoring of, services identified in the HAP to manage chronic conditions. Includes updates to the HAP, monitoring service delivery, and progress toward goals. Care coordination is accomplished through face-to-face and collateral contacts with the client, family, caregivers, medical, and other providers. Examples include:

- Implement the HAP
- Monitor progress towards short- and long-term goals
- Coordinate with service providers, case managers, and health plans as appropriate to secure necessary care and supports
- Conduct or participate with multidisciplinary teams
- Assist and support the client with scheduling health related appointments and accompany if needed
- Communicate and consult with providers and the client as appropriate

Health Promotion

Providing information for optimal health outcomes and promoting wellness. Examples include:

- Provide individualized wellness and prevention information specific to the needs and goals of the client
- Provide links to health care resources that support the client's HAP goals
- Promote participation in community educational and support groups
- Act as a health coach to support the client in initiating and sustaining behavioral change

Comprehensive Transitional Care

Facilitating services for the client and family/caregiver when the client is transitioning, between levels of care. Examples include:

- Participate on multidisciplinary planning teams such as nursing facility discharge planning
- Review post discharge with client/family to ensure discharge orders are understood and acted upon including medication reconciliation
- Assist with access to needed services or equipment and ensure it is received
- Providing education to the client and providers that are located at the setting from which the person is transitioning

Individual and Family Supports

Coordinating information and services to support clients and their families or caregivers to maintain and promote the quality of life, with particular focus on community living options. Examples include:

- Provide education and support of self-advocacy



- Identify and access resources to assist client and family supports in finding, retaining, and improving self-management, socialization, and adaptive skills
- Educate client, family or caregiver regarding Advance Directives, client rights, and health care issues

Referral to Community and Social Services Supports

Providing information and assistance for the purpose of referring clients and their families or caregivers to community-based resources that can meet the needs identified on the client's HAP. Examples include:

- Identify, refer, and facilitate access to relevant community and social services
- Assist clients to apply for or maintain eligibility for health care services, disability benefits, housing and legal services not provided through other case management systems
- Monitor and follow-up with referral sources to confirm appointments and other activities were established and clients were engaged in services

Working with Care Coordinators

Care Coordinators do not duplicate or replace services or case management provided by HCS, DDA, or AAA. Clients who participate in the HH program will continue receiving their primary medical, specialist, behavioral health, and long-term services and supports from their current providers. Participation will not change the way a client's other services are currently managed, authorized, or paid.

The CCs complement the work of HCS/AAA/DDA Case Managers. A CC may contact you to inform or share information about one of your clients to help support them in reaching one of their health-related goals, to work together on an issue that needs resolution, or provide advocacy in the work you do.

HCS/AAA/DDA Case Manager Roles

Once a client is participating in the HH program, staff should:

- Coordinate with the CC to facilitate resources and referrals. In some cases, the CC may request a copy of a client's CARE assessment. If requested, a consent form (HCA 22-852) will be shared.
- Include the CC as a collateral contact in CARE
- Collaborate and communicate with the CC
- Know that the CC is considered a member of the client's health care team. In some instances, they may attend the CARE assessment visit.

Table: HCS v CC Case Management

SERVICE DESCRIPTION	HH CC	HCS/AAA/DDA
Determine eligibility for LTC services and supports.		X

SERVICE DESCRIPTION	HH CC	HCS/AAA/DDA
Perform a face-to-face CARE assessment with the client in their residence to determine service needs and program eligibility at least annually.		X
Assist the client to develop a plan of care to enable them to reside in the setting of their choice and monitor that plan.		X
Authorize services with the client's choice of qualified provider according to their plan of care.		X
Termination Planning for personal care services/LTSS.		X
Report abuse, abandonment, neglect, self-neglect, or financial exploitation to Adult Protective Services or the Complaint Resolution Unit.	X	X
Report Suicide Ideation	X	X
Make referrals for services identified by the client to improve health and prevent additional disease or disability.	X	X
Provide comprehensive care management including review of PRISM risk scores to Health Home high needs and utilization patterns.	X	
Assist to develop and implement a person-centered Health Action Plan	X	
Provide transitional care services following a discharge from institutions into the community.	X	
Administer the Patient Activation, Caregiver Activation, or Parent Activation Measure used for Health Action Planning and self-management skill development.	X	
Provide care coordination and comprehensive care management across the client's team of health care professionals.	X	
Provide health promotion services/information to the client including health education, development of a self-management plan and improving social and community networks promoting healthy lifestyles (smoking cessation, weight loss, and physical activity).	X	
Identify resources for the client and their family in the community to allow the client to attain their highest level of health and functioning.	X	
Educate family members about disease processes, what to expect, and caregiving skills necessary to assist the client in achieving their HAP goals.	X	

Determining if a client is enrolled for HH services

There is no notification system to let the HCS/AAA/DDA Case Manager know when a client is part of the HH program. Case managers will need to:

- Check CARE ProviderOne screen
 - Click on Managed Care and it may indicate HH program and the Lead organization
- Check ProviderOne
 - Select client search with ProviderOne ID
 - Check if the Health Home Clinical Indicator is populated with current dates
 - Check Managed Care Enrolled screen which may indicate HH and the Lead organization
- Contact the clients Apple Health managed care organization, HH Community Lead in your area, or HCA at HealthHomes@HCA.WA.GOV regarding questions of enrollment or how to refer a client
- Find the contact information for Health Home Leads at <https://www.hca.wa.gov/assets/billers-and-providers/hh-leads-contacts.pdf>

RESOURCES

Related WAC

[WAC 182-557-0100](#) Health Home

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
8/2/19	Integration Unit	Updated into new template	

Health Home Print Resources

[Form 10-481: Health Action Plan \(HAP\)](#)

[Form 10-481: Health Action Plan \(HAP\) Instructions](#)

[Health Homes Fact Sheet](#)

Health Home

[Health Home | Department of Social and Health Services](#)



[Health Home | Washington State Health Care Authority](#)

[Health Home – Washington’s State Plan Amendment](#)

[Final Demonstration Agreement between CMS and the State of Washington December 2024](#)



Program of All-Inclusive Care for the Elderly (PACE)

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Kathryn Pittelkau PACE Policy Program Manager
360.725.2366 Kathryn.Pittelkau@dshs.wa.gov

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OVERVIEW OF MANAGED CARE

The purpose of the managed care service delivery model is to integrate services an individual may need in one delivery system with one payment called a capitated payment. The managed care plan must furnish all of an individual's services included in the managed care contract using this capitated payment. This puts the managed care plan at risk for high-cost services as well as creates incentives to use prevention and pro-active techniques to keep a person well.

HCA, DSHS, and CMS have contracts with managed care entities. The contract between HCA, DSHS and/or CMS and the Managed Care entity details what services are covered in the contract and what the MCO is responsible for. Contract examples include:

- Apple Health (Medicaid)
- Program for all Inclusive care for the Elderly (DSHS & CMS)
- Medicare Advantage and D-SNP (CMS)

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE stands for Program of All-inclusive Care for the Elderly. It is an innovative Medicaid/Medicare program that provides frail individuals age 55 and older comprehensive medical and social services coordinated and provided by an interdisciplinary team of professionals in a community-based center and in their homes, helping program participants delay or avoid long-term nursing home care.

Each PACE participant receives customized care that is planned and delivered by a coordinated, interdisciplinary team of professionals working at the center. The team meets regularly with each participant and his or her representative in order to assess the participant's needs. A participant's care plan usually integrates some home care services from the team or residential placement with several visits each week to the PACE center, which serves as the hub for medical care, rehabilitation, social activities, and dining.

The PACE model was developed in San Francisco in the 1970s as ON LOK, the Chinese American community's alternative to nursing home placement. It was formally established by CMS as a permanent Medicare Advantage option in 1997.

Offering PACE as a Choice

The following elements are directed and required by legislation (SBH 1499) to ensure that PACE is provided as an option for possibly eligible clients living within a PACE available service area. At each assessment, AAA and HCS staff within the PACE service area will see a required question on Care Plan screen in CARE related to PACE. The question is:

"PACE is available in certain zip codes in the county the client resides, would the client like to receive more information about the PACE integrated managed care program?" Yes/No/Already enrolled.

Assessor is to ask client and respond to question accordingly. If response is “yes” and client resides in King County, it will ask an additional question if client has a preference as to which PACE program:

“If yes, are you interested in a particular PACE program?”

- **Providence PACE**
- **International Community Health Services**
- **PNW PACE**
- **No preference**

For clients whose response is “yes”, PACE organizations will contact them to provide more information on PACE managed care.

Staff will no longer complete nor submit form 17-218 “PACE Request for More Information”.

A report that has the “yes” responses compiled will be generated weekly to the PACE Organization (PO) of clients who indicated they would like more information about the PACE program. The PO will coordinate with the client and inform HCS/AAA should client choose to enroll and be accepted.

Staff Training

Training is set up and offered through the PACE Organization (PO) at regular intervals for both HCS and AAA staff. Trainings are meant to be interactive and jointly held. The PACE training link is provided below as an ongoing resource for HCS and AAA staff.

Please use Chrome for the below link:

<http://intra.ALTSA.dshs.wa.gov/videos/PACE/story.html>

Private Pay

HCS is also responsible for assessing individuals not eligible for Medicaid or Medicare who are interested in enrolling in PACE to determine initial functional eligibility as well as ongoing functional eligibility. These referrals generally come directly from PACE organization.

Service Providers

DSHS currently contracts with the PACE organizations (PO) Providence PACE, International Community Health Services (ICHS) and PNW PACE Partners (PNW PACE) to administer the PACE program.

To be enrolled in PACE the client must live in a zip code in the PO’s service area.

Please see below the hyperlinked spreadsheet which notes PACE available Zip codes per County per PO:

[Zip Codes per County Per PACE Organization](#)

There are nine PACE centers in Washington State.

Providence PACE - Seattle

4515 Martin Luther King Way South
Seattle, WA 98108
(206) 320-5325

Providence PACE - Renton

350 S 38th Ct
Renton, WA 98055
(206) 320-5325

Providence PACE - West Seattle

4831 35th Ave. SW
Seattle, WA 98126
(206) 320-5325

Providence PACE – Kent

1404 Central Ave S
Kent, WA 98032
(206) 320-5325

Providence PACE - Redmond

8632 160th Ave. NE
Redmond, WA 98052
(206) 320-5325

Providence PACE - Everett

1615 75th Street SW
Everett, WA 98203
(206) 320-5325

Providence PACE - Spokane

6018 N Astor
Spokane, WA 98208
(509) 482-2475

International Community Health Services (ICHS)

939 Golf Drive South
Seattle, WA 98144
Phone: (425) 755-1100

Pacific Northwest PACE Partners (PNW PACE)

6442 Yakima Ave
Tacoma, WA
Phone: (253) 459-7270

Services

PACE provides its participants with all services covered by Medicare and Medicaid, without the limitations normally imposed by these programs. It also provides any other services deemed necessary by the interdisciplinary team that would allow program participants to remain in the community.

Services provided by PACE include, but are not limited to:

- Primary care (including doctor, dental and nursing services)

- Prescription drugs
- Adult day health care
- Home and personal care services
- Nutrition services,
- Case management
- Hospital and nursing home care if and when needed.
- Transportation to and from the center and all off-site medical appointments

Eligibility

To participate in PACE, an individual must be 55 years of age or older, require NFLOC but be able to live safely in the community at time of enrollment with the services of PACE and reside in the service area of a PO. PACE participants may disenroll from the program for any reason and those with Medicare or Medicaid who disenroll will be assisted in returning to their former or preferred health care coverage.

Both the PO and the client agree to the PACE enrollment by signing an enrollment agreement. This agreement means the client agrees to receive services exclusively through the PO and its contracted network.

This may mean that the participant will need to change providers including PCP.

Determining Eligibility

**In Spokane, Pierce and Snohomish Counties, the breakdown of which entity handles ongoing PACE assessments is as follows:
AAA—in-home PACE clients
HCS—Residential PACE clients**

HCS/AAA will assess clients and determine whether they:

- Are age 55 or older;
- Meet nursing facility level of care (NFLOC) as defined in WAC [388-106-0355](#);
- Reside in the PACE service area/or will at the time of enrollment; ***and***
- Are financially eligible per WAC [182-515-1505](#). (MAGI clients are financially eligible);
- Remain functionally eligible by Reassessing Clients (Annual or Significant Change)

The PO is responsible for notifying HCS/AAA of any significant changes in the client's condition:

1. Collaborate with the PACE social worker prior to each assessment. Review the previous assessment/SERs and information given by the PO before the visit.
2. Communicate with collateral contacts as needed to obtain information and include relevant parties to complete an accurate assessment.



3. Complete the face-to-face assessment. Be sure that you have:
 - Assigned the PO as the paid provider
 - Assigned relevant tasks to the PO. No provider schedule is necessary.
4. Verify financial eligibility at least annually, document on the Financial Screen in CARE and document in the file.
5. Once complete, move the assessment to current per procedures in Chapter 3 of the LTC Manual, send the CARE Assessment Details and Service Summary to the PO. Send Service Summary and CARE Results (when necessary) to client.
6. Extend PACE RAC, if applicable, for the new plan period (only available and needed if care plan is in-home).

Continued Functional Eligibility

PACE services can continue even though a PACE participant no longer meets State Medicaid NFLOC if the HCS case manager reasonably expects that the participant would again meet NFLOC in the next 6 months should PACE services end. This is called “deeming”. “Deemed eligible for PACE” is what will display in care plan as the desired program choice in this situation.

State Staff Responsibilities:

1. HCS/AAA staff will continue to complete annual reassessments of all PACE participants. If the assessment results in the client not meeting NFLOC, staff will review the assessment and consider whether the:
 - a. Participant’s health status is maintained or benefited, at least partially, because of the services PACE currently provides; *and*
 - b. Participant’s health and/or functional status are likely to decline over the next six (6) months without PACE services.

Examples of information that would support deeming of continued eligibility could include, but are not limited to:

- Physician and/or nursing progress notes documenting the treatment and impact of a chronic/disabling condition;
 - List of services currently provided to the participant (OT, PT, dietary management, blood glucose/blood pressure checks, diabetic foot care, etc.);
 - Frequency of medical appointments and/or frequency of medical treatments/interventions that point to an unstable medical condition that must be treated/monitored regularly to avoid complications;
 - Decline or loss of mobility combined with cognitive decline or progression; etc.
2. If HCS/AAA case managers deem continued eligibility, they will continue to conduct full annual reassessments (and any significant change assessments) and determine NFLOC and/or that deeming criteria continues to be met.
 3. If the client meets deeming criteria, staff will choose “Deemed Eligible for PACE” in the program drop down in CARE.



4. HCS/AAA staff will note in a CARE SER the decision to deem eligibility in the PACE program.
5. If HCS/AAA staff determine that a previously deemed participant no longer meets NFLOC or deemed continued eligibility or the client is not financially eligible for Medicaid a denial notice and appeal rights will be issued to the participant with a copy sent to the PO.
6. If the participant requests a Department administrative hearing to dispute the State's denial of continued eligibility, PACE services may continue until the appeal is heard and a decision is rendered. If the denial is upheld, the participant may be required to pay the cost of PACE services rendered after the initial denial effective date.
7. If a request for administrative hearing is not received, PACE enrollment will be terminated at the end of the month in which the PAN was issued if the PAN was issued at least 10 days prior to the end of the month; if PAN was issued less than 10 days prior to the end of the month, PACE enrollment will be terminated at the end of the following month.

Forms

AAA/HCS Case Managers are required to complete the following forms:

- **PAN** – Once you assess the client in CARE, you must send the client the Planned Action Notice. The Planned Action Notice for PACE clients must include information that tells the client:
 - They are eligible for services;
 - That PACE is the program of choice;
 - The number of personal care hours or daily rate they are eligible for.
- **Rights and Responsibilities**
- **Consent Form** – Complete when working with collateral contacts to gather/share information. The PO is an "HCLA paid provider".

Roles

Note: Clients are eligible for PACE services on the first of the month in which they are enrolled following the date the client is financially/functionally eligible. Clients can only be enrolled effective the first of the month.

HCS/AAA ASSESSOR	Determine Eligibility Complete the CARE assessment to determine functional eligibility (specifically nursing facility level of care) for long-term care services. If the client is functionally eligible for nursing facility level of care, offer PACE as an option for receiving services. Client Seeks Enrollment Once you receive confirmation from the client that they wish to enroll, provide a copy of the CARE Assessment Details and Service Summary to the PO for review.
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	Enrollment Confirmed Once you received notification from PO that client will enroll in PACE: • Send a copy of the Service Summary and Assessment Details in “current” status to the PO (if not already done). The Service Summary does not have to be signed by the client or PO. • Send a Planned Action Notice (DSHS 14-405)* to the client or their representative stating the effective enrollment date along with Service Summary (and CARE Results if necessary) • *Below are current instructions for PAN per PACE enrollment: 1) Send PAN indicating PACE approval with the following PACE specific details a. Effective date is the first day of the month of PACE enrollment b. Select PACE as the ‘Program. c. Enter CARE rate in the new amount field. d. PACE WACs will auto-populate when ‘functionally eligible’ is chosen related to PACE approval: 388-106-0700, 388-106-0705 • Send DSHS 14-443 to Financial with enrollment start date, and ProviderOne ID of PACE provider*, and indicate if it will be in-home or residential care. For the latter include the CARE daily rate. • * ProviderOne IDs of PACE providers: Providence PACE ProviderOne #: 105011001 ICHS ProviderOne #: 209579901 PNW PACE ProviderOne # 217922601 • Add PACE RAC in CARE. This will only be available if the setting is in-home. • End all ProviderOne authorizations for end of month prior to enrollment. • ProviderOne payment authorizations are not done by HCS. • Add PO as the “formal caregiver” in collateral contacts. • Assign all unmet and partially met tasks to the PO as paid provider on care plan support screen. • If client is receiving wellness education service under COPES complete interim to remove this treatment. This service is not available to clients in PACE. • If client is receiving ADH service under COPES and any ADLs are partially met and informally assigned to ADH provider, complete interim to make these ADLs unmet.
PUBLIC BENEFIT SPECIALIST	If not already established, determine financial eligibility for long-term care (PACE). Upon confirmed enrollment: enter P1 ID of PO in ACES so award letters and all correspondence gets sent to the PO.
PACE ORGANIZATION (PO)	Prior to Enrollment • Contact interested clients to discuss program • Schedule site visit and evaluation • Review CARE assessment Enrollment Denied



	- PO informs client and sends information to HQ with reason as to why Enrollment Confirmed - Notify HCS/AAA of enrollment decision including enrollment start date. - Send a monthly electronic enrollment file by the 23rd of the month for enrollment the following month that contains client enrollment effective dates to the PACE Program Manager with a cc to the HCS/AAA field supervisor. Enrollments only occur at the start of a given month. - Send disenrollment letters for enrollees with other coverage.
PACE HQ PROGRAM MANAGER	- Enroll the client into PACE via the ProviderOne system if eligible. - Review and evaluate any enrollment denials submitted by the PO.

Ongoing Client Management / Roles & Responsibilities

Case Management for PACE Clients

Once a client is enrolled in the PACE program, the PO assumes case management responsibilities.

Ongoing HCS/AAA SW Responsibilities	Ongoing PO Responsibilities
- Annual functional assessments - Significant change assessments - Verify financial eligibility for each face-to-face assessment - Coordination with PO case managers - Obtain medical records from PO - Process disenrollments - Communicate necessary info to financial as needed - Notify financial of SNF stays that go beyond 30 days	- Implement and oversee care plan - Day to day case management - Enlist, contract, and pay providers (including IPs) - Communicate changes to HCS (address, telephone #, milieu of care (including SNF placements)) - Request significant change assessments (vetting request/reviewing current CARE first) - Staff cases with PO interdisciplinary team as needed - Distribute CARE assessment and plan of care to providers - Assist clients with eligibility reviews

HCS/AAA and PO Coordination

HCS/AAA and the PO must report the following client changes to one another when they occur:

- Admit or discharge from a nursing facility. HCS must notify financial if over 30 days;
- Need for home maintenance allowance (HMA). Requested by PO, HCS processes.
- Change in address or phone number;
- Change in plan of care which includes:
- Change in care setting (in home, residential, SNF)
- Disenrollment from plan (including expedited disenrollment);



- Move out of the service area;
- Changes in or termination of Medicaid eligibility;
- Change from Medicaid to private pay and vice versa. PO makes HCS aware.
- Financial reports changes in cost of care to the PO via award letter.
- Client passes away

PO Responsibilities

- Must maintain services for the enrollee while enrolled, regardless of how much service needs increase or decrease;
- Is responsible for admitting and/or discharging PACE enrollees from the various living environments.
- Must collect participation from the enrollee.
- Will contract providers for all PACE services).
- Must have an internal “exception to rule” policy as it relates to needed services above what CARE assessment indicates. (HCS ETR is N/A for PACE)
- Review current CARE assessment prior to requesting significant change
- Must notify HCS of any:
 - Address changes;
 - Changes in income or resources; *or*
 - Changes in living situations (in-home, residential, nursing facility);

HCS/AAA Field Manager/Supervisor Responsibilities

- Point person for HQ PACE PM as it relates to PACE programs’ field-level operations
- Point person for other HQ PACE PMs as needed (ProviderOne, contracts, FLSA, etc.)
- Point person for PO management related to day-to-day operations of PACE programs
- Troubleshoot and address enrollment issues including lapses in enrollment
- Point person to provide assistance to PO (or their subcontractor) navigating ProviderOne as it relates to payment authorizations for individual providers
- Point person for PO intake and management staff related to enrollments and disenrollments
- Point person for work with RCS as needed related to PACE clients in residential settings
- Oversee and receive new enrollments monthly and assign to HCS workers
- Assist HQ PACE PM reconciling payment issues with PO on a monthly basis
- Meet with PO and their subcontractors as needed or requested

CARE Rules & PACE Enrollees

- All CARE minimum standards are applicable to PACE enrollee assessments.

- When determining “status” for PACE enrollee, the PO is considered the HCLA paid provider, not the IP, Homecare Agency, Residential or other provider. The actual providers are not to be considered “informal” supports because they are being paid by the PO.
- On the Support Screen, assign the PO as the paid provider for all applicable “unmet” and “partially met” needs. As well, tasks that would otherwise be assigned to PCP/MD should generally be assigned to PO.
- Potential referrals triggered from the CARE assessment are the responsibility of the HCS/AAA worker prior to enrollment into PACE, including the assessment that determines functional eligibility. Once the client is enrolled, the PO assumes all case management for the client.

The PO may request and be granted view access in CARE for clients enrolled in the contractor’s PACE program. The PO should contact the HQ program manager to request access to CARE.

Payment

POs receive a set amount of Medicare and Medicaid funds each month to ensure participant care, whether services are provided in the home, community or in a nursing home setting. This capitated funding arrangement rewards providers who are flexible and creative in providing high quality care and gives them the ability to coordinate care across settings and medical disciplines.

The program also accepts participants who pay privately.

Provider Payments

- The PO contracts & enlists their own providers for all PACE services. This includes homecare agencies, AFH’s, AL’s and all other covered services.
- The PO is responsible for directly paying all their providers.
- IPs are paid via ProviderOne though the PO is billed back for the costs.
 - The PO inputs IP payment authorizations directly into ProviderOne using their own RU.
 - No other payment authorizations will be visible in CARE for PACE clients.

Disenrollment

Disenrollment is effective the last day of the month.

Voluntarily

- Request disenrollment;
- Are no longer Medicaid eligible; i.e. client is not financially or functionally NFLOC;



Involuntarily

- Move out of the PACE service area or leave for more than 30 days (unless an arrangement has been made or client is receiving referred treatment from the PO); *or*
- Engage in disruptive or threatening behavior and involuntary disenrollment is reviewed and approved by the HCS Headquarters Program Manager; *or*
- Fail to pay or to make satisfactory arrangements to pay any amount due to the provider after a 30-day grace period; *or*
- Are enrolled with a PO that loses its contract and/or license and is no longer able to offer services.

Process

1. The PO must send a written notice to the HQ PACE PM that fully documents that one of or more of the conditions exist to justify involuntary disenrollment.
2. The HQ PACE PM will consult with the regional supervisor regarding any concerns with the disenrollment or timeframes. Once approved/denied the HQ Program Manager will notify the regional supervisor and the PO of approval/denial within 15 days of receipt.

Roles

HCS/AAA Case Manager

1. Send the client a Planned Action Notice (DSHS 14-405), stating effective disenrollment date.
2. Follow procedures for setting up other long-term care program/services and supports, if desired by client. This would include enlisting a new formal/paid caregiver and, if it's an IP, work with CDWA to get IP in place to provide services for the client.
3. Coordinate with HQ and the PO.

PACE Organization

1. Send a monthly electronic disenrollment file by the 15th of the month to HQ PACE PM with a cc to the regional supervisor with the effective dates of participant disenrollments.
2. Coordinate with HCS (field and HQ) and AAA on any disenrollments. Timely notification to HCS/AAA field is critical; HCS/AAA field should be notified at the time PACE becomes aware of a disenrollment to allow time for HCS to implement new plan of care.
3. Determine and communicate safe, ongoing plan of care to HCS/AAA for implementation.
4. Assist client in establishing new PCP.
5. Assist client in signing up for new Medicare Part D plan.

HCS HQ Program Manager

1. Process disenrollments in the ProviderOne payment system.
2. Approve/deny any involuntary disenrollment requests.
3. Coordinate with the field and the PO.



Grievance, Appeals and Hearing Rights

- The PO must report to the HQ PACE PM quarterly regarding all grievance and appeals filed.
- If the PO denies or reduces a previously authorized service, the participant may appeal the denial to the PO.
- If the PO upholds its denial or does not respond timely to a request, the participant may request an administrative hearing.
- The participant must exhaust the appeal process before requesting an admin hearing on a PO determination.

Grievance

The client has the right to file a grievance either verbally or in writing to the PO any time they are dissatisfied with a service, the quality of care received or an interaction with PO staff.

Appeal

The client has the right to appeal any decision made by the PO to reduce, deny or terminate a service or an enrollment. This includes the right to appeal an involuntary disenrollment by the PO. The client should contact the PO to file an appeal.

Administrative Hearing

A client has a right to an administrative hearing only when entitled by the law and when aggrieved by a Department or PO decision or action. Clients have a right to a hearing:

1. For any action taken by the Department and indicated on the Planned Action Notice (PAN) including approval, denial, reduction or termination of services or eligibility.
2. When the department determined a client received more benefit than they were eligible for an overpayment was issued; and
3. When they have exhausted the appeal process regarding a PO determination or the PO did not respond timely to the request.

Administrative hearings are coordinated through the admin hearing coordinator for the service area. The department may be a witness.

Per WAC 182-526-0155, an appellant may represent themselves or may be represented by a lawyer, paralegal, relative, friend or any other person of his or her choice. **The appellant cannot be represented by an employee of the Department or the PO.**

RESOURCES

Related WACs & eCFRs

WAC 182-526-0155	HCA & Appellant's Representation
WAC 182-538	Washington State Health Care Authority Managed Care
WAC 182-513-1230	PACE (HCA website)

CFR 42-438	Managed Care
CFR 42-460	PACE

Acronyms

AAA	Area Agency on Aging
ACES	Automated Client Eligibility System
AHC	Apple Health Foster Care
CC	Care Coordinator
CCW	Coordinated Care of Washington
CFC	Community First Choice
CMS	Centers for Medicare and Medicaid Services
COPEs	Community Options Program Entry System
DDA	Developmental Disability Administration
DSHS	Department of Social and Health Services
D-SNP	Dual Special Needs Plan
FFS	Fee-for-Service
FIMC	Fully Integrated Managed Care
HAP	Health Action Plan
HCA	Health Care Authority
HCS	Home and Community Services
HH	Health Home
LTSS	Long-Term Services and Supports
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
NFLOC	Nursing Facility Level of Care
PACE	Program for All Inclusive Care for the Elderly
PCCM	Primary Care Case Management
PO	PACE Organization
RSA	Regional Service Area
SSI	Supplemental Security Income
TPL	Third Party Liability

Glossary

Care Coordination	An approach to healthcare in which all of a patient's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the patient and the patient's caregivers and works with the patient to make sure that the patient gets the most appropriate treatment, while ensuring that health care is not duplicated.
Disenrollment	The process by which an enrollee's participation in a managed care program is terminated. Reasons for disenrollment include death, loss of eligibility, or choice not to participate, if applicable.
Fee-For-Service	A service delivery system where health care providers are paid for each service separately (e.g. an office visit, test, or procedure).
Long-Term Services and Supports	A wide variety of services and supports that help people with functional impairments meet their daily needs for assistance in qualified settings and attain the highest level of independence possible. LTSS includes both Home and Community-Based Waiver Services and Medicaid Personal Care Services.
Managed Care	A prepaid, comprehensive system of medical and health care delivery. - <i>Medical</i> : Includes preventive, primary, specialty care and ancillary health services - <i>Integrated</i> : Includes Medical services PLUS behavioral health and long term services and supports.
Third Party Liability	Refers to the legal obligation of third parties (e.g., entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a state plan. By law, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state plan.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
8/2/19	Integration Unit	Updated into new template	
5/9/23	Office of Policy and Integration	Split Chapter 22 into three parts: Chapter 22a, 22b, and 22c	

Web Resources

PACE

[DSHS – PACE webpage](#)

[HCA – PACE webpage](#)



Community Behavioral Health Supports (CBHS)

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Genevieve Boyle	Managed Care Systems Consultant (564) 999-3062	Genevieve.Boyle@dshs.wa.gov
Laura Botero	Managed Care Systems Consultant (564) 999-3089	Laura.Botero@dshs.wa.gov
Jennifer Torres-Salas	Managed Care Systems Consultant (360) 764-9240	jennifer.torressalas2@dshs.wa.gov
Kelli Emans	Senior Strategic Integration Advisor (360)725-3213	Kelli.emans@dshs.wa.gov

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BACKGROUND

Community Behavioral Health Support (CBHS) Services

In 2021, Legislation directed the Health Care Authority (HCA) and Home and Community Living Administration (HCLA) to work with Center for Medicare/Medicaid (CMS) on creating a Medicaid benefit under the HCA behavioral health benefit that would more fully support individuals with mental health needs in long-term care residential settings. The title of this new state plan program, which was implemented in July 2024, is Community Behavioral Health Support Services (CBHS). It is authorized under a 1915(i) State Plan amendment.

CBHS eligibility is determined by the Health Care Authority (HCA), this is not an HCLA authorized program or service.

You can find more information on the HCA website [Community Behavioral Health Support \(CBHS\) services](#) and on the [HCA billing guide](#).

Service provided under CBHS

CBHS provides Supportive Supervision and Oversight.

- Supportive supervision provides 1:1/enhanced in person monitoring, redirection, diversion, and cueing of the client to prevent at risk behavior that may result in harm to the client or to others.
- Services are individually tailored to help clients acquire, retain, restore and improve the self-help, socialization and adaptive skills necessary to reside successfully in community-based settings.
- These services assist clients in building skills and resiliency to support stabilized living and integration. Interventions are coordinated as appropriate with other support services, including behavioral health services.
- Interventions are not related to the provision of Personal Care.

Functional and Financial Eligibility for CBHS

For full CBHS eligibility requirements see [WAC 182-561](#)

Individuals may be eligible for CBHS if they:

- Are financial and functional eligible for Home & Community Services (HCS), as defined in WAC [388-106-0010](#) and
- Interested in residing or living in a long-term care residential setting
- Have a qualifying CBHS diagnosis
- Meet CBHS Risk Criteria

CBHS Risk Criteria

An individual must meet one or more criteria under Risk Criteria #1, **AND** one or more criteria under Risk Criteria # 2 OR #3 as outlined in the CBHS referral form [HCA 13-0124](#)

- Risk Criteria #1: The client's care needs can only be served through CBHS as evidenced by meeting at least one of five risky behaviors over the past year or having a history of them **AND**



- **Risk Criteria #2:** The client has a history of being unsuccessful in community living settings **OR**
- **Risk Criteria #3:** The client has past psychiatric history, where significant functional improvement has not been effectively maintained without CBHS

Residential provider types allowed for CBHS:

- Adult Family Home (AFH)
- Assisted Living Facilities (ALF)
- Enhanced Adult Residential Care Facilities (EARC)
- Adult Residential Care Facilities (ARC)
- Enhanced Services Facilities (ESF)

Who determines CBHS Eligibility, tiering and authorizes payment for CBHS?

- **Referral:** Home and Community Services case manager completes the referral.
- **Eligibility:** HealthCare Authority determines CBHS eligibility.
- **Tiering:** CBHS level of service (tiering) is determined by Managed Care Organizations (MCOs) for MCO enrollees and HealthCare Authority for Fee-for-Service (FFS) clients.
- **Authorization:** The Managed Care Organization authorizes for MCO enrollees; HealthCare Authority (HCA) authorizes CBHS for Fee for Service (FFS) clients.
- **Payment:** Payment for Supportive Supervision services is divided into six tiers. HCA and the MCOs use the information in the [tier guidance table](#) to determine the appropriate level of care.

CBHS Referral Process

When to submit the CBHS Referral form

- **Initial referral** (clients who are not on CBHS): CBHS referrals should only be submitted at the time of the client's Initial/Re-Apply, Annual and Significant Change CARE Assessment.
- **Renewal referrals** (clients who are on CBHS): CBHS referrals should be submitted at the time of the client's Annual and Significant Change CARE Assessment.

- It is important to review services with the client.
- Does the client appear to meet CBHS eligibility?
- Is the client agreeable to the service?
- Would the client benefit from 1:1 enhanced in person monitoring, redirection, diversion, cueing, or supportive supervision?

CBHS Referral Workflow:

When a qualifying CBHS diagnosis is entered in CARE assessment 'medical screen', a message will appear in the Behavior Screen: *"Based on selected diagnosis, client may be eligible for Community Behavioral Health Support Services."*

Community Behavioral Health Support (CBHS) Services/1915i

Based on selected diagnoses, client may be eligible for [Community Behavioral Health Support Services](#). Please see Help screen for additional eligibility criteria and referral instructions.

Was a referral made for CBHS/1915i eligibility?

- Assessor to review [CBHS Brochure](#) and CBHS eligibility with client/AREP
- Determine with the client/AREP interest for CBHS services and if they appear to [meet risk criteria](#)
- If client is interested in CBHS supportive supervision and appears to meet CBHS eligibility criteria:
- The referring case manager to complete sections 1 and 2 of the CBHS referral form [HCA 13-0124](#)
 - If a residential provider is NOT identified in section 1 see CBHS referrals when there is no residential provider identified

To assist with the CBHS Eligibility process, case managers can add additional information in the comment boxes to questions 2 & 3 to clarify the need for CBHS.

Where to submit CBHS referrals:

Emails for clients assigned MCO/HCA Medicaid plan can be located on page 1 of the CBHS referral form [HCA 13-0124](#)

- Confirm client is active on an LTC Medicaid program
 - Client pending Medicaid due to hospitalization stay: If client is hospitalized (Not in a State Hospital) and financial is awaiting confirmation of the transition to the community before they can turn on Medicaid see [Provisional CBHS referrals for clients in an acute/psych hospital or state hospital setting pending Medicaid eligibility](#).
- Review ProviderOne Details – Managed Care Screen
 - For clients who have a Managed Care plan identified as Fully Integrated Managed Care (FIMC) or Behavioral Health Services Only (BHSO), send the CBHS referral packet to the clients assigned Managed Care Plan using the email identified on page 1 of the CBHS referral form.
 - For clients without an identified FIMC or BHSO program BUT confirmed active on Medicaid in Fee- For- Service (FFS), send the CBHS referral packet to Fee-for Service (FFS) email identified on page 1 of the CBHS referral form.

What is submitted with the CBHS referral?

The HCS/AAA Assessor is responsible for submitting a completed CBHS referral package- see below

- CBHS referral form [HCA 13-0124](#)



- CARE Assessment Details
- CARE Service Summary
- Behavior Support Plan (for RSW Behavior Support clients)
- [Case Manager to use the CBHS Email Template](#)

If additional clinical information is needed, the MCO/HCA will follow up with the medical provider, residential provider or hospital to obtain required information to determine CBHS eligibility.

- The referring case manager can provide the medical providers' contact information to the MCO/HCA if needed.

Case Managers **should not** be providing third party clinical documentation to the MCO/HCA. HCA/MCO should obtain information directly from medical providers.

Referral timeline for CBHS referrals:

- The MCO or HCA will confirm receipt with the Case Manager in two business days.
 - Clients in an inpatient setting: CBHS referrals will be reviewed and returned within 7 business days. **Staff to use the Subject line: CBHS Referral – Inpatient [DSHS Secure]**
 - Clients not in an inpatient setting: CBHS referrals will be reviewed and returned within 13 business days. **Staff to use the Subject line: CBHS referral [DSHS Secure]**

What additional steps are needed if no provider is identified at the time of the CBHS referral?

- If an accepting residential provider is not identified at the time of the CBHS referral and client is found eligible for CBHS, Section 5 – CBHS service authorization – will be returned without authorization dates. The assessor must:
- Notify the MCO/HCA once an accepting provider and transition date has been identified via email and request a finalized CBHS form.
- The assessor must provide the facility name, Provider Name, Email, address and phone number AND transition date.
- [No Provider Email Template Link](#)
- HCA/MCO will send the completed form back to the referring case manager and to MCOBHOforms@dshs.wa.gov

Provisional CBHS referrals for clients in an inpatient setting (state or community hospital) pending Medicaid eligibility.

For clients who have been assessed and confirmed to meet both the functional and financial eligibility requirements for Home and Community Services (HCS), but whose Medicaid is still pending due to their inpatient status, it is possible for them to request CBHS.

A provisional approval does not guarantee authorization of services or service level for CBHS services. Instead, it indicates that the client is *functionally eligible* and may receive CBHS services once Medicaid becomes active. Final service authorization is contingent upon Medicaid approval. See process below:

State hospital clients:

- Confirm client is financially eligible from Public Benefits Specialist (PBS) and functionally eligible.
- Case manager to send CBHS referral to the client's assigned managed care plan using the email identified on the referral form. (i.e. Your client is pending transition from a State Hospital)

Acute/Community Psych hospital clients:

- Confirm client is financially eligible from Public Benefits Specialist (PBS) and functionally eligible.
- Case manager to send CBHS referral for clients who have not been assigned a managed care plan to HCA using the email identified on the referral form.

How does HCA determine CBHS eligibility dates?

New Referrals (Initial/Re-Apply CARE Assessment)

- For new referrals received by the 20th day of the month, the effective date is the first day of the month in which the referral was received.
 - Example: If HCA receives the CBHS referral for a new CBHS client on March 15th, CBHS eligibility will begin March 1st.
- CBHS eligibility is authorized for 12 months at a time.

Annuaals or Significant Change CARE Assessment (CBHS renewals)

- CBHS referrals submitted, CBHS eligibility start date effective the first day of the following month.
 - Example: The CBHS referral is submitted on March 12th, CBHS is approved, CBHS eligibility will start the following month on April 1st.
- Exception: If CBHS eligibility ends before the first of the following month, the eligibility date will be the first of the month after CBHS eligibility ends.

CBHS Approvals – What constitutes a completed CBHS referral

A CBHS referral is fully approved when
CBHS eligibility (Section 4) has:

- “Meets Functional Eligibility” AND “Meets Financial Eligibility” selected AND
- 1915i Eligibility dates are identified

AND

CBHS service authorization (Section 5) has

- Supportive Supervision tier selected AND
- Service Authorization dates identified AND

- Signature and date

Steps to take when a CBHS referral is approved

- Notify client/AREP and send the completed CBHS approval form to the residential provider along with the CARE Assessment details and Service Summary.
- Add CBHS treatment: *Supportive Supervision and Oversight* to the CARE Assessment in treatment section.
 - Frequency: QD (once daily)
 - Provider: Assign to residential provider
- Send the completed CBHS referral form to DMS via dshs.altadms@dshs.wa.gov
- Set a reminder (CARE tickler) for at least 30 days before the end of the CBHS approval period (*end date noted in Section 4 of CBHS form*).
- Document approval in an SER note using “CBHS/1915i” purpose code.
 - SER sample “Received authorization for CBHS services from [HCA or MCO plan name] Client has been approved for supportive supervision and oversight at Tier _ (1-6). Approval dates ___ to ___.”

Steps to take when a CBHS referral is provisionally approved

A provisional approval does not guarantee authorization of services or service level for CBHS services. Instead, it indicates that the client is *functionally eligible* and may receive CBHS services once Medicaid becomes active. Final service authorization is contingent upon Medicaid approval.

Once client’s Medicaid is active and client has transitioned to a residential LTC setting:

- Case manager reviews for MCO assignment
- Case manager sends the following via email to client’s assigned MCO for tier level determination and finalized form:
 - CBHS provisional approval
 - Assessment Details and Service Summary
- [Steps to take when a CBHS referral is approved.](#)

The MCO and HCA will finalize sections 4 & 5 of the CBHS referral and send the completed form back to the case manager.

Steps to take when a CBHS approval is pending identifying a residential provider

If an accepting residential provider is not identified at the time of the CBHS referral and client is found eligible for CBHS, Section 5 – CBHS service authorization – will be returned without authorization dates. Once an accepting residential provider is identified the assessor must:

- Notify the MCO/HCA once an accepting provider and transition date has been identified via email and request a finalized CBHS form.



- The assessor must provide clients name, ProviderOne, the facility name, Provider Name, Email, address and phone number AND transition date.
- [No Provider Email Template Link](#)
- HCA/MCO will send the completed form back to the referring case manager and to MCOBHOforms@dshs.wa.gov
- [Steps to take when a CBHS referral is approved.](#)

Steps to take when the CBHS referral is denied:

- Notify client of CBHS decision.
- Document denial in a SER note using "CBHS/1915i" purpose code
- Send the denied referral form to DMS dshs.altsadms@dshs.wa.gov
- Send the denied CBHS referral form to the residential LTC provider.
- Document denial in a SER note (include explanation of client not meeting CBHS eligibility found in section 4 of the referral form)

NOTE: Financial does not need to be notified of CBHS being opened or closed.

Required Notifications to MCOs and HCA for CBHS approved clients

Notifications are required to the MCO/HCA, via a Change of Circumstance form (16-275), when:

- The client is planning or has already moved to a different residential LTC setting.
- Client is hospitalized and will not be returning to LTC residential setting.
- The MCOs and HCA open and close authorizations for CBHS. Client/AREP/Guardian is no longer interested in receiving CBHS service.
- Client's LTC services are closing.
- Client passed away

Steps for Case Managers completing Change of Circumstance form:

- Communicate to the MCO/HCA with the Change of Circumstance form: Community Behavioral Health Supports (CBHS) [DSHS Form 16-275](#)
- Send copy of 16-275 to DMS dshs.altsadms@dshs.wa.gov
- If CBHS is no longer needed due to reasons above, CM will:
 - Document the closure in a SER under the CBHS service code.

- For CBHS ending mid-plan period: Update the assessment to remove supportive supervision treatment and send the provider the updated CARE Assessment and Service Summary.

CBHS Re-tiering Guidance

Residential providers in consultation with clients can submit the [Supportive Supervision re-tiering request form \(CBHS\) \(HCA 13-0126\)](#) to request an increase or decrease in the client's CBHS Supportive Supervision tiering.

- The requestor (Provider or client) must support, with data, any increase or decrease in the client's behaviors that result in the need for change in the client's one-on-one support.
- Re-tiering requests are requested by the LTC residential provider, *not the HCS/AAA case manager* and determined by the MCO and HCA for FFS clients.
- The LTC provider should remain in contact with the MCO/HCA (FFS) when a re-tiering request is made.

Can clients receive Residential Support Waiver and CBHS services concurrently?

- CBHS is the first program of consideration for 1:1/enhanced staffing in a residential setting consistent with the requirement of state plan services authorized before waiver services
- **If eligible for both programs (CBHS and RSW), clients must access CBHS for the 1:1/enhanced staffing, as CBHS supportive supervision is a state service plan.**
- If CBHS is denied, clients can access RSW (SBS, CSS, ESF) for their 1:1/enhanced staffing needs.
- Clients who decline CBHS 1:1/enhanced staffing may access supplementary behavioral support through ECS
- **Declining a referral for 1:1/enhanced staffing through CBHS will also be a decline for the 1:1/enhanced staffing referral through RSW (SBS, CSS and ESF).**

See [LTC Manual Chapter 7F – Residential Support Waiver](#) to review criteria and services under RSW

RESOURCES

Related WACs and RCWs

- Community Behavioral Health Supports [WAC 182-561](#)
- Community Behavioral Health Supports Eligible diagnosis [WAC 182-561-0700](#)
- LTC Functional and Financial Eligibility [WAC 388-106-0010](#)

Acronyms

AAA	Area Agency on Aging
ACES	Automated Client Eligibility System
CBHS	Community Behavioral Health Support
CFC	Community First Choice
CMS	Centers for Medicare and Medicaid Services
COPEs	Community Options Program Entry System
DSHS	Department of Social and Health Services
D-SNP	Dual Special Needs Plan
FAQ	Frequently Asked Questions
FFS	Fee-for-Service
FIMC	Fully Integrated Managed Care
HCA	Health Care Authority
HCS	Home and Community Services
HRSN	Health-Related Social Needs
IBSS	Intensive Behavioral Supportive Supervision
ILOS	In Lieu of Service
LTSS	Long-Term Services and Supports
MAGI	Modified Adjusted Gross Income
MCSC	Managed Care Systems Consultant
MCO	Managed Care Organization
NFLOC	Nursing Facility Level of Care
PBS	Public Benefits Specialist
PCCM	Primary Care Case Management
PCM	Primary Case Manager
SSI	Supplemental Security Income

Glossary (if needed)

WORD	DEFINITION
Long-Term Services and Supports	A wide variety of services and supports that help people with functional impairments meet their daily needs for assistance in qualified settings and attain the highest level of independence possible. LTSS includes both Home and Community-Based Waiver Services and Medicaid Personal Care Services.
Managed Care	A prepaid, comprehensive system of medical and health care delivery. - <i>Medical</i> : Includes preventive, primary, specialty care and ancillary health services - <i>Integrated</i> : Includes Medical services PLUS behavioral health and long-term services and supports.
Fee-For-Service	A service delivery system where health care providers are paid for each service separately (e.g. an office visit, test, or procedure).



Community Behavioral Health Supports	CBHS under 1915 (i) State Plan WAC 182-561-0400 covers one-on-one supportive supervision for clients enrolled in Long-Term Care Services who have complex behaviors related to a qualifying mental health diagnosis. CBHS eligibility is determined by the Health Care Authority.
Intensive Behavioral Supportive Supervision	IBSS is an In Lieu of Service that provides funding for one-on-one supportive supervision. IBSS is a service of last resort that supports people with cognitive impairment and complex behaviors in community residential settings. IBSS is available for clients enrolled under HCLA for both HCS and DDOS clients.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
9/2/2026	Laura Botero; Genevieve Boyle; Jennifer Torres-Salas	New Chapter 22d	H26-015
7/15/2026	Laura Botero, Jennifer Torres-Salas; Genevieve Boyle	Formatting and grammatical corrections Clarified processes for policy for CBHS approvals, denials, provisional & pending provider approvals.	

OTHER MANAGED CARE ORGANIZATION (MCO) FUNDING

Appendix I Behavioral Health Wraparound Supports (BHWS)

Behavioral Health Wraparound Support (BHWS) provides additional personal care hours in addition to the CARE generated hours for in-home clients only with a primary diagnosis of a serious mental health diagnosis. The client's behavior(s) or symptom(s) of the mental health diagnosis(es) are the primary reason for the client's need for assistance with personal care.

BHWS information can be found in the [LTC Chapter 22a](#).

Appendix II Intensive Behavioral Supportive Supervision (IBSS)

Intensive Behavioral Supportive Supervision (IBSS) is a voluntary In Lieu Of Service (ILOS) available to Apple Health (Medicaid) clients enrolled with a Managed Care Organization (MCO). ILOS is managed by



the MCOs, in coordination with Health Care Authority (HCA). Providers are contracted and paid directly by the MCOs.

IBSS should only be considered after all other state plan and waiver program (CBHS, RSW etc.) have been explored by the case manager.

Residential providers will need to communicate directly with MCOs and MCOs will need to assist residential providers with the contracting and billing processes. Once the MCO receives the IBSS referral, it is their responsibility to complete the clinical review to determine IBSS eligibility and tiering.

Where to find additional information for IBSS:

- [HCA Webpage](#)

HCS/AAA Case Managers role when IBSS is approved:

- Case manager (CM) will document in a Service Episode Record SER regarding IBSS approval using purpose code "Information & Referral".
- Document that the client was approved for IBSS and by which MCO.
- CM to add "other" under treatments in the medical screen in CARE; Frequency: QD (once daily)".
- Assign residential provider "other" treatment in CARE Support Screen.
- Document that the client was approved for IBSS and by which MCO.



Quality Assurance and Improvement

The purpose of this chapter is to explain quality assurance and quality improvement (QA and QI) activities, processes, and expectations.

Ask the Expert

If you have questions about Social Services QA/QI, please contact:

Bill McBride QA Unit Manager
360.725.2604 william.mcbride@dshs.wa.gov

OR

Kristian Rodriguez QA Policy Program Manager
360.725.2623 kristian.rodriguez@dshs.wa.gov

If you have questions about Financial QA/QI, please contact:

Bill McBride QA Unit Manager
360.725.2604 william.mcbride@dshs.wa.gov

If you have questions about Adult Protective Services quality assurance, please contact:

APS Quality Assurance Unit
APSQAUnit@dshs.wa.gov

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BACKGROUND

The purpose of this chapter is to outline QA/QI activities and responsibilities for Aging and Long-Term Support Administration (ALTSa), Home and Community Services (HCS) Division.

To provide quality, well-planned, efficient, and accountable home and community-based care is one of the central missions of ALTSa. The development of a Quality Assurance (QA) system is critical in accomplishing this mission. This QA system encompasses both financial and social services quality assurance/improvement and includes activities such as:

1. Quality assurance procedures that will enable ALTSa to evaluate and ensure its ongoing compliance with Federal Funding Participation (FFP) thus ensuring federal match for ALTSa programs, Centers for Medicaid and Medicare Services (CMS) protocols, Home and Community Based Service waiver requirements, and State and Federal law;
2. Gathering a consistent broad range of information to identify trends, strengths and areas for improvement across all programs;
3. Identifying training needs for quality improvement. Development of training is necessary to address trends at all levels – individual, local unit, regional/Area Agency on Aging (AAA), and statewide;
4. Identifying best practices within HCS and AAA operations with the purpose of sharing strategies across the state;
5. Collecting client feedback to determine satisfaction with the services;
6. Within the electronic QA Monitor Tool, assessing compliance with existing regulations, policies and standards;
7. Reviewing the overall quality of client cases, focusing on the quality and accuracy of the assessment, care plan, and determining whether issues identified in the case regarding quality of care are responded to in a timely manner;
8. Reviewing the level of care determinations to assure that clients require the care and services for which they have been authorized;
9. Confirming provider qualifications;
10. Verifying that mandatory referrals are being made;
11. Assuring that client services and payments for those services are appropriately authorized and paid; and
12. Assuring that clients are financially eligible for Long-Term Care (LTC) services.



WHY IS QUALITY ASSURANCE AND QUALITY IMPROVEMENT IMPORTANT

All staff are invested in ensuring that quality services are being provided to the clients served by the department. Looking at quality from a global perspective, the reasons we do quality work are to:

- Ensure that all services promote the health, safety, and self-determination of the people we serve; and
- Make sure that the department is accountable to the state and federal stakeholders who provide funding for the services provided to our clients.

So much of what HCS does is to help the client obtain appropriate quality services to maximize their independence, dignity, and quality of life. The client is the ultimate beneficiary of our quality assurance and quality improvement activities.

In addition, we are accountable to the state and federal governments. About half of every dollar that is spent on our state's long-term services and supports programs is "matched" by the federal government. But, in order to get that match, ALTSA has to provide information to the federal government (CMS) to show that we are accountable for the funds we receive and that we are meeting their quality standards. CMS establishes quality standards for all states with regard to:

- waiver oversight
- client level of care assessments
- independence and choice
- person-centered client service plans
- client health and welfare
- provider qualifications, and
- financial accountability for the funds spent

In fact, if ALTSA cannot provide the evidence to CMS to show that we are meeting their quality standards, they could:

- Not approve of our waiver or state plan programs
- Not renew our existing programs
- Put a moratorium on waiver enrollments
- Withhold the federal match for services until compliance is achieved
- Impose financial penalties
- Require the state to hire an outside technical contractor to help develop compliance protocols and activities



- Take other actions as determined by the CMS Secretary

In addition to the federal compliance requirements, our state has developed additional quality standards based on important issues and priorities such as Skin Observation Protocol, nursing referrals, and client treatment questions.

PHILOSOPHY

Everyone is invested in quality – the goal of HCS has always been for HCS Headquarters (HQ), the Regions, and AAAs to work collaboratively toward quality assurance and improvement. Though a compliance review will always be required, the focus is moving to a more collaborative quality improvement process. The quality approaches and processes within this chapter support these goals and meet the state and federal monitoring requirements.

CMS REQUIREMENTS

Much of the work that we do has a federal overlay. The Centers for Medicare and Medicaid Services (CMS) requires states to provide evidence of discovery, remediation, and continuous quality improvement by developing and reporting on one or more performance measures for each CMS prescribed assurance and sub-assurance. States work with CMS to define their own performance measures based on the CMS requirements.

CMS defines four functions of a quality improvement cycle. These functions are Design, Discovery, Remediation, and Improvement. In order to maintain our waivers, CMS requires evidence that these functions are being implemented in a quality improvement strategy.

Design

Design is the process for describing how monitoring will occur and how issues will be addressed when detected. It is the plan for how the state will proactively strive for quality by identifying and addressing areas for improvement.

Discovery

Discovery is the process of gathering data and information on service participants to determine if there is adequate access to services and supports; the services and supports are delivered as indicated in their plan of care; that health and welfare is achieved; only qualified providers are used; and payments are accurate. Both positive and negative issues are identified.

Remediation

Remediation is the process of correcting individual problems that are discovered during the discovery process. The federal standard of compliance is 100%. This means that to reach the 100% required remediation, ALL identified QA findings must be addressed and resolved. The evidence report must include how many problems were identified (i.e., those issues with less than 100% compliance), how and when each problem was corrected, and the outcome of each issue.



Improvement

Quality Improvement includes changes at a systemic level to increase proficiency and improve the outcome of issues that were identified.

CMS FEDERAL ASSURANCES

To see how this all ties in together, the CMS Assurances, Sub-Assurances, and Performance Measures document is located at: <http://adsaweb.dshs.wa.gov/hcs/QA/>.

RESOURCES

Related WACs and RCWs

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #



Quality Assurance and Improvement – Social Services Monitoring

Chapter 23A describes the Quality Assurance process reviews mandated by the Centers for Medicare and Medicaid (CMS). This chapter includes the sampling methodology, timeframes, and requirements from field staff.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

William McBride Quality Assurance Unit Manager
360.725.2604 william.mcbride@dshs.wa.gov

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QUALITY ASSURANCE UNIT MONITORING PROCESS OVERVIEW

- All HCS and AAA case manager who have completed a CARE assessment are eligible to have a QA process review completed.
- A statistically valid sample of clients is pulled statewide.
 - Samples are pulled for waiver programs, CFC, and other state plan programs, and per focused review type.
- Each area's sample is pulled based on the percent of population for each program in each geographical area (see sampling below).
- The updated 12-month QA Monitoring Schedule is available on the QA intranet site. If dates or number of reviews change from the original release at the beginning of the monitoring year, which is distributed in a Management Bulletin (MB), the updated information can be found on the [QA intranet site](#).
- Initial QA Process Review Notice will go out to each area prior to the start of each area's process review cycle.
- Monitoring occurs at headquarters; therefore, all required documents must be in the Document Management System (DMS) prior to QA process review.
- Areas have 3 working days to address high priority issues (client safety, payment, and financial eligibility errors) identified during the review.
- An Exit Conference is optional and conducted via video conferencing using TEAMS at the completion of the review.
- Areas have 30 calendar days to make required corrections.
- QA conducts a 30-day review to document remediation.
- Issues identified in the 30-day QA Process Review as not fully remediated must be corrected within 30 calendar days for the 60-day QA Process Review.
- QA conducts a 60-day Process Review and documents remediation.
- QA completes the Regional/AAA Final Report which is a summary of all QA Unit findings for that Region/AAA.
- Questions below the expected proficiency level will need to be addressed in the area's Proficiency Improvement Plan (PIP).

- QA completes the statewide Final Report which is a summary of all QA Unit findings for the annual review for all Regions and AAAs.

Sampling

CMS requires compliance monitoring utilize a statistically valid sample. For determining population size for sampling, the state is allowed to combine waiver programs: CFC+COPES, Residential Service Waivers (RSW), and New Freedom into one population. This population must be stratified by waiver program when the distribution of the sample is determined.

The QA unit uses Raosoft to help determine the statistically valid sample size. The parameters used in Raosoft are to following: 5% Margin of Error, 95% Confidence Level, and 50% Response Distribution.

- **Margin of Error:** The margin of error is the amount of error that you can tolerate. If 90% of the respondents answer *yes*, while 10% answer *no*, you may be able to tolerate a larger amount of error than if the respondents are split 50-50 or 45-55.
- **Confidence Level:** The confidence level is the amount of uncertainty you can tolerate. Suppose that you have 20 yes-no questions in your survey. With a confidence level of 95%, you would expect that for one of the questions (1 in 20), the percentage of people who answer *yes* would be more than the margin of error away from the true answer. The true answer is the percentage you would get if you exhaustively interviewed everyone. Higher confidence level requires a larger sample.
- **Response Distribution:** For each question, what do you expect the results will be? If the sample is skewed highly one way or the other, the population probably is, too. If you don't know, use 50%, which give the largest sample.

Sampling example to determine statistical sample size:

- There are the following authorizations in the state:
 - COPES = 38,468
 - RSW = 2,046
 - New Freedom = 426
 - TOTAL POPULATION = 40,940
- Using Raosoft to determine a statistically valid sample size of the total population of 40,490 using a 5% margin of error, 95% confidence level, and 50% response distribution will yield a statewide sample size of 382 cases to be reviewed.

Increasing sample size while stratifying waiver programs:

Beginning in 2018, CMS required the statewide sample size to be stratified between the three waiver programs: COPES, RSW, and New Freedom. Further, the state has the discretion to increase the sample size over the minimum statistically valid amount. Using Raosoft and adjusting either the Margin of

Error, Response Distribution or both, a sample size for each waiver program is generated so that the total files to be reviewed are equal to or greater than the statewide sample size of 382.

Adjusting the formula to a 7% Margin of Error, 95% Confidence Level, and 70% Response Distribution and uniformly applying this formula to each individual program yields the following results:

- COPEs (38,468 cases) = 164
- RSW (2,046 cases) = 153
- New Freedom (426) = 119
- TOTAL REVIEWS TO BE COMPLETED: 436.

Note: Since the total files to be reviewed is greater than 382, this is an acceptable stratification of the waiver programs. The new statewide sample size is now 436

Determining the number of files to review per HCS/AAA office

QA determines the number of cases to be reviewed per HCS and AAA based on how much that area contributes proportionally to the total statewide population (see sampling example below).

- Region X has 1,565 COPEs cases which = 3% of the statewide total.
- 3% of 164 is 4.92 or 5.
- Region X will have 5 COPEs cases reviewed.

This sampling process is repeated for each Regional and Area Agency on Aging (AAA) office.

Monitoring Schedule

A QA monitoring schedule will be distributed by MB prior to the annual monitoring cycle. The schedule will include the following activities:

1. Each Region's process review cycle and timelines (initial, 30-day and 60-day Reviews)
2. Exit Conference dates
3. Final Report due dates
4. Statewide activities such as New Freedom Financial Management Service Reviews, QA Consultations, and various client survey and service verification activities.

QA Process Review Notices

An Initial QA Process Review Notice will be emailed to each area prior to the start of each area's process review cycle. The QA Review Notice will identify the begin dates and end dates of the process review cycle; the number of regular file reviews; and the number of focus reviews to be completed.



Exit Conferences

1. Exit Conferences are optional. The QA lead will ask the Regional Administrators and/or the Area Directors if they wish to have a QA Exit Conference at the time the office is notified of their upcoming initial review. If a QA Exit Conference is requested, the conference will be conducted through MS Teams by the QA Lead and the QA Unit Manager with the following staff who may be attending via MS Teams or phone.
 - a. HQ staff, including QA Policy Program Manager, AAA Liaison, SUA Office Chief, HCS Chief of Field Operations, and
 - b. Regional/AAA Management and line staff at the discretion of the management team.
2. The QA Unit presents the following in power point format:
 - a. What QA reviewed
 - b. QA questions that met or exceeded proficiency.
 - c. QA questions that did not meet expected proficiency.
 - d. Why proficiency was not met.
 - e. Remediation, Change Request, PIP process; and
 - f. 30-day due dates.

Notification of 3-Day Response Time Issues

1. QA Lead will notify the Region/AAA contact of a 3-day response issue at the end of each monitoring day.
2. Action must be initiated and documented within 3 working days after notification.
3. QA staff will verify at the 30-day review if each 3-day remediation was initiated within the appropriate time frame.

30-Day and 60-Day QA Process Reviews

CMS requires full remediation on **all** QA findings at the individual level that do not meet 100% proficiency.

1. All QA findings that require remediation must be completed within 30 calendar days. All documents needed for remediation verification will need to be scanned and emailed to the QA



Lead and a copy of the scanned document(s) should be made available in DMS by the 30-day due date. If the documentation is required in the client Service Episode Record (SER), add it directly into the SER. If the remediation requires an interim CARE assessment, it must be moved to current and synchronized for QA viewing online prior to the 30-day due date.

2. Remediation documentation completed by the field is analyzed by Quality Assurance Staff (QAS) at the 30-day review.
3. Any outstanding QA findings after the 30-day process review are identified on the “Cases Requiring Action” report and that remediation are expected to be completed by the 60-day due date. The QA Lead is available to the Region/AAA to help on any outstanding issues.
4. Remediation documentation completed by the field will be analyzed by QAS at the 60-day review.
5. All QA findings that are still outstanding after the 60-day review will be reviewed with the Region/AAA contact who will be expected to have the QA finding fully remediated. The Region/AAA contact will need to inform the QA Lead when the finding is fully remediated so that final analysis can be completed.
6. Remediation completed after the 60-day due date will be documented as to why the remediation was not made within the time frame allotted and how much time past the due date remediation occurred. Remediation time frames will be included in the Final Region/AAA Report.
7. All issues that cannot be resolved will be forwarded to the Executive Management team for action.

CHANGE REQUEST COMMITTEE

The intent of the Change Committee is to interpret policy, make decisions on change requests, and make recommendations if policy is not clear.

1. The Change Committee consists of the following members:
 - a. QA Policy Program Manager (facilitator and active member);
 - b. Standing Members: Case management unit manager or representative; Waiver Program Manager or representative; CFC Program Manager or representative.
 - c. QA Lead for the area.
 - d. SUA lead or representative.
 - e. The field monitoring contact (either in person or by telephone); and



- f. Other managers depending on the policy under discussion (e.g., IP Program Manager, Nursing Program Manager, Representative from APS, etc.).

2. Change Committee Process:

- a. Prior to submitting a change request the field's representative must determine if the finding in question has been previously heard by the Change Committee and thus a precedent-setting decision was made.
- b. For change requests that may be taken to the Change Committee, the local office documents the requested change in the Review Cycle Notes (RCN), using "QA Change Request" drop down. The QA Lead will review the requests.
- c. QA reviews the issue and makes corrections if a QA process review error has been made. Consultation with a policy program manager may occur if needed for clarification.
- d. The QA team reviews prior decisions by the Change Committee. If the issue is the same, the QA Unit will make the change based on the Change Committee's prior decision. These issues are not forwarded to the committee.
- e. Issues not corrected by the QA Unit, or which have not had a previous decision are forwarded to the Change Committee and documented in the SharePoint database.
- f. The QA Lead sets up the Change Committee meetings with at least a three-day advanced notice of the meeting date according to the QA calendar. If possible, the QA lead will provide more notice. The meeting notice will include a write-up of the Change Request. The QA Lead invites the appropriate HQ program managers to the meeting.
- g. The Change Committee:
 - i. Reviews the change request documentation
 - ii. Hears the field's analysis
 - iii. Hears the QA Lead's analysis; and
 - iv. Consults with other managers if the issues relate to their program.
- h. If a decision cannot be made within the Change Committee, the QA Policy Program Manager will have it addressed at the Executive Management level whose decision is final.
- i. If the Change Request is approved, QAS will change the "no" to a "yes" or "NA". If the change is not approved, the Region/AAA contact will ensure the corrections are made. QAS documents the decision in the RCN.
- j. The QA Policy Program Manager documents the decision in the SharePoint database.
- k. If changes to policy are recommended, the QA Policy Program Manager identifies who will be responsible for follow-up and response to, or completion of, the recommended policy change.

- I. At the end of the process review cycle, the QA Policy and Unit Managers review the Change Requests for possible impact on the next review cycle.

FINAL LOCAL REPORT SUMMARY AND COVER LETTER

1. After the 60-day process review, the QA Lead prepares the “Final Report Summary” which includes:
 - a. Attachments of the local reports; and
 - b. The Proficiency Improvement Plan template.
2. PIPs from the AAA offices will be reviewed and signed by the State Unit on Aging Office Chief or representative. PIPs from HCS Regional Offices will be reviewed and signed by the Deputy Director of Field Operations or representative.
3. The Final Report is due to the AAA Directors/Regional Administrators within 30 calendar days after completion of the 60-day QA process review.

PROFICIENCY IMPROVEMENT PLAN (PIP) FOR SOCIAL SERVICES MONITORING

A PIP outlines a plan for increasing future proficiency. The threshold for when a PIP is required will be specified in the QA Exit Conference. Both HCS HQ and the Regions/AAAs are responsible for developing and implementing a PIP.

1. Regional/AAA action is required for PIP development (based on initial findings). A Regional/AAA PIP is not required for the current QA Unit review cycle:
 - a. When the required proficiency is reached on all QA questions.
 - b. When HCS HQ is conducting the PIP on a QA question that does not meet statewide proficiency.
2. Regions/AAA will use the PIP template provided for all questions below the expected proficiency level.
3. HQ will identify items that need to be addressed at a statewide level and develop a HQ PIP. Information/trainings in response to the HQ PIP will be maintained on the QA intranet site and should be utilized by the field offices.



4. Regions/AAAs are required to address all other items that did not meet proficiency, except those items being addressed in the HQ PIP. Items being addressed by HCS HQ may also be addressed on a local PIP if the Region/AAA wants to focus on improving local proficiency. The Region/AAAs will support and reinforce strategies to increase proficiency and supervisors will continue to work with individual staff to increase proficiency in identified areas.
5. AAA Specialist, designated delegate, and other HQ program managers are available to assist in development and revision of the PIP.
6. The Region/AAA must submit the PIP to the QA Lead within 30 calendar days from the date the Final Report summary was emailed. The QA Lead tracks the time frame, if the PIP has not been received within 30 calendar days, the QA Lead will notify the HCS Deputy Director of Field Operations or the SUA designated delegate for additional follow-up.

7. HQ Review and Approval

- a. **AAA** – When the PIP is received, the designated delegate and AAA specialist jointly review the plan. The field representative is contacted by email if there are recommended changes. If changes are needed, the revised document is reviewed with the SUA Office Chief, AAA Specialist, and SUA designated delegate; and approved.

The State Unit on Aging Office Chief or delegate by the State Unit on Aging Office Chief will be responsible for signing the PIP.

- b. **HCS** – When the PIP is received, the HCS Deputy Director of Field Operations reviews the plan. The field representative is contacted by email if there are recommended changes. If changes are needed, the revised document is reviewed with the HCS Deputy Director of Field Operations and approved.

The HCS Deputy Director of Field Operations or delegate by the HCS Chief of Field Operations will be responsible for signing the PIP.

8. Reporting Progress

- a. Regions/AAAs

- i. Progress reporting is unique to each item within the PIP and unique to each Region/AAA.
 - ii. The Region/AAA completes the “Progress Reporting Section” and sends it to the SUA designated delegate or HCS Deputy Director of Field Operations, when due. If the progress report is not received on time, the SUA designated delegate or HCS Chief of Field Operations will follow up with the field and notify Executive Management, if necessary.
- b. HQ
 - i. Upon review of the progress report the SUA designated delegate, AAA specialist or other management staff may share other ideas or strategies for quality improvement.
 - ii. The QA Unit Manager reports the HQ PIP status on an “as needed” basis and at least quarterly to Executive Management at a regularly scheduled
 - iii. Office Chief meeting.

ALTSA HCS Statewide PIP Process

1. The QA Policy Program Manager will develop a statewide PIP in collaboration with the QA Unit Manager, Wellness, Improvement, and Nursing Unit, and other program managers based on data in the review cycle Final Report and analysis/experiences/feedback/data, etc., provided by the QA Unit. Any QA question which has a statewide proficiency (for the previous process review cycle) of less than the approved threshold (86%) will require a HQ PIP. Prioritization of PIP timelines may be based on existing PIPs in process and workload impacts. Prioritization is given to those QA questions reported to CMS as part of the federal assurances and sub-assurances and where the client could be negatively impacted.
2. Implementation time frames are individually determined by items identified.
3. The HQ PIP will be reviewed and approved for implementation by Executive Management.

STATEWIDE FINAL REPORT

1. After the statewide review is completed, the QA team prepares the “Home and Community Services Quality Assurance Final Report” which includes:
 - a. Questions monitored
 - b. Changes to the QA review process, if applicable

c. Compliance results

2. The Aging and Long-Term Support Administration (AL TSA) Quality Assurance Administrator has final approval of the Home and Community Services Quality Assurance Final Report. This report is distributed and presented to the Executive Management team, the Medicaid Agency Waiver Oversight Committee, the HCS Regional Administrators, the AAA Directors, and the regional HCS/AAA offices. The report is also distributed to the State Auditor’s Office (SAO) and other stakeholders as requested. Once finalized the report is also posted on the QA intranet site.

SUPERVISOR MONITORING

The QA reviews completed by supervisors in the HCS and AAA offices are very important because they ensure that we are following CMS requirements, and that quality work is being completed by field staff. Supervisor QA reviews help identify training, staff performance, and policy issues. Supervisors review QA questions above and beyond the QA Unit process reviews, ensuring the health and welfare of the client. As a result, the supervisor’s role is a critical part of the foundation for overall HCS quality compliance.

HCS/AAA supervisors have the following quality assurance and improvement responsibilities:

1. Training
 - a. Annual Training Plan – Each Region/AAA will develop an annual training plan that outlines how mandatory and optional training will occur for new and experienced staff (employed one year or longer). This document is revised annually at the regional/AAA level. A separate plan does not need to be developed if these elements are included in the PIP.
 - b. Training Documentation Form – Supervisors will use a method of their choice to document training completed for new and experienced staff.
 - c. Monthly Manual Chapter – Supervisors must train all case management staff on at least one chapter of the LTC manual each month.
 - d. Trends Identified through Required Monitoring – Supervisors must identify individual training needs for their staff and arrange for the provision of that training.
2. Monitoring Results – Supervisors will use the “Reviewed Cases with Questions Requiring Action” report to ensure that corrections identified by the QA Unit have been completed.



3. Supervisor QA Monitoring – Supervisors must inform their staff of the QA monitoring process and expectations. Supervisors monitor that their staff are:
 - a. Creating an adequate need assessment.
 - b. Authorizing, providing, and terminating services in a timely manner.
 - c. Following department policies and procedures.
 - d. Correctly determining eligibility and funding sources; and
 - e. Completing required forms.
4. Supervisory Monitoring of New and Experienced staff:
 - a. New staff without CARE experience
 - i. Review of first five assessments –
 1. The goal is to provide training on correct assessment techniques and corrections can be made without having to create another assessment.
 2. Review must occur in a timely manner to meet the 30-day response time.
 - ii. After the first five, review 50% of assessments for the next 3 months.
 - iii. After 3 months, additional reviews are done at the supervisor’s discretion based on performance.
 - iv. Reviews must be completed using the QA Monitoring tool.
 - b. New Staff transferring within the ALTSA system with CARE experience
 - i. Evaluate skills by reviewing the first three assessments using local QA monitoring tools.
 - ii. Additional reviews are done at the supervisor’s discretion based on performance.
 - c. Experienced staff (1 year or more of CARE experience)
 - i. Random monitoring of three records per worker, over the course of a year.
 - ii. Use of the QA Monitor Tool is required, and reviews completed in the QA Monitor Tool will count toward the annual Supervisory reviews of three per year, per worker.
 - iii. The QA Unit will notify supervisors of their monitoring status mid-year.



HCS QUALITY ASSURANCE AND IMPROVEMENT INTRANET SITE

The HCS QA/QI Intranet Site (<http://adsaweb.dshs.wa.gov/hcs/QA/>) was developed for headquarters and field staff to learn more about quality assurance and quality improvement activities for HCS and the AAAs, and to share best practices.

The site contains information about and links to the:

- HCS QA monitoring schedules.
- List of the QA questions for the current process review cycle.
- Log of the QA Change Requests and Non-Concur requests submitted by field offices in response to QA Unit process review findings. (This has a searchable feature so offices can determine whether a same/similar finding was disputed in the past and the outcome of the disputed finding as determined by the Change and Non-Concur Committee.);
- Innovation center where social and financial workers, case managers, and supervisors can submit their ideas to the HCS QA Unit and program managers for improving and/or maintaining the quality of their work.
- Copies of the annual HCS QA process review reports.
- Updates about the statewide proficiency improvement projects in process by HCS Headquarters.
- State and Federal Audits of HCS; and
- Copies of Evidence Reports submitted to the Centers for Medicare and Medicaid Services for continued waiver renewal and approval.

Staff are encouraged to refer to this site at least quarterly for information and updates about HCS quality assurance and improvement.

AUTHORITY FOR POLICIES AND PROCEDURES

[Section 1915 \(k\) of the Social Security Act #17](#): Authorizes the Community First Choice (CFC) State Plan Amendment and requires that the State of Washington have a formal system in place for monitoring the quality standards outlined in the SPA and that all problems identified by monitoring are addressed.

[Section 1915 \(c\) of the Social Security Act #17](#): Authorizes the COPES Waiver and requires that the State of Washington have a formal system in place for monitoring the quality standards outlined in the waiver and that all problems identified by monitoring are addressed.

[RCW 74.39A.050](#): Requires DSHS to implement a LTC care QI system that focuses on consumer satisfaction and positive outcomes for consumers. This statute outlines 15 QA principles consistent with federal laws and regulation.



[RCW 74.39A.090:](#) Requires DSHS to monitor the degree and quality of case management services provided to elderly and disabled clients by AAA.

[RCW 74.39A.095:](#) Specifies the minimum elements that must be included in AAA oversight of care being provided to clients.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
1/2025	Bill McBride	Revision and updated formatting	



Quality Assurance and Improvement – Financial Services Monitoring

Chapter 23B describes the Quality Assurance process reviews that are mandated by the Health Care Authority (HCA). This chapter includes sampling methodology, timeframes, and requirements from the staff.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

William McBide

Quality Assurance Unit Manager

360.725.2604

william.mcbride@dshs.wa.gov

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FINANCIAL SERVICES MONITORING

Financial Quality Assurance Unit Monitoring QA Process Review

- A statistically valid sample is pulled for each regional area based on the combined number of completed financial applications and reviews that were processed for each region in an annual time period.
- The 12-month QA Monitoring Schedule is available on the QA intranet site. If dates or number of reviews change from original release at the beginning of the monitoring year, which is distributed in a MB, the updated information can be found on the [QA intranet site](#);
- An Entrance Conference letter is sent at the start of an areas' QA Process Review period.
- Monitoring occurs at headquarters.
- An Exit Conference is conducted via MS TEAMS at the completion of the review.
- The region has 30 calendar days to make required corrections.
- ALTSA QA staff conducts a 30-day review to document remediation.
- Issues identified in the 30-day QA Review as not fully remediated must be corrected within 30 calendar days for the 60-day QA Review.
- ALTSA QA staff conduct a 60-day review and document remediation.
- ALTSA QA staff complete the Regional Final Report which is a summary of all QA Unit findings for that Region.
- Questions below the expected proficiency level will need to be addressed in the area's Proficiency Improvement Plan (PIP).
- QA Unit Manager completes the statewide Final Report which is a summary of all QA Unit findings for the annual review for all Regions.

Sampling

- A statistically valid sample will be used for each region.
- The number of QA reviews being completed will be based on the combined number of applications and reviews that were processed for each Region per year.

Sampling example:

- 292 applications + 1,427 reviews in Month Y for Region X = 1,719
- 1,719 applications/reviews x 12 months = 20,628
- Statistically valid sample for Region X = 378

This sampling process would be repeated for each region.

Monitoring Schedule

A QA monitoring schedule will be distributed by MB prior to the annual monitoring cycle. The schedule will include the following activities:

1. Each Region's QA Process Review cycle and timelines (initial, 30-day and 60-day Reviews)
2. Entrance and Exit Conference dates
3. Final Report due dates

Entrance Conferences

The Entrance Conference email is sent prior to monitoring each regional area and provides information about:

1. The monitoring processes
 - a. Expectations
 - b. Philosophy
 - c. Changes to the QA process review, tool or questions from the previous year
2. Monitoring
 - a. Schedule
 - b. QA questions
3. Regional Reports
4. Exit Conference
5. 30-day Response QA questions
6. Remediation
7. Non-Concur Request Process
8. Proficiency Improvement Plan (PIP)

Exit Conferences for each Region

1. Exit Conferences are optional. The QA lead will ask the Regional Administrator if they wish to have a QA Exit Conference at the time the office is notified of their upcoming initial review. If a QA Exit Conference is requested, the conference will be conducted through MS Teams by the QA Lead and the QA Unit Manager with the following staff who may be attending via MS Teams or phone:
 - a. HQ staff, including the Chief of Field Operations, Chief of LTC Financial Eligibility & Policy, and
 - b. Regional Management and line staff at the discretion of the management team.
2. The QA Unit presents the following in power point format:
 - a. The Proficiency Improvement Plan (PIP) activities from the previous year for the area being reviewed and for the current year for HQ.
 - b. What QA reviewed.
 - c. QA questions that met or exceeded proficiency.
 - d. QA questions that did not meet expected proficiency.
 - e. Why proficiency was not met.
 - f. Remediation, Non-Concur Request, PIP process, and
 - g. 30-day due dates.

30-Day and 60-Day Reviews

Full remediation is required on **all** QA findings at the individual level that do not meet 100% proficiency.

1. All QA findings that require remediation must be completed within 30 calendar days. Remediation documentation completed by the field is analyzed by the ALTSA QA staff at the 30-day review.
2. Any outstanding QA findings after the 30-day review are identified on the “Cases Requiring Action” report and remediation are expected to be completed by the 60-day due date. ALTSA QA staff are available to the Region to offer assistance on any outstanding issues.
3. Remediation documentation completed by the field will be analyzed by the ALTSA QA staff at the 60-day review.
4. All QA findings that are still outstanding after the 60-day review will be reviewed with the Social & Health Program Manager (SHPM) or Regional Representative who will be expected to have the QA finding fully remediated. The SHPM or Regional Representative will need to inform the

Financial QA Program Manager when the finding is fully remediated so that final analysis can be completed.

5. Remediation completed after the 60-day due date will be documented as to why the remediation was not made within the time frame allotted and how much time past the due date remediation occurred. Remediation time frames will be included in the Final Regional Report.
6. All issues that cannot be resolved will be forwarded to the Executive Management team for action.

NON-CONCUR REQUEST COMMITTEE

The intent of the Non-Concur Committee is to interpret policy, make decisions on non-concur requests, and make recommendations if policy is not clear.

1. The Non-Concur Committee consists of the following members:
 - a. Chief of LTC Financial Eligibility & Policy.
 - b. Financial QA Program Manager.
 - c. Members of the LTC Financial Eligibility & Policy Unit; and
 - d. The QA Regional contact representing the field
2. Non-Concur Committee Process
 - a. Prior to submitting a non-concur request the SHPM/field representative would need to determine if the finding in question has been previously heard by the Non-Concur Committee and thus a precedent-setting decision was made.
 - b. For Non-Concur requests that may be taken to the Non-Concur Committee, the regional office documents the requested change in the Review Cycle Notes (RCN), using “QA Non-Concur” drop down. The ALTSA QA staff will review the requests.
 - c. The ALTSA QA staff review the issue and make corrections if a process review error has been made. Consultation with the LTC Financial Eligibility & Policy Unit may occur if needed for clarification.
 - d. The ALTSA QA staff review prior decisions by the Non-Concur Committee. If the issue is the same, the ALTSA QA staff will make the change based on the Non-Concur Committee’s prior decision. These issues are not forwarded to the committee.
 - e. Issues not corrected by the ALTSA QA staff, or which have not had a previous decision are forwarded to the Non-Concur Committee and documented in the SharePoint database.
 - f. The ALTSA QA staff sets up the non-Concur meetings with at least a one-week advanced notice of the meeting date according to the QA calendar. The meeting notice will



- include a write-up of the Non-Concur Request. The ALTSA QA staff invites the appropriate HQ staff to the meetings.
- g. The Non-Concur Committee:
 - i. Reviews the non-concur request documentation.
 - ii. Hears the field QA contact's analysis.
 - iii. Hears the ALTSA QA staff's analysis; and
 - iv. Makes a final decision based on policy
 - h. If a decision cannot be made within the Non-Concur Committee, the QA Unit Manager will have it addressed at the Executive Management level whose decision is final.
 - i. If the Non-Concur Request is approved, the ALTSA QA staff will change the "no" to a "yes" or "N/A". If the change is not approved, the field QA contact will ensure the corrections are made. The ALTSA QA staff documents the decision in the RCN.
 - j. The QA Unit Manager documents the decision in the SharePoint database.
 - k. If changes to policy are recommended, the Chief of LTC Financial Eligibility & Policy will identify who will be responsible for follow-up and response to, or completion of, the recommended policy change.
 - l. At the end of the review cycle, the QA Unit Manager, and the Chief of LTC Financial Eligibility & Policy review the Non-Concur Requests for possible impact on the next review cycle.

FINAL LOCAL REPORT SUMMARY AND COVER LETTER

1. After the 60-day review, the ALTSA QA staff prepares the "Final Report Summary" which includes:
 - a. Attachments of the local reports, and
 - b. The Proficiency Improvement Plan template
2. The Financial Policy unit Office Chief reviews the PIP and upon approving the PIP forwards the PIP to the Deputy Director of Field Operation for signature.
3. The Final Report is due to the Regional Administrators within 30 calendar days after completion of the 60-day review.

PROFICIENCY IMPROVEMENT PLAN (PIP) FOR FINANCIAL SERVICES MONITORING

A PIP outlines a plan for addressing items that do not meet proficiency. The proficiency threshold will be specified in the QA Exit Conference. Both HCS HQ and the Regions are responsible for developing and implementing a PIP.

1. Regional action is required for PIP development (based on initial findings). A Regional PIP is not required for the current QA Unit review cycle:
 - a. When proficiency is reached on all QA questions.
 - b. When HCS HQ is conducting the PIP on a QA question that does not meet statewide proficiency.
2. Regions will use the PIP template provided for all questions below the expected proficiency level.
3. HQ will identify items that need to be addressed at a statewide level and develop a HQ PIP if necessary. Information about the HQ PIP status will be maintained on the QA intranet site.
4. Regions are required to address all other items that did not meet proficiency except those items being addressed in the HQ PIP. Items being addressed by HCS HQ may also be addressed on a local PIP if the Region wants to focus on improving local proficiency. The Region will support and reinforce strategies to increase proficiency and supervisors will continue to work with individual staff to increase proficiency in identified areas.
5. QA Unit Manager, ALTSA QA staff, and other HQ staff are available to assist in development and revision of the PIP.
6. The PIP is due to the ALTSA QA staff within 30 calendar days from the date the Final Report summary was emailed. ALTSA QA staff tracks the time frame, follows up and offer assistance, if not received on time.
7. HQ Review and Approval
 - a. When the PIP is received, the ALTSA QA staff, QA Unit Manager and HCS Chief of Financial Eligibility & Policy jointly review the plan. The field representative is contacted by email if there are recommended changes. If changes are needed, the revised document is reviewed and approved.
8. Reporting Progress



- a. Regions
 - i. Progress reporting is unique to each item within the PIP and unique to each Region.
 - ii. The Region completes the “Progress Reporting Section” and sends it to the Financial QA Program Manager, when due, with a copy to the QA Unit Manager. If the progress report is not received on time, the ALTSA QA staff will follow-up with the field and notify Executive Management if necessary.
- b. HQ
 - i. Upon review of the progress report the ALTSA QA staff or other management staff may share other ideas or strategies for quality improvement.
 - ii. The QA Unit Manager reports the HQ PIP status on an “as needed” basis and at least quarterly to Executive Management at a regularly scheduled Office Chief meeting.

PUBLIC BENEFIT SPECIALIST SUPERVISOR MONITORING

The Financial QA process reviews completed by Supervisors in the Regional HCS offices are very important because they ensure that we are following Financial Eligibility Requirements and that quality work is being completed by field staff. Public Benefit Specialist Supervisor QA process reviews help identify training, staff performance and policy issues. Financial QA process reviews completed by Supervisors are mandated to be completed in the QA Monitor Tool only.

Public Benefit Specialist Supervisors have the following quality assurance and improvement responsibilities:

1. Monitoring Results – Supervisors will use the “Reviewed Cases with Questions Requiring Action” report to ensure that corrections identified by the QA Unit have been completed.
2. Supervisor QA Monitoring – Supervisors must inform their staff of the QA monitoring process and expectations. Supervisors monitor that their staff are:
 - a. Correctly determining benefits that are issued.
 - b. Processing all case actions in a timely manner.
 - c. Following department policies and procedures.
 - d. Required verifications are received and/or documented.
3. Supervisory Monitoring of New and Experienced staff:
 - a. New Public Benefit Specialists (PBS) staff and experienced PBS new to long-term care (LTC) eligibility:

- i. After an initial mentoring period when the PBS is assisted with case actions as they occur, 25%-100% of all case actions will be reviewed based on their learning level until the new worker demonstrates the ability to accurately determine financial eligibility.
- b. Experienced staff (processed Applications and/or Reviews):
 - i. Experienced staff is defined as staff that are authorized to process applications and/or eligibility reviews issuing a Medicaid benefit.
 - ii. Three (3) full case reviews per worker(s) per year when the worker(s) have completed at least 3 full case actions in a calendar year.
 - iii. Use of the QA Monitor tool is required, and QA process reviews completed in the QA Monitor Tool will count toward the annual Supervisory reviews of three per year, per worker.

AUTHORITY FOR POLICIES AND PROCEDURES

[Section 1915 \(k\) of the Social Security Act #17](#): Authorizes the Community First Choice (CFC) State Plan Amendment and requires that the State of Washington have a formal system in place for monitoring the quality standards outlined in the SPA and that all problems identified by monitoring are addressed.

[Section 1915 \(c\) of the Social Security Act #17](#): Authorizes the COPES Waiver and requires that the State of Washington have a formal system in place for monitoring the quality standards outlined in the waiver and that all problems identified by monitoring are addressed.

[RCW 74.39A.050](#): Requires DSHS to implement a LTC care QI system that focuses on consumer satisfaction and positive outcomes for consumers. This statute outlines 15 QA principles consistent with federal laws and regulation.

[RCW 74.39A.090](#): Requires DSHS to monitor the degree and quality of case management services provided to elderly and disabled clients by AAA.

[RCW 74.39A.095](#): Specifies the minimum elements that must be included in AAA oversight of care being provided to clients.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
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**CHAPTER 23B: QUALITY ASSURANCE AND
IMPROVEMENT – FINANCIAL SERVICES MONITORING**
Long-Term Care Manual



9/2/2026	Bill McBride	Revision and updated formatting	
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Adult Protective Services

The purpose of Chapter 23c is to outline Quality Assurance and Quality Improvement activities for the Adult Protective Services (APS) Division.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

APS QA Unit Office of the Assistant Secretary QA Team for APS

APSQAUnit@dshs.wa.gov

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QUALITY ASSURANCE OVERVIEW

A Quality Management System (QMS) is a commonsense approach of organizing the business and support processes that affect the quality of regulatory and service delivery. While an individual is critical to the success of the system, they are only one component. The success of any QMS relies upon clearly documented policy and procedures, adequate training, review of the processes being used, and when necessary, a plan for improvement.

The Aging and Long-Term Services Administration (AL TSA) QA unit is located within the Office of the Assistant Secretary (OAS) and collaborates with the Quality Improvement (QI) Unit and Adult Protective Services (APS).

The QA Unit's purpose is to complete process reviews which provide data to show required standards are met, to work collaboratively with the divisions, to act as an internal control, and to help identify areas for improvement.

The APS QI Unit's purpose is to examine processes within APS and identify areas to address system gaps. The QI unit develops Proficiency Improvement Plans (PIPs) in response to the QA process reviews in partnership with APS staff. Additionally, the QI unit leads the APS division in the development and implementation of all statewide QI policies, processes, and procedures to assist in assuring division compliance with all state and federal requirements, as well as agency and administration policies. APS must comply with the following federal regulations and Revised Code of Washington (RCW) chapters:

- A. RCW 74.34
- B. WAC 388-103
- C. 42 U.S. CODE § 1396R (g)(1)(D)
- D. 42 U.S. Code § 1395i-3 (g)(1)(D)
- E. SOCIAL SECURITY ACT 1819(G)(2)(D)
- F. SOCIAL SECURITY ACT 1919(G)(2)(D)
- G. RCW 43.17.385 QUALITY MANAGEMENT, ACCOUNTABILITY, AND PERFORMANCE SYSTEM
- H. RCW 74.39A.051 QUALITY IMPROVEMENT PRINCIPLES
- I. CMS QUALITY MEASURES AND REPORTING MEMO:
 - 1. SECTION 3 – 86% PROFICIENCY THRESHOLD AND PIP REQUIREMENT
 - 2. SECTION 2 – INDIVIDUAL FINDING REMEDIATION REQUIREMENT
- J. STRATEGIC PLAN
 - 1. STRATEGIC GOAL #2: HONOR INDEPENDENCE, RIGHTS, HEALTH & SAFETY FOR VULNERABLE ADULTS LIVING IN HOME- AND COMMUNITY-BASED SETTINGS.
 - 2. STRATEGIC GOAL #4: IMPROVE QUALITY, ACCOUNTABILITY AND RESPONSIVENES

This document contains information about the QMS within APS related to QA process reviews and QI activities. The content is relevant to APS staff, external stakeholders, and anyone seeking to understand the APS QMS.



Starting January 2016, Adult Protective Services (APS) Headquarters (HQ) Program Managers (HQ PMs) began completing Quality Assurance (QA) process reviews and entering data into the QA Monitor Tool. Additionally, in 2017 Field Supervisors and Subject Matter Experts (SME) began completing QA reviews in the QA Monitor Tool. In 2024 Quality Improvement Coordinators (QICs) began the work of supporting the continuous improvement process in central intake and the regions.

Timely completion of quality assurance activities helps protect the health and safety of clients and provides oversight of operations. Activities include completing QA reviews to ensure compliance with quality measures; data analysis to identify gaps in the processes being used based on QA review results; developing proficiency improvement plans and creating solutions using feedback from staff at all levels. Identified findings are addressed and improvement plans are developed and monitored to ensure continuous quality improvement. Through these functions, APS will obtain more predictable outcomes that ensure protection of adults who are vulnerable with consistent and timely investigations while offering protective services, supports and referrals.

STATEWIDE QUALITY ASSURANCE OBJECTIVES

1. Analysis of external and internal issues that affect the quality of service delivery that is relevant to the division's purpose and its strategic plan;
2. Evaluating and ensuring ongoing compliance with State and Federal law;
3. Ensuring that policies and procedures are clearly documented, and information is available, useable, and updated when needed;
4. Identifying areas in the process that need improvement and developing appropriate counter measures to address areas of concern at all levels – individual, local unit, regional, and statewide;
5. Completing QA process reviews that will assess compliance with existing regulations, policies, and standards;
6. Gathering a consistent and broad range of information to identify trends, strengths, and areas for improvement across the division;
7. Identifying best practices within APS with the purpose of sharing strategies across the state;
8. Developing Proficiency Improvement Plans (PIP) with the objective of continuously improving current processes that affect the quality of service delivery and ensure the health and safety of vulnerable adults;
9. Ensuring a continuous flow of communication between all levels of APS.

HQ QUALITY ASSURANCE UNIT PROCESS OVERVIEW

- QA process review occurs at the Office of the Assistant Secretary QA Unit staff level.
- The 12-month QA Activities and Schedule is available on the OAS QA for APS SharePoint site.
- Statistically significant samples are pulled for each regional area based on the number of completed Investigations and Investigations Closed No APS that were processed for each region in an annual time period.
- Statistically significant samples are pulled for screened-in intakes and screened-out intakes that were processed by APS Central Intake within an annual time period.
- Statistically significant samples are pulled for all investigations closed statewide within an annual time period.
- QA Review Entrance letters are sent at the start of each process review cycle.
- APS Central Intake and the Regions have 30 business days from receiving the initial QA proficiency reports to complete the necessary remediations and to also submit change requests.
- APS Central Intake and the Regions then have 5 business days to complete remediation if necessary for findings that were upheld by the change committee.
- An Exit Conference may be conducted via Microsoft Teams at the completion of the review, following any decisions from the change committee.
- OAS QA Consultants(s) conduct a 30-day HQ QA review to document remediation.
- Issues identified in the 30-day HQ QA Review as not fully remediated must be completed immediately by APS Designated Staff.
- OAS QA Consultants(s) complete the Final Report which is a summary of all QA findings.
- A Proficiency Improvement Plan (PIP) will need to be developed for QA questions designated by APS Director and/or the Aging and Long-Term Support Administration (AL TSA) Assistant Secretary.

PART 1: QUALITY ASSURANCE PROCESS REVIEWS

A. GENERAL GUIDELINES

Background

QA was developed for APS as part of AL TSA's Quality Management System (QMS) to improve processes within APS and to ensure guidelines for participation in federal programs are maintained. Starting January 2016, Adult Protective Services (APS) Headquarters (HQ) Program Managers (HQ PMs) began completing Quality Assurance (QA) process reviews and entering data into the QA Monitor Tool. Additionally, in 2017 Field Supervisors and Subject Matter Experts (SME) began completing QA reviews in the QA Monitor Tool. In 2020 the QA unit was transitioned to the Office of the Assistant Secretary (OAS) and continues to work with APS leadership and staff to complete QA activities. In 2024 Quality Improvement (QI) consultants began supporting APS in implementation of the QMS.

Timely completion of QA activities helps protect the health and safety of clients and provides oversight of operations. Through the QMS system APS will obtain more predictable outcomes that ensure protection of adults who are vulnerable with consistent and timely investigations while offering protective services, supports, and referrals.

For information about each setting or program area reviewed by QA, see Appendix D: Resources and Forms.

Procedure

1. QA Unit will:

- a. Conduct required process reviews to determine compliance with standards, state law, APS policy, and federal regulations.
 - b. Follow all procedures to ensure consistent QA process reviews.
 - c. Complete process reviews in a timely manner.
 - d. Monitor the APSQAUnit@dshs.wa.gov email box and respond to inquiries within 2 working (business) days (WD).
 - e. Clearly communicate findings and trends.
- Note: The purpose of findings is to demonstrate an identified gap between policy guidance and what was found during the process review.
- f. Always maintain professional and respectful conduct.

2. QI Unit will:

- a. Participate in any collaborative training sessions with the QA unit.
- b. Assist with facilitating discussions with APS staff when process questions arise.
- c. Monitor the ImproveAPS@dshs.wa.gov email box and respond to all inquiries within 2 WD.
- d. Clearly communicate information.
- e. Always maintain professional and respectful communication.

3. Region/central intake will:

- a. Maintain one point of contact within the region or central intake for QA information and work directly with the QI team. This is known as the Designated Staff (DS).
- b. Enter all new staff with appropriate area and permissions into the QA Monitor application (QAM).
- c. Inactivate any staff within their respective area in QAM.
- d. Notify Program Integrity (PI) Unit Manager of new hires and start dates.
- e. Notify QA Unit Manager of any position changes requiring permissions changes to QAM.

Definition of Roles within the QA Unit

1. ALTA QA Unit Manager

- a. Recruits, hires, and ensures that new QA staff are trained.
- b. Supervises and provides oversight to the QA Unit to ensure all processes and procedures are followed and QA reviews are completed as required.
- c. Performs regular spot checks of QA Consultant work for quality, consistency, and interrater reliability.
- d. Assists the unit in completion of tasks to ensure work is completed timely and efficiently.
- e. Assures the statistical relevance for all sampling and sample methodology and determines samples sizes required.
- f. Ensures QA staff maintain a working knowledge of all relevant policy.
- g. Requests clarification from APS and ALTA leadership as needed.
- h. Maintains the QA SharePoint site.

- i. Maintains the QA Monitor Tool.
 - i. Provides updates on QA Questions, No Responses, and review types based on changes to the review process.
 - ii. Ensures trainings are available related to use of the QA Monitor Tool.
 - iii. Coordinates with Management Services Division (MSD) to repair bugs, create reports, or work on issues as they arise.
2. Process Review Lead
- a. The Process Review Lead (QA Lead) is the QA Consultant assigned to coordinate the process review and all associated tasks to ensure completion.
 - b. Creates and distributes statistically significant and accurate samples.
 - c. Ensures all information and files are available for the process review, including updated reports, updated question documents, information sheets, required files, and any other information needed for the review.
 - d. Coordinates information requests to or from the program to be sure all questions and data requests for the review are addressed. Tracks responses to ensure any required updates to documents and processes are complete.
 - e. Ensures all QA reviews are entered and closed correctly during reviews, at the end of the review, and at the end of the calendar year to validate reviews are completed in the QA Monitor Tool.
 - f. Creates or runs required reports to ensure historical records are available.
3. QA Consultant
- a. Is a member of the QA Unit who coordinates and completes QA process reviews.
 - b. Completes process reviews in the manner prescribed in the instruction documents, in this chapter, and in documents produced through the question document review process.
 - c. Works within the unit to ensure all work is completed in a professional and collaborative manner.
4. ALISA Management Analyst (MA)
- a. Is a member of the ALISA QMS who reports directly to the ALISA Senior QA Administrator.
 - b. Provides QA and APS QI Coordinators (QICs) data analysis one WD prior to the exit conference and two WD after initial proficiency reports are finalized.
 - c. Collaborates and consults with QA and QI when reviewing data.
 - d. Provides Ad Hoc data analysis and reports as requested by agreed deadlines.
 - e. Documents potential enhancements to QA reports throughout the year.
 - f. Work with the QA Monitor Development Team to correct issues with QA reports, suggest improvements, and test changes to the QA tool or reports.

Definition of Roles within the QI Unit

1. APS Program Integrity Unit Manager

- a. Supervises and provides oversight to the QI Unit to ensure all processes and procedures are followed and QI activities are completed as required.
- b. Recruits, hires, and ensures that new QI staff are trained.
- c. Ensures QI staff demonstrate a working knowledge of this policy.
- d. Conducts supervisory reviews of QI staff work to ensure policies and procedures are followed.

- e. Requests clarification from APS leadership as needed.
- f. Performs regular spot checks of QIC work for quality, consistency, and accuracy.
- g. Assists the unit in completion of tasks to ensure work is completed timely and efficiently.
- h. Distributes QA Process Review result reports to the Regional Administrators (RAs) and Program Managers (PMs), following both the initial proficiency reports, as well as the final statewide exit conference.
- i. Present overview of QA/QI in collaboration with the QA Unit Manager, coordinated with the training unit.
- j. Maintains the QI SharePoint site.
- k. Ensures all APS staff have access to QIC Central Resources.
- l. Collaborates with APS leadership, policy, and statewide and regional trainers on QI activities.
- m. Coordinates quarterly program meetings with the following units:
 - i. Policy – Send the invite to the Senior Policy Advisor.
 - ii. Training – Send the invite to the Training Unit Manager.

2. QI Program Lead

- a. The Program Lead is the QIC assigned to coordinate all QI activities for the assigned program. This includes but is not limited to QA process reviews response, including data analysis, change requests, root cause analysis, and PIP development, as well as associated tasks to ensure completion and ongoing monitoring. The lead is responsible for the success of all QI activities.
- b. Supports, coordinates creation, and delivery of any QI driven trainings related to PIP activities and form updates in cooperation with appropriate APS staff.
- c. Presents QI Overview at program specific trainings, coordinated with the training unit.
- d. Coordinates trainings for QI team members (i.e., needed QI checks, etc.).
- e. Responds to all communications related to the assigned program received via the ImproveAPS@dshs.wa.gov email inbox.
- f. Ensures all QI monitoring checks are entered and closed per the process defined in the section labelled 'Thirty Day Reviews.'
- g. Lead will coordinate QI activities with their Co-Lead.

3. QI Program Co-Lead

- a. Supports the QI Lead in completing program related QI activities.
- b. If the QI Lead is unavailable, the Co-Lead will take additional Lead responsibilities as needed.
 - i. If what is needed is unclear, consult with the Unit Manager.
- c. Provide technical support, including note taking, during any QI provided in-services and presentations.
- d. Co-Lead will coordinate QI activities with the QI Program Lead.

4. QI Coordinator

- a. Is a member of the QI Unit who coordinates and completes QI activities.
- b. Works within the unit to ensure all work is completed in a professional and collaborative manner.

B. PROCESS REVIEW SCHEDULE

Background

ALTSA QA maintains a 12-month QA Process Review Schedule, which runs January through December. The schedule is available on the OAS QA for APS SharePoint site.

QA reviews are entered into the QA Monitor Tool or SharePoint Forms by QA or as a check by QI.

Reviews in QA Monitor must be closed and completed before the system lock-out in December when updates are processed for the next review cycle. This includes adding necessary 30-Day reviews and overturning findings when required. When reviews are not fully closed by the end of the calendar year, they are locked in place and remain in the QA Monitor as open reviews with no way to close them. This creates a layer of complexity that interferes with the functionality and ease of use of the system.

Procedure

The QA Unit Manager will publish a Management Bulletin (MB) at the beginning of each year to update the process review schedule. If the dates or the number of reviews change after the original release, staff will be notified, and the OAS QA for APS SharePoint site will be updated.

The Process Review Schedule includes key information, such as:

1. Each process review area being completed for the year.
2. Review dates: QA team trainings, entrance dates, and file review dates.
3. Dates the initial proficiencies will be provided to QI.
4. Change request and remediation due dates.
5. Change Request Committee (CRC) dates.
6. Exit conference dates.
7. PIP due dates.

QA Unit Manager Responsibility

1. Creates QA schedule.
2. Creates and submits the annual MB to the APS Policy unit for publication to provide APS with the updated schedule and process review information.
3. Ensure training for new QA staff occurs.
4. Ensures QA staff demonstrate a working knowledge of this policy.
5. Conducts end of year review verifications to ensure staff are following the policy.
6. Assures that weekly updates are sent for posting when changes to the schedule are required.

PIP due dates

Program Integrity Unit Manager Responsibility

1. Review QA schedule.
2. Ensure appropriate staff are made aware of required dates and scheduled meetings.
3. Refer questions to QA Unit Manager as they arise.

Adult Protective Services Responsibility

4. Review QA schedule.
5. Ensure appropriate staff are made aware of required dates and scheduled meetings.
6. Refer questions to QA Unit Manager as they arise.

C. QA QUESTION DOCUMENT REVIEW

Background

QA is responsible to complete process reviews using specific questions developed to ensure we are meeting federal, state, and ALTSA leadership guidelines. The questions are reviewed and updated with input from APS Policy, Training, QI, and other subject matters experts. The questions are approved by the APS Director.

Questions are updated based on current policies, procedures, the DSHS and ALTSA Strategic Plans, federal legislation, federal requirements for State Plans, Waivers, and Home and Community-Based setting rules, state legislation, current issues the division is experiencing, or in response to external audits or litigation.

How QA reviews each of the questions is developed by the QA Unit with input from subject matter experts (SMEs) and feedback from staff. This process is key to providing the opportunity for all staff to provide input and ensure QA has as much information as possible to complete the review accurately and efficiently.

QA data is tracked and may be reported to federal partners to provide evidence of compliance with Medicare and Medicaid programs. The information gathered from QA process reviews is also intended to assist the division with process improvement activities, act as an internal control, as well as maintain compliance with applicable laws and policies

All current QA question documents are located on the QA SharePoint site and are available by contacting QA at APSQAUnit@dshs.wa.gov.

Procedure

1. Documents are reviewed, updated, and revised as changes are required.
2. The QA Unit Manager will facilitate communication with policy, training, area specific SMEs, and other designated staff to review and discuss QA questions. All sections of the documents may be reviewed and revised.
3. Once final drafts are completed, significant changes to questions or proficiency expectations are reviewed and approved by the APS Director.
4. When MBs or new policies are published, QA will conduct reviews to that standard on the date the MB or policy is effective.
5. QA question materials to be used for the year are published to the How to Review SharePoint Page. Documents and links are also provided in the QA Schedule MB.

QA Unit Manager Responsibility

1. Outlines required changes with the APS Director to obtain final approval.
2. Ensure training for new QA staff occurs.
3. Ensures QA staff demonstrate a working knowledge of this policy.
4. Researches and responds to inquiries from the QA Unit.
5. Conducts supervisory reviews of QA staff work to ensure policies and procedures are followed.

Program Integrity Unit Manager Responsibility

1. Participate in all QA question document review conversations.
2. Maintain a log of potential policy updates between process reviews for tracking purposes.

Adult Protective Services Responsibility

1. Notify QA and QI by email of process changes that may affect how QA Process Reviews are completed.
 - a. It is encouraged to notify QA as topics arise.

D. SAMPLE METHODOLOGY

Background

The QA Unit uses the statistically valid sampling methodology recommended by the Centers for The QA Unit uses the statistically valid sampling methodology recommended by the Centers for Medicare and Medicaid Services (CMS). Raosoft's Sample Size Calculator is used to determine statewide sample sizes using the recommended 5% margin of error and 95% confidence level.

There are reviews in which entire population subject to review is too small to use only a sample of the population. In these cases, the entire population is reviewed.

Procedure

Investigations

- o Samples from each region will be investigations closed inconclusive, substantiated, and unsubstantiated, and a sample of investigations closed No APS.
- o The sample will be pulled from the three months after the PIP interventions are completed if possible.
- o Regional sample is based on the percentage of cases closed by unit during the time frame.
- o The random sample of cases to be reviewed are then generated by usage of the RAND function

in Microsoft within the DataMart tool.

- o This sampling process repeats for each Region and APS Central Intake.

Example of a sample calculation:

2,038 Investigations Closed No APS for Region X, during prior calendar year.

9,638 Investigations (inconclusive, substantiated, unsubstantiated) for Region X, during prior calendar year.

2,038 entered into RaoSoft = 324 (statistically significant sample)

9,638 entered into RaoSoft = 370 (statistically significant sample)

Total investigations in prior three months = 2,169

Total Closed No APS in prior three months = 500

Unit A closed 5% of 2,169 Investigations and 7% of 500 Closed No APS.

- o Sample size calculation size for Unit A:

- o $370 \times .05 = 19$ Investigations,

- o $324 \times .07 = 22$ Closed No APS

Unit B closed 1% of 2,169 Investigations and 2% of 500 Closed No APS.

- o Sample size calculation size for Unit B:

- o $370 \times .01 = 4$ Investigations,

- o $324 \times .02 = 6$ Closed No APS

Unit C closed 7% of 2,169 Investigations and 3% of 500 Closed No APS.

o Sample size calculation size for Unit C:

o $370 \times .07 = 26$ Investigations,

o $324 \times .03 = 10$ Closed No APS

Intake

o APS Central Intake data sample Intake Screen-Out and Intake Screen-In.

Example of a sample calculation:

9,525 total screen in intakes processed during prior calendar year.

4,752 total screen out intakes processed during prior calendar year.

9,525 entered into RaoSoft = 370 (statistically significant sample).

4,752 entered into RaoSoft = 356 (statistically significant sample).

During the three months prior to the QA review start date, Central Intake created 2,578 screen in intakes and 1,980 screen out intakes.

Intake Worker A created 3% of 2,578 screen in intakes and 2% of 1,980 screen out intakes created during the three months prior to the QA review start date.

• Sample size calculation size for Intake Worker A:

o $370 \times .03 = 11$ screen in intakes,

o $356 \times .02 = 7$ screen out intakes

Intake Worker B created 6% of 2,578 screen in intakes and 5% of 1,980 screen out intakes created during the three months prior to the QA review start date.

• Sample size calculation size for Intake Worker B:

o $370 \times .06 = 22$ screen in intakes,

o $356 \times .05 = 18$ screen out intakes

Statewide

o 90-day reason code review

o Safety and Risk review

o Documentation Timeliness

o Statewide sample is stratified by cases closed by region within the population

Example of a sample calculation:

Total statewide investigations closed during prior calendar year with a 90-day reason code other than No Good Cause = 9,959

9,959 entered into RaoSoft for a statistically significant sample of 370

During the 2-month period prior to the QA review start date 1,850 investigations were closed with a 90-day reason code other than No Good Cause.

o Region A closed 480 or 25.9%

o Region B closed 732 or 39.6%

o Region C closed 638 or 34.5%

Sample size calculation for Region

- A: $370 \times .259 = 95.83$ Sample size calculation for Region
B: $370 \times .396 = 146.52$ Sample size calculation for Region
C: $370 \times .345 = 127.65$

Region A would round to 96, Region B would round to 146, and Region C would round to 128.

The entrance documents will be sent to the program's designees prior to the start of the process review as described in section labeled 'Process Reviews'. The timeframe for the entrance communication may be adjusted based on program need.

QA Unit Manager Responsibility

1. Ensures sample methodology meets required standards.
2. Ensure training for new QA staff occurs.
3. Ensures QA staff demonstrate a working knowledge of this policy.
4. Conducts supervisory reviews of QA staff work to ensure policies and procedures are followed.
5. Requests training or clarification from leadership as needed.

E. PROCESS REVIEWS

Background

The QA Unit is responsible for determining whether specific proficiencies were met based on a prescribed set of questions.

The process reviews discussed in this section are defined as: the entrance, the initial process review work completed by QA, and the preliminary reporting. Process reviews are conducted remotely by the ALTSA QA Unit and staff are not required to travel.

Each process review is assigned a QA Process Review Lead (QA Lead), who is responsible for ensuring process review activities are completed. The QA Lead is considered the liaison and the SME for QA activities for the areas to which they are assigned. For information about which QA Unit Member is assigned as QA Lead for a specific area, please email APSQAUnit@dshs.wa.gov.

Procedure

ENTRANCE:

1. QA will e-mail entrance correspondence to the Designated Staff (DS) for the area being reviewed. This will include pertinent information related to the process review, such as the name of the QA Lead and an information sheet with pertinent dates and information for the review.
2. QA receives all correspondence via APSQAUnit@dshs.wa.gov.
3. The QA Lead will contact the Designated Staff to communicate any questions, concerns, or needs of the unit prior to the start of the review.
4. The QA Lead is responsible for ensuring communication between the staff and QA occurs during the review, as questions arise.
5. The QA Unit Manager or their designee will communicate with Policy, Training, QI, and other SMEs,

as needed to ensure the review is as accurate as possible, and new policies and procedures are communicated to QA.

6. The QA Lead will track any issues with the review, with questions, or with question documents. This information is gathered so that any issues are addressed at the next question document review meeting to inform potential updates.

INITIAL PROCESS REVIEW WORK:

At the beginning of the review, the QA Lead will ensure the area subject to review is aware the review has begun.

THE QA LEAD WILL:

1. Establish an open line of communication for the process review, and act as the primary point of contact.
2. Notify the Central Intake or Regional Designated Staff (DS) and QI Lead of any immediate remediation work necessary. Examples of immediate remediation work include sending a law enforcement referral or updating person management with safety concerns.
3. Monitor the QA mailbox and respond to inquiries within 2 WD.

DURING THE PROCESS REVIEW, THE QA LEAD WILL:

1. Track all issues and work toward a resolution before QA begins the review.
2. Notify DS of any immediate remediation requests and the date they are due and follow up until all remediation requests are addressed.
3. Add an RCN when immediate remediation action is required including the date the field was notified.
4. Verify the action when the field notifies QA the immediate remediation action was taken and add corresponding RCN.
5. Pull reports on a regular basis and identify issues which must be resolved. The QA Lead will manage this process and ensure issues are found and corrected as soon as possible during the process review.

QA Unit Manager Responsibility

1. Work with QA Staff during the process review to complete the review and address any concerns or specific questions related to how to complete any part of the review.
2. Ensure training for new QA staff occurs.
3. Ensures QA staff demonstrate a working knowledge of this policy.
4. Requests training or clarification from leadership as needed.

Adult Protective Services Responsibility

1. Designate one specific contact person for information and actions related to the process review, known as Designated Staff (DS).
2. When notified of immediate remediation action, ensure action is taken the same or next business day.
3. Inform QA Lead when immediate remediation action is completed.

F. INITIAL PROFICIENCY REPORTS

Background

At the completion of the review of records, initial proficiencies are sent to the QI unit and the Designated Staff. These are the preliminary results prior to any changes made during the change request process or at the Change Request Committee (CRC) meetings (refer to section labelled 'Change Requests' for more information). These preliminary results are subject to change once change requests are finalized.

Finalization of results in the QA Monitor tool occurs after the 30-day process described in the section labeled 'Thirty-Day Reviews' is completed.

Procedure

1. The ALTSA QA MA will send preliminary reports by the date posted on the official QA Unit Schedule. Reports are sent to the QA Unit Manager and the Program Integrity Unit Manager.
2. The QA Unit Manager or designee will forward the preliminary reports to the APS Director, APS Deputy Director, APS Office Chiefs, and the ALTSA Senior QA Administrator.
3. The Program Integrity Unit Manager or designee will compile the results and provide a breakdown of the data by Region and Unit. Results will include overview graphs, the proficiency reports, and the

QA Analysis Comments. Reports will be distributed to the RAs, DRAs, and PMs for the region or to the Unit Manager for CI.

- a. Email to RAs and PMs should include details of next steps, including when change requests are due. Sample email template can be found in Appendix C.
- b. The QIC enters Change Requests into the QA Monitor Tool by the due date identified on the official QA Unit Schedule. To ensure timely receipt and review of all submitted change requests, any requests must be submitted by APS staff to QI 5 WD prior to the due date on the schedule.

G. REMEDIATION

Background

Remediation is the process of correcting an issue found during the QA review. Some findings relate to health and safety, some issues could result in litigation, and other issues may result in monetary penalties or federal payback of funds. These types of findings require the issue to be corrected. There are times when remediation is not possible. QA question documents identify these questions by using "Historical data, unable to remediate" as a remediation option.

Law enforcement referrals are required during intake and investigation activities. When there is a finding related to a missing law enforcement referral, remediation is required to be completed the same or next business day from the notification of the finding.

For any QA finding where an action was possible, QI staff will enter the appropriate remediation response for each finding during the 30-day review cycle or indicate that remediation was not possible.

This input is required to allow the QA Monitor Tool to function properly at the end of each review year.

Procedure

1. Upon receipt of the initial deficiencies, QI and the DS for the region or central intake will review the findings and determine remediation actions in cooperation with APS workers, supervisors, and program managers as necessary.
2. The DS in partnership with the QI lead for the region or central intake will track and coordinate remediation requests and ensure all remediation activities are completed as required.
3. QA will monitor APSQAUnit@dshs.wa.gov during the 30-day cycle.
4. QI will enter all remediations into QA Monitor during the 30-day review process.

QI Staff Responsibility

1. Review all QA findings and work with regional and central intake staff on potential remediation actions.
2. In the QA Monitor Tool, QI will add a Review Cycle Note (RCN) to the process review to explain what was done to remediate the finding, using the code "Action Taken" for the RCN type.
3. If a review requires multiple remediation actions, those actions may be documented within the same RCN. It is not necessary to enter multiple RCNs within the same review. This does not apply for RCNs with the code "Change Request".
4. Notify QA via email when all remediation actions have been completed.
5. Ensure all remediation actions are completed on or before the required due date.
6. Notify APS leadership if deadlines are not being met.

APS Staff Responsibility

1. When notification of a finding is received, review the finding documentation to determine what needs to be done. If you do not know what to do, contact QI for assistance.
2. Complete the appropriate remediation by the required due date.
3. E-mail QI that you have completed the remediation and what action you took to complete the remediation. Do not send personal or confidential information via email. If you are not sure what to say or what to send, contact QI.
4. If notified by QI staff that deadlines are not being met, APS leadership will work with regional or intake staff to ensure priority is taken to address all remediation actions and communicate with the QI staff.

QA Unit Manager Responsibility

1. Respond to inquiries and train staff on remediation processes and procedures.
2. Ensure training for new QA staff occurs.
3. Ensures QA staff demonstrate a working knowledge of this policy.
4. Request training or clarification from leadership as needed.

H. CHANGE REQUESTS

Background

The purpose of the change request process is to allow staff the opportunity to provide additional

explanation or information so that QA findings can be reconsidered. When QA receives a change request, the actions QA may take regarding the finding include:

- **Overturn:** When QA agrees with the information provided, they will overturn the finding.
- **Uphold:** When both QA and QI agree that the information provided does not support overturning the finding, they will uphold, and QI will follow up to determine any necessary next steps.
- **Change Request Committee:** When QA and QI do not have enough information to overturn or to uphold the finding or determines that leadership needs to make the final determination, the QA Unit Manager will forward the finding to the Change Request Committee (CRC) to be considered.

Change requests must be submitted by 5:00 PM on the due date provided on the QA schedule. All requests must be submitted as an RCN in the QA Monitor Tool using Contact Code "Change Request." Email submissions and RCNs which do not include a correct contact code will not be considered. For reviews completed in SharePoint forms, all requests will be entered into the specific form by the designated due date and time.

Procedure

Requesting Changes to QA findings:

Prior to sending the change request, APS Designated Staff and QI will:

1. Review applicable QA question documents and instructions.
2. Review the policy in place at the time the investigation or intake work was completed.
3. Review historical Change Request Committee (CRC) decisions located on the QA SharePoint site.
 - a) If CRC has upheld a QA determination on the same issue, the request will not be forwarded to CRC and the QA finding will be upheld.
 - b) If there has been a change to policy or a compelling reason exists for leadership to discuss the issue again, QA will forward the request to CRC.
4. For investigation reviews, discuss the request with the Regional Administrator for the area who will have the final say if the change request will be entered into the QA Monitor Tool.
5. For intake reviews, discuss the request with the Central Intake Unit Manager who will have the final say if the change request will be entered into the QA Monitor Tool.

After determining the Change Request should be sent to QA:

1. QI will enter the RCN into the QA Monitor Tool.
2. Use the contact code "Change Request". This code must be selected, or the request will not be visible to QA and will not be considered.
3. All change requests must appear on the 2309 Change Request Report in ALTSA Reporting to be considered. (Using the contact code "Change Request" accomplishes this).
4. The change request language should include the question and no response requested to be changed, the reason why the change is requested, and policy language that supports the requested change. The change request should not hold confidential information including AV or AP names, dates of birth, or other identifying information.
5. If multiple questions and/or no responses within a review require a change request, enter a

separate change request RCN for each item.

THE QI UNIT WILL:

1. Ensure APS staff are aware of change request due dates and dates for when requests must be received by the QI Unit for processing.
2. Review all change requests in collaboration with region or intake leadership in determining what will be forwarded to QA.
3. Collaborate with QA Unit Manager to determine what will be upheld or overturned and which requests will be sent to the CRC for consideration.
4. Report back to requestors to advise them of the outcome of their requests.

THE QA UNIT WILL:

1. Review and research each change request received considering the additional information.
2. Request additional information from appropriate SMEs (e.g., Training, Policy, Regional Staff, etc.) as needed to clarify the issue.
3. Collaborate with the Program Integrity Unit Manager to determine what will be sent to CRC.
4. Forward requests that require a CRC decision to the committee prior to the CRC meeting.
5. QA Consultants will update findings in the QA Monitor Tool as directed by the CRC within 5 WD after the CRC Meeting and will complete the 30-day reviews before the Final Exit Conference.
6. The ALTSA QA MA will e-mail updated reports to QA and QI within 2 WD when the proficiencies have changed from the initial proficiencies or when required.

Change Request Committee (CRC) Responsibility

Purpose

To make the final determination as to whether to overturn or uphold QA findings. Each topic area or finding will be discussed during the meeting and a determination will be made only by the voting members as to the outcome of the QA finding(s).

Due to time constraints, countermeasures are not determined or discussed in detail at these meetings.

CHANGE REQUEST COMMITTEE MEETINGS:

1. CRC meetings are scheduled by QA and dates are published on the QA Schedule.
 - a. A scheduled CRC Meeting may only be changed with the approval of the APS Deputy Director.
 - b. When a voting member is unable to attend, they have the option to send a designee who will stand in for them and act as a voting member.
 - c. It is preferred, but not required that all voting members attend. If one or two members are unable to attend, the meeting may proceed without them.
2. CRC does not repeat change requests which have been decided in historical committee meetings unless there is a compelling reason for them to hear the request again.
3. CRC may not hear change requests that have clear internal, state, or federal policy guidance. In these cases, QA and QI will discuss these requests to determine the outcome.

THE CRC INCLUDES THE FOLLOWING VOTING MEMBERS:

1. APS Deputy Director
2. APS Office Chiefs who are not in charge of the area subject to review

3. Senior Policy Advisor

ALL NON-VOTING CRC ATTENDEES WILL SUPPORT THE CRC'S PURPOSE BY:

1. Allowing the process to flow without interruption.
2. Responding to questions from CRC voting members and others who require their expertise.
3. Responding to requests to provide evidence, policy guidance, best practice, or experience.
4. Refraining from voting or expressing a desired outcome.
5. Holding comments and questions about next steps, countermeasures, or follow-up.
6. Not forward invitations to CRC meetings.
 - a. For those whose attendance is required to provide expert opinion or information the CRC voting members need, they will e-mail the meeting organizer to add the individual.

THE CRC WILL:

1. Review all change requests submitted and all supporting documentation.
2. Discuss each issue and ask questions that enable them to make an appropriate determination based on the policies and procedures in place at the time the work was completed.
3. Vote to determine whether to uphold or overturn the QA finding.
 - a. If the vote is a tie, the APS Director or their designee will make the final decision.
 - b. When the CRC upholds the finding, APS must remediate the finding within 5 WD if remediation is possible.
 - c. When the CRC overturns the finding, QA will correct the review within 5 WD.

QA Unit Manager Responsibility

1. Provide clarification for QA findings and collaborate with QI to determine which requests are overturned, which are upheld, and which are forwarded to CRC.
2. Only forward invitations to those whose attendance is required to provide expert opinion or information the CRC voting members need.
3. Facilitate CRC meetings, maintain professionalism, and ensure the meeting stays on task.
4. Ensure training for new QA staff occurs.
5. Ensures QA staff demonstrate a working knowledge of this policy.
6. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility

1. Ensure training for new QI staff occurs.
2. Ensures QI staff demonstrate a working knowledge of this policy.
3. Collaborate with QA to determine which change requests will be overturned and which are forwarded to CRC.
4. Ensure staff are provided the opportunity to present their request through their program's representative, their PM, or appropriate SMEs.
5. Only forward invitations to those whose attendance is required to provide expert opinion or information the CRC voting members need.
6. Request training or clarification from leadership as needed.

I. THIRTY-DAY REVIEWS

Background

Within the APS System, 30-day reviews are completed after the initial review when the initial review included at least one finding (at least one question was answered with no). The purpose of the 30-day reviews is to show all work has been finalized, all required remediation is complete, and the review requires no further action.

Anyone entering QA reviews, including those individuals entering supervisory reviews or QI checks, must also enter all 30-day reviews within 45 calendar days after the initial review is entered or before the QA Monitor blackout period begins in December, whichever occurs first.

The QA Monitor blackout period occurs in December during which no reviews can be entered into the system. During the QA Monitor blackout, the prior year is closed out and frozen, so any open reviews create complications and unnecessary work for those using the system.

Procedure

THE QA UNIT WILL:

1. Complete 30-day reviews by the due date listed on the schedule.
 - a. When remediation is not possible and considered to be historical, QA will answer with N/A and choose the remediation “Historical data-unable to remediate”
 - b. When remediation has been completed, QA will answer Yes and choose the appropriate remediation option.
2. The QA Lead will verify all reviews entered by QA are closed at the end of each review.
3. The QA Unit Manager or their designee will verify all reviews entered by anyone other than QA are closed by the end of the year prior to the blackout period.

THE QI UNIT WILL:

1. Enter checks into the QA Monitor Tool periodically throughout the year to gauge impact and effectiveness of PIP countermeasures or systemic changes.
2. Verify that all reviews entered are closed within 45 calendar days of the date the review was entered, or before the QA Monitor Tool blackout dates, whichever comes first.

QA Unit Manager Responsibility

1. Ensure training for new QA staff occurs.
2. Ensures QA staff demonstrate a working knowledge of this policy.
3. Conducts supervisory reviews of QA staff work to ensure policies and procedures are followed.
4. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility

1. Ensure training for new QI staff occurs.
2. Ensures QI staff demonstrate a working knowledge of this policy.
3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
4. Request training or clarification from leadership as needed.

J. FINAL EXIT CONFERENCE AND PROFICIENCY REPORTS

Background

Once all change requests and 30-day reviews are completed, proficiencies are re-calculated, and a final Exit Conference is held by QA to disseminate final QA results.

This process was initiated at the beginning of the 2024 QA cycle in response to feedback from staff that initial results are not as helpful as final results.

Procedure

THE QA UNIT WILL:

1. The QA Lead will verify the review is completed and all reviews are closed in the QA Monitor Tool.
2. The ALTA QA MA will send final proficiencies to the QA Unit Manager and Program Integrity Unit Manager at least one (1) WD prior to the exit conference.
3. The QA Lead will coordinate and facilitate a Final Exit Conference which will include the following information:
 - a. Information related to how the sample is chosen.
 - b. QA questions asked during the process review.
 - c. Review of findings and proficiencies achieved.
 - d. Highlights from the review, including how the change request process impacted proficiencies.
4. ALTA QA will send an invitation to the Designated Staff and regional leadership. This meeting may be forwarded to allow anyone with an interest in attending. Meetings are held remotely and typically use Teams.

THE QI UNIT WILL:

1. Attend all Final Exit Conferences and will present information about upcoming Root Cause Analysis meetings and next steps, including PIP due dates if a PIP is required.
2. Once completed, the QI Unit Manager or designee will distribute any updated proficiency reports to RAs and PMs, if applicable.

QA Unit Manager Responsibility

1. Ensure training for new QA staff occurs.
2. Ensures QA staff demonstrate a working knowledge of this policy.
3. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility

1. Ensure training for new QI staff occurs.
2. Ensures QI staff demonstrate a working knowledge of this policy.
3. Request training or clarification from leadership as needed.

Adult Protective Services Responsibility

1. Forward the exit conference meeting information to staff within the region or unit and encourage attendance.

2. Review provided reports to understand information presented.

K. PROFICIENCY IMPROVEMENT PLAN (PIP)

Background

Expected Proficiencies:

The expected proficiencies for each QA question take into consideration the minimum required proficiency levels for the Centers for Medicaid and Medicare Services (CMS) waivers, any areas outlined on the ALTSA strategic plan, and the required proficiencies required by external auditors. Some questions require a higher proficiency level because of expectations by CMS, an external auditor, or executive leadership. The APS Director makes the final determination as to APS expected proficiencies.

Proficiency Improvement Plans:

A Proficiency Improvement Plan (PIP) outlines a plan for addressing QA questions that did not meet the required proficiency.

The action required for PIP development is based on the findings of the process review once all change requests are considered and the final proficiency results are distributed.

Action is required for PIP development. A PIP is not required for the current QA Unit review cycle:

- a. When required proficiency of 86% is reached on all QA questions.
- b. When the APS Director has requested APS staff and the PIPA unit to develop a PIP on a QA question that does not meet required or expected proficiency at a statewide level.

Procedure

1. PIP development and completion is the responsibility of the QIC in partnership with APS staff.
 - a. The QA Unit is not involved in PIP development activities and does not direct the work that needs to be accomplished to complete the PIP.
 - b. The use of Lean and Continuous Improvement tools is encouraged. Information and tools for ALTSA's Lean program can be found [here](#).
 - c. Any units or staff assigned a task on the PIP must be notified of the assignment before the PIP is signed by the APS Deputy Director.
2. The completed PIP must be submitted to the APS Deputy Director for final approval within 30 WD after the regional final report. This due date is included on the published QA Schedule.
3. A copy of the approved PIP must be saved to QIC Central in both PDF and Word formats (Word is used as a working document) once it is signed by the APS Deputy Director.
4. PIP Monitoring:
 - a. The QI Lead will send the final signed PIP to any staff assigned a task.
 - i. The QI Lead tracks due dates on the final approved PIP to monitor for completion.
 - ii. The QI Lead will notify the Program Integrity Unit Manager if there are any potential barriers to completing interventions within the defined timelines.
 - iii. The QI Lead provides written monitoring updates to leadership staff on a quarterly basis.
 - b. QI Unit Manager provides APS leadership with status reports as requested.
 - c. If PIP interventions or due dates change, the QI Lead will update the working version.

- d. There should only be one working PIP at any given time for a process review. If the previous PIP is not yet completed by the next process review, the PIP should be closed with notation that interventions can be found on current PIP.
- e. QI will make every attempt to utilize the same Sample Methodology process when completing monitoring checks to determine if PIP interventions are working.

QA Unit Manager Responsibility

- 1. Train new staff and ensure they can demonstrate they understand this procedure.
- 2. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility

- 1. Ensure training for new QI staff occurs.
- 2. Ensures QI staff demonstrate a working knowledge of this policy.
- 3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
- 4. Request training or clarification from leadership as needed.

Adult Protective Services Responsibility

- 1. Ensure robust participation in the data gathering and root cause analysis process by regional leadership, supervisors, and workers.
- 2. Encourage curiosity in examining systems.
- 3. Actively demonstrate shifting attitudes from blame to accountability and encouraging examination of process within and outside of the individual's control.
- 4. Allow space within monthly regional leadership meetings to discuss root cause analysis process, interventions, and data from monitoring of the interventions.
- 5. Regional leadership/Central Intake Unit Manager approves and signs the written PIP before forwarding to APS Deputy Director.
- 6. Implement identified interventions.
- 7. Ensure information on the process, interventions, and monitoring are made available to APS staff by way of newsletters, staff meetings, and other appropriate communications.

L. RECORD RETENTION

Background

Records are retained for historical information, data, and public disclosure purposes. For APS records retention information, please visit Policy Tech.

This section will provide an overview of how the QA Unit retains records of process reviews completed.

Procedure

- 1. QA Reviews are performed in the QA Monitor application or in Microsoft Forms.
- 2. If desired, QA unit members may use paper checklists or electronic checklists while completing the process review to ensure all process review questions are answered and input into the QA Monitor Tool correctly.
- 3. Once the review is completed, the review must be entered into the QA Monitoring Tool or Microsoft Forms Review as soon as possible. All information pertinent to the findings must be included in the

analysis comments in the QA Monitoring Tool or Microsoft Forms Review.

4. QA unit members may retain paper or electronic checklists only until the 30-day reviews are completed and the full review process is closed.

5. All paper documents related to the QA process review must be shredded in confidential shredding to avoid the release of any alleged victim names or other protected information.

6. All electronic documents created on OneNote, on the computer's desktop, or using any other programs created by the QA Consultant will be deleted once the 30-day reviews are completed. The QA Monitor Tool is the final and complete record for all QA reviews.

7. Records will be retained in the QA Monitor tool for six (6) years, after which, the records will be purged, unless there is a reason for which the record must be retained.

a. The QA Unit Manager will send a notification annually to Central Files prior to the scheduled record purge to determine which records may not be purged from the system and the reason the record may not be purged.

8. Reviews created utilizing Microsoft Forms will be downloaded to Excel and saved in the shared Q drive for six (6) years, after which, the records will be purged, unless there is a reason for which the record must be retained.

QA Unit Manager Responsibility

1. Request training or clarification from leadership as needed.

M. FINAL REPORTS

Background

The QA Lead creates a report for each region or central intake following the completion of their review cycle.

The QA Unit Manager develops an Annual Statewide Final Report to publish results of the cumulative QA process review cycle for APS. This report outlines the results for each review type on a statewide basis and compares any historical data for the reader's analysis.

The Program Integrity Unit Manager develops an Annual Report to publish information about the status and effectiveness of all Quality Improvement interventions implemented in response to QA Process Reviews.

Procedure

THE QA LEAD WILL:

1. Create the report based on the final proficiencies for Central Intake or the region.
2. Provide the report to the QA Unit Manager two (2) WD prior to the due date for approval and signature.
3. Send the signed report to Central Intake Unit Manager or regional leadership, and APS leadership on the due date.

THE QA UNIT MANAGER WILL:

1. Review the Central Intake and Regional Final Reports for accuracy.
2. Once the Central Intake and Regional Final Report is completed and verified to be accurate, signs the report.
3. Create and post the statewide final report annually and seeks clarification and information from programs as needed to clarify results or explain circumstances that may be needed to properly analyze the data.
4. Publish the statewide final report in an MB and on the QA SharePoint site once the report is complete.

THE PROGRAM INTEGRITY UNIT MANAGER WILL:

1. Create and post the report annually to demonstrate the effectiveness of PIP interventions on overall proficiencies.
2. Post the report on the QI SharePoint site.

QA Unit Manager Responsibility

1. Creates and distributes any required final reports.
2. Requests training or clarification from leadership as needed.

ALISA QA Senior Administrator Responsibility

1. Review and approve the statewide final report prior to presentation to APS Leadership for review, approval, and distribution.

The Program Integrity Unit Manager will:

1. Create and post the report annually to demonstrate the effectiveness of PIP interventions on overall proficiencies.
 - a. Program Integrity Unit Manager will send draft information to the process review QI Lead to verify information, including data and status of interventions.
2. Post the report on the SharePoint site.

Adult Protective Services Leadership will:

1. Read the QA and QI final reports.
2. Ensure information from the QA and QI reports regarding process, interventions, and monitoring are made available to APS staff by way of newsletters, staff meetings, and other appropriate communications.

PART II: QUALITY CHECKS

The QA checks completed by Quality Improvement Coordinators (QIC) are very important because they ensure staff are protecting our vulnerable adults by following policy, procedure, and conducting thorough investigations. QIC QA reviews help identify training and policy concerns. The QIC reviews QA questions ensuring the health and welfare of the alleged victim. As a result, the QIC role is a critical part of the foundation for overall APS quality compliance and consistency.

- a. Reviews are completed by QICs or their designee.
- b. QA reviews and PIP checks are performed for new and experienced staff according to the direction of APS leadership.



- c. All reviews are completed within the QA Monitor Tool, in Microsoft Forms, or tracked in Excel.
- d. All remediation activities must be completed, and the review cycle closed within 30 working days of initial review.
- e. Review data will be saved and reviewed from year to year for quality improvement purposes. Review activities are performed throughout the entire calendar year.

PART III: INTERRATER RELIABILITY

Purpose: To ensure consistency within the APS QA review process.

Prior to beginning the review cycle,

- The QA/QI team will complete three reviews together in training QA Monitor discussing each question and identifying what to look for.
- After that process, three intakes/investigations of each type (screen in, screen out, investigation, closed No APS) will be selected for independent practice review. Each reviewer will independently complete 3 reviews in training QA monitor. The other reviewer(s) and the QA Unit Manager will review those answers (Yes, No, or N/A) and any no responses given and compare for accuracy using the check spreadsheet. Any comments will also be reviewed to ensure accuracy and helpfulness. The group will return back together to discuss each review and the individual findings.
- Any discrepancies will be reviewed and verified within the How to Review guide.

During the compliance review cycle

- The QA unit manager will review 10% of each reviewer's cases for accuracy. Reviews will be completed on the check spreadsheet and shared with each reviewer.
- Each reviewer will select 2-3 reviews per week for peer review. Reviews will be completed on the check spreadsheet and shared with each reviewer.
- Any peer review will be completed with feedback provided at least 3 days before the end of the review cycle to ensure any necessary changes are made before providing QA data to central intake or the region.

Throughout the cycle, the reviewers are in communication with each other when questions arise on how to review situations which are not outlined in the How to Review guide or the training videos. If not in agreement, a discussion is held with the QA Unit Manager who will review the situation and applicable policy in addition to prior guidance. For questions if policy was followed that cannot be identified through review of Policy Tech guidance or previous decisions from executive leadership, the Senior Policy Advisor will be consulted for the final decision.

Check spreadsheets will be maintained in the APS QA Q: drive.

During the reviewer's probationary period,

- Complete the QA review training videos.
- Shadow a minimum of two other reviewers for 5 reviews each.
- The trainee reviewer will look at 10 historical reviews, comparing the historical reviewer's

answers and comments to information found in TIVA2 and the How to Review guide. The trainee reviewer will outline thoughts and questions to review with the QA Unit Manager.

- The trainee reviewer will complete 10 reviews in training QA monitor with review by the QA Unit Manager.
- This process will be completed before beginning QA reviews in production QA Monitor.

PART IV: APPENDICES

A. GLOSSARY OF TERMS

Agency – State agency

Change Request Committee – means QA and QI do not have sufficient information to determine if a change request should be upheld or overturned and determines APS leadership needs to make the final determination.

Department – This term refers to the Washington state Department of Social and Health Services (DSHS).

Designated Staff – Refers to the regional or Central Intake point of contact for QA/QA process.

Finding – A term used to describe an identified gap between policy guidance and what was found during a QA process review.

Overturn – means QA agrees with the information provided within a change request and overturns the process review finding.

Population –The entire population subject to review.

Unit Leadership – means the individuals responsible for the activities of a designated unit. This can include Unit Managers, Program Managers, and Regional Administrators.

Uphold – means QA and QI agree that the information provided in the submitted change request does not support overturning the finding, and the finding will remain in place.

Working days (business days) – defined as Monday through Friday, excluding federal and state holidays.

B. ACRONYM LIST

ALTSA Aging and Long-Term Support Administration

CMS Center for Medicare and Medicaid Services

CRC Change Request Committee

DRA Deputy Regional Administrator

DS Designated Staff

DSHS Department of Social and Health Services

MA Management Analyst

MB Management Bulletin

MSD Management Service Division

OAS Office of the Assistant Secretary

PIP Proficiency Improvement Plan

PM Program Manager

QA Quality Assurance



QI Quality Improvement
QIC Quality Improvement Coordinator
QMS Quality Management System
RA Regional Administrator
RCN Review Cycle Note
RCW Revised Code of Washington
SHPC Social and Health Program Consultants
SME Subject Matter Expert
SPA State Plan Amendments
TIVA Tracking Incidents for Vulnerable Adults
WAC Washington Administrative Code
WD Working Day

C. SAMPLE QA PROCESS REVIEW RESULT EMAIL TEMPLATE

Region X APS HQ QA Process Review has been completed and the following reports are attached to this email:

- The QA Review Data workbook includes the 2307 Proficiency with Details report, the data broken down by supervisor, case manager, a heatmap by offices and the 2303 Questions Requiring Action Report broken down by supervisor.
- The Findings and Analysis workbook provides a Data Analysis report with the questions, findings and analysis comments for each review that received a finding, the 2310 Analysis Comment Report, the 2303 Questions Requiring Action Report.

Also attached is the Remediation and Change Request Process guide, 2023 Remediations for APS Investigation guide and the Region X tracker.

What's Next?:

- Region X's 30-day remediation timeline is XXXX –XXXXX. Change Requests will need to be submitted by close of business on XXXXX (via QA Monitor).
- Most remediation items will be considered "Historical Data," which require no physical action; please encourage supervisors to facilitate learning opportunities with their staff regarding these items. Remediation completed by region must be documented in a Review Cycle Note (RCN) when an action is completed to remediate findings. Using the "Action Taken" drop down, the Review Cycle Note (RCN) must include information about how the finding(s) was remediated.

D. RESOURCES AND FORMS

Background

The QA Unit has transitioned to using a QA SharePoint as the primary means of communication with APS staff, Policy, Training, and anyone at APS interested in QA activities.

Members of the QA Unit have access to the QA Unit's internal SharePoint site. This site is only accessible to the QA Unit and other leadership staff as required. The site provides the tools, templates, and information needed to complete process reviews.

Procedure

Process Review Areas and Programs

1. Investigation

a. QA reviews the following areas:

- i. Timeliness
- ii. Documentation
- iii. AV Interview
- iv. AP Interview
- v. Collaterals
- vi. Decision Making Ability Screening
- vii. Law Enforcement Referrals
- viii. Outcome Reports
- ix. Vulnerable Adult Status
- x. Allegations
- xi. Finding
- xii. Protective Services
- xiii. Supervisor Actions

2. Closed No APS

a. QA reviews the following areas:

- i. Finding
- ii. Law Enforcement Referrals
- iii. Outcome Reports

3. Intake Screen In

a. QA reviews the following areas:

- i. Timeliness
- ii. VA Status
- iii. Safety
- iv. Referrals
- v. Screen In accuracy
- vi. Allegations
- vii. Intake Priority

4. Intake Screen Out

a. QA reviews the following areas:

- i. Timeliness
- ii. VA Status
- iii. Referrals
- iv. Screen out reason

5. 90-Day Reason Code

a. QA reviews the following areas:

- i. Reason code documentation

6. Safety and Risk Screening (Biennial)



- a. QA reviews the following areas:
 - i. Screening evidence
 - ii. Staffing
 - iii. Timeliness

7. Documentation Timeliness (Biennial)

- a. QA reviews the following areas:
 - i. Case notes
 - ii. File Uploads

Additional Information

- a. Only closed investigations or completed intakes will be reviewed.
- b. Additional reviews may be conducted as requested by executive leadership. Reviews are subject to change by leadership and a schedule is posted each year to clarify which reviews will occur that year and when during that year those reviews will occur.

QA Unit Manager Responsibility

- 1. Train new staff and ensure they can demonstrate they understand this procedure.
- 2. Conducts supervisory reviews of QA staff work to ensure policies and procedures are followed.
- 3. Request training or clarification from leadership as needed.



Nursing Services and Triggered Nursing Referrals

This chapter outlines the process for identifying and referring clients who may benefit from Nursing Intervention within Home and Community Services (HCS) and Area Agencies on Aging (AAA) programs. Policies and procedures described in this chapter apply to HCS and AAA clients. For Developmental Disabilities Agency (DDA) clients, please refer to applicable DDA policies and procedures.

This chapter also defines the responsibilities of Nursing staff, including:

- Responding to nursing referrals.
- Performing nursing service activities (e.g., CARE/CARE Assessment reviews, consultations, or assessments); and
- Documenting the recommendations and activities.

This chapter also defines the responsibilities of the case manager (CM) which includes:

- Meeting and understanding referral timelines.
- The CM is responsible for ensuring Nurse referrals are acknowledged and completed within required timelines. Documentation of referral receipt and completion is completed by the Nurse.
- Ensuring Nurse findings and recommendations are added to the CARE Assessment's Plan of Care ideally before moving to current but otherwise via an interim assessment, if necessary, all while ensuring no conflicting findings/documentation.
- Address and document in SER note the client follow-up and outcomes for each Nurse recommendation.

[Ask the Expert](#)

If you have questions or need clarification about the content in this chapter, please contact:

Marlo Moss, MS, RN Nursing Services Program Manager nursingservices@dshs.wa.gov

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BACKGROUND

What Are Nursing Services?

Nursing Services (NS) are administered by Nurse Care Consultants (NCCs), RN Case Managers (RNCMs), Registered Nurse Consultants (RNC) and Licensed Practical Nurses (LPN), contracted Nurse Delegators, Private Duty Nurses and Skilled Nurses. These nurses provide focused CARE triggered nursing assessments and clinical consultation to clients eligible for Medicaid Long-Term Services and Supports (LTSS). These services are available to clients, their providers, and case managers to support the development, coordination, and implementation of person-centered plan of care. The protocols outlined in this chapter are critical to ensuring the ongoing health, safety, and well-being of clients receiving long-term care services. See WACs under Resources.

Nurse Care Consultants (NCCs), AAA Case Managers, HCS regional Case Managers, RN Case Managers (RNCMs), Registered Nurse Consultants (RNC) and input from Licensed Practical Nurses (LPN) collaborate to develop and implement appropriate care plans for all clients with triggered nursing referrals, most importantly, those related to skin integrity and the prevention of pressure injuries.

According to the National Pressure Injury Advisory Panel (2024), a pressure injury is defined as:

“Localized damage to the skin and underlying soft tissue, usually over a bony prominence or related to a medical or other device.”

The Skin Observation Protocol (SOP) supports the early identification and monitoring of concerns related to a client’s skin integrity. The SOP provides a structured process for case managers, caregivers, nurses and providers to recognize potential indicators of skin breakdown, pressure injuries, or other skin-related conditions and ensures appropriate follow-up when concerns are identified.

SOP supports prevention, timely communication, and referral to a nurse when clinical consultation may be necessary. The SOP does not replace clinical assessment by a licensed nurse and is intended to support safe care planning and coordination within the Long-Term Care Manual (LTCM).



Pressure injuries may present as intact skin, redness, or open wounds and can be painful. These injuries result from intense and/or prolonged pressure, or pressure combined with shear. Tissue tolerance may also be affected by microclimate, nutrition, perfusion, comorbidities, and the overall condition of the soft tissue.

Licensed Practical Nurses (LPNs)

Area Agencies on Aging (AAAs) may employ Licensed Practical Nurses (LPNs) as nurse consultants to complete focused assessments for the Skin Observation Protocol (SOP) and other CARE-triggered referrals for the purpose of data collection. The collected data is reviewed by a Registered Nurse (RN) for care planning purposes.

For additional information on LPN scope of practice, refer to the Washington State Department of Health – Board of Nursing Advisory Opinion on the Registered Nurse and Licensed Practical Nurse Scope of Practice (NCQA 3.02):

<https://nursing.wa.gov/sites/default/files/2022-07/NCAO13.pdf>

Role of the Nurse Consultant-Emergent Care

When the Nurse conducts a consultation/assessment visit as outlined in this policy they do not provide ongoing clinical treatment or routine hands-on care during these visits.

If an urgent or emergent situation arises while the Nurse is present in the home, the Nurse may provide immediate assistance within the scope of the Washington Nurse Practice Act, limited to actions necessary to address immediate client safety, until emergency responders arrive and assume care.

If a wound dressing is observed to be soiled, displaced, or removed during the assessment process, the caregiver should replace the dressing using the client's supplies. When necessary to protect the client's health or safety, the Nurse should check the physician order and then can temporarily cover or secure the wound using the client's available supplies.

Any assistance provided by the Nurse must be limited to temporary measures necessary to maintain client safety. The Nurse must document the circumstances, actions taken, and any instructions or follow-up provided in the client record.

Exception:

If a contracted Skilled Nurse is in the home and authorized to do an SOP and has an authorization to do a skilled task, then both can be completed.

Related Nursing Services Chapters:

For additional nursing-related policies, refer to the following:



- Skilled Nursing: COPES Waiver Skilled Nursing – [Chapter 7D](#)
- Nurse Delegation: [Chapter 13](#)
- Private Duty Nursing: [Chapter 25](#)
- Adult Day Health: [Chapter 12](#)

NURSING SERVICES RESPONSIBILITIES – NCC, RNCM, RNC, RND, SN or LPN

Nurses are responsible for performing the following activities related to client health and skin integrity:

- Conducting focused nursing assessments from CARE triggered referrals, including Comprehensive Assessment Reporting Evaluation (CARE) assessments.
- Completing nursing assessments per the Skin Observation Protocol (SOP) and all other nursing triggered referrals.
- Providing one-on-one education and instruction for care providers and clients.
- Coordinating care and health resources ensuring continuity of care with case manager.
- Evaluating health-related care needs and ensuring clients will receive appropriate care for all triggered referrals based on circumstances.
- All nurses must work within their scope of practice.

IDENTIFYING CLIENTS FOR NURSING SERVICES

Eligibility

Per [RCW 74.09.520 \(2\) \(b\) and \(c\)](#):

“The rules shall require clients be assessed as having a medical condition requiring assistance with personal care tasks. Plans of care for clients requiring health-related consultation for assessment and service planning may be reviewed by a nurse. The department shall determine by rule which clients have a health-related assessment or service planning need requiring registered nurse consultation or review.”

Nursing Services are available to all Title XIX clients who are eligible for any of the following programs:

- Medicaid Personal Care (MPC)
- Community First Choice (CFC)
- CFC-COPES
- Roads to Community Living (RCL)
- Residential Support Waiver (RSW)
- New Freedom Waiver
- LTSS Presumptive Eligibility

Note: Veterans Direct Care Program nursing needs are referred to the VA hospital Primary Care team not to RNC.



Regulatory References:

- For MPC – [WAC 388-106-0200\(3\)](#)
- For COPES – [WAC 388-106-0300](#) and [WAC 388-106-0305](#)

ELECTRONIC SIGNATURES

- Electronic signatures are permitted on person-centered service plans, orders, and other required documentation unless otherwise specified.
 - The person-centered service plan must be finalized and agreed to in writing in accordance with [42 C.F.R. § 441.540](#).
 - Signatures may be provided in any format that demonstrates the signatory's agreement with the person-centered service plan, including handwritten (wet), electronic, stamped, or other legally recognized signature formats.
 - The signature must clearly identify the signatory and be attributable to the individual signing the document.
 - Electronic signatures must comply with applicable federal and state requirements, including [chapter 1.80 RCW](#).

TRIGGERED REFERRAL CRITERIA

Certain client health conditions automatically trigger a referral to a Nurse through the CARE assessment system.

The Skin Observation Protocol supports the assessment and care planning processes within Long-Term Services and Supports (LTSS). Information obtained through CARE assessments, provider reports, caregiver observations, or other communications may indicate potential concerns related to skin integrity.

When such concerns are identified, the case manager will decide based on SOP protocols when to initiate a referral to the nurse for clinical consultation. Any recommendations resulting from nursing consultation should be considered as part of the client's person-centered plan of care and coordinated through the case management process.

Health-related needs that are not identified as critical indicators or triggered referrals may still be referred to the nurse at the case manager's professional discretion. These referrals should be limited to circumstances in which clinical nursing consultation is **necessary** to support care planning or address a health-related concern. Prior to initiating a non-triggered referral, the case manager should:

- Review the client's assessment and available records to ensure the issue has not already been addressed.
- Complete applicable case management actions within the case manager's scope of responsibility; and



- Clearly identify the specific health-related concern or clinical question for which nursing consultation is requested.
- Discuss the situation with their supervisor and follow local office protocol.
- Document all pertinent information in CARE.

The following are considered critical indicators for Nursing Services referral criteria. **One or more** of these criteria may indicate the need for a Nursing Services referral.

1. The presence of any one or combination of diagnoses that are unstable or changing:

- a) Diagnosis of insulin dependent diabetes **and** one or more of the following:
 - ≥ 3 ER visits in the last six months (consider if data self-reported or actual)
 - Recurrent infections
 - Non-healing/deteriorating lesions
 - Open lesions (foot screen)
 - Vision impaired and the client is administering the injection(s)
 - The client does not adhere to the prescribed nutritional eating plan.
 - BMI < 19 or > 30
 - Presence of diagnosis of depression
 - Presence of diagnosis of cellulitis
 - Infection (cellulitis, drainage, or infection in foot)
- b) Diagnosis of quadriplegia **and** one or more of the following:
 - UTI
 - Current pressure injury
 - Recurrent infection
 - CPS (Cognitive Performance Score) > 3
 - Overall self-sufficiency has declined in the past 90 days
 - Treatment includes a ventilator or tracheotomy
 - Incontinence
 - Fecal Impaction
- c) Two or more hospitalizations or emergency room visits in the past 6 months.
- d) An indication on the assessment that the client has:
 - Pain daily, *or*
 - A pain scale rating > 4 (5-10) **and** pain impact is “limiting activity” **and** pain treatment is ineffective
- e) Treatment needs that include one or more of the following, with the listed indicators:
 - Tracheotomy/suctioning,
 - Indwelling catheter care,
 - Injections,



- Wound/skin care,
- Passive ROM, and/or
- Tube feedings **and**
 - The client has any of the following:
 - A UTI,
 - Recurrent infections,
 - ≥ 3 hospitalizations OR ≥ 3 ER visits in the last six months (consider if data self-reported or actual), **and/or**
- If any of the providers below are already involved in case then another nurse referral is not necessary, however, notify them if a change in condition is discovered.
 - Nurse Delegator
 - Home health agency
 - Hospice
 - Skilled Nursing (Waiver)

2. The presence of a medication regimen that affects client assessment, service planning and delivery:

a) Medication management is “must be administered to person” **and client:**

- Chokes or gags on medications, **or**
- Is not taking medication as prescribed

b) Client is declining assistance with medications **and:**

- Is not taking medication as prescribed, **and**
- Had 2 or more ER visits or hospitalizations in the past 6 months

c) Medication regimen is complex **and client:**

- Has multiple prescribers, **and**,
- Had 2 or more ER visits or hospitalizations in the past 6 months, **and**,
- Is not taking medication as prescribed

d) Client live alone, **and:**

- Needs assistance with medications and the need is unmet, **and**,
- Frequency is daily, **and**
- Classification Category is A Low or B Low

3. Nutritional status or weight concerns affecting service planning and delivery as evidenced by the client having (triggers could include oral problems/hygiene and dental problems):

a) Weight loss or gain, **and a BMI of less than 18.5 or greater than 30, **and** one or more of the following:**

- Chewing problem
- Current swallowing problem
- Non-compliant with prescribed or advised eating plan



- Poor appetite
- Appetite change
- b) A current swallowing problem **and** a BMI of < 18.5 or > 30 **and** the client is:
 - On a mechanically altered diet, or
 - Using a dietary supplement
- c) Nutritional approaches that include:
 - Enteral, or,
 - Parenteral **and** the provider type is one of the following:
 - CDWA (IP)
 - Home care agency worker
 - Informal support
 - Client, **and** there none of the following are in place:
 - Nurse Delegation
 - Home Health
 - Self-directed care
 - Skilled Nursing Waiver
- d) A client aged 2-20 with a BMI of underweight (BMI for age, 5th percentile) or overweight (BMI for age > 95th percentile)

*****NOTE: To document Chairfast or Bedfast use the guidelines below:**

- Chairfast = unable to ambulate (may be up in a chair/wheelchair; may or may not be able to wheel self, a Hoyer lift or other means is used to place client in chair)
- Bedfast = unable to ambulate or be up in a chair, i.e., essentially confined to bed

Code based on ability and safety, not preference.

Example:

If a client *could* get up/transfer/ambulate safely (even if they choose not to), that generally should not be coded as bedfast/chairfast. If there are medical restrictions or safety limitations that effectively prevent mobility, that should be reflected.

Separate “definition” from “risk considerations.”

Example:

Items like ability to offload pressure, sensation at pressure points, and repositioning needs are very important clinically for care planning and pressure injury risk — but they are not, by themselves, the definition of bedfast/chairfast. We should treat them as additional clinical considerations.

4. The client is bedbound or has care needs related to immobility that affect the assessment, service planning, and delivery. This may be triggered by:



- a) The client is assessed as needing **but not receiving**:
 - Passive ROM, active ROM that does not need to be delegated, splint or brace assistance, transfer or walking assistance, **and**
 - The client's overall self-sufficiency has declined in the last 90 days, **or**
 - The provider code is either:
 - Client or family/informal supports
 - CDWA (IP)
 - Self-directed care
- b) The client is assessed as bladder *or* bowel incontinent most or all the time, **and**
 - Uses incontinent supplies and has leakage, **or**
 - Does not use incontinent supplies but has occasional incontinence, **or**
 - The client is assessed as having one or more of the following:
 - Diarrhea
 - UTI
 - History of recurrent UTIs
 - Constipation
 - Fecal impaction
- c) The client ADL self-performance code is **limited or extensive** assistance for one or more of the following ADLs:
 - Bed mobility
 - Transfer
 - Walk in room (incl. hallway and rest of immediate living environment)
 - Locomotion in room/immediate living environment **and** the client is assessed as having a fall in the last 6 months.

5. Skin breakdown or history of skin breakdown. This may be triggered by:

- a) An indication in CARE that the client has one or more of the following skin problems NOT related to pressure **and** the status is non-healing or is deteriorating:
 - Abrasions, skin tears, or cuts
 - Burns
 - Open lesions
 - Rashes
 - Skin fold / perineal rash
 - Surgical wounds
 - Stasis ulcers **and** on the Treatment Screen one or more of the following is not there:
 - Application of dressing
 - Application of medication
 - Wound/skin care



- Client needs treatment but does not receive it
 - b) Foot problems include:
 - Fungus
 - Infection
 - Open lesions
 - Ingrown toenail **and** the problem is non-healing or deteriorating **and** on the Treatment screen one or more of the following is not there:
 - Application of dressing
 - Application of medication
 - Wound/Skin care
 - Client needs treatment but does not receive it
- 6. **CARE assessment identifies the need for the Skin Observation Protocol (SOP) and the creation of a pressure injury prevention plan.** Pressure injuries are also called bed sores, decubitus ulcers, pressure sores, and pressure ulcers. **The SOP:**
 - a) Is a pressure injury prevention plan in place that case managers, Nurses, caregivers and clients can follow to prevent a pressure injury or the progression of a pressure injury.
 - b) Specifies the responsibilities of case managers **and** nursing service respondents when a client meets the highest risk indicators identified in CARE.
 - CM sends all SOPs requiring a nurse consultation to the nurse consultant. If the nurse consultant is not available this must be documented and approved by supervisor, then send to RND or SN to complete.
 - c) The SOP may be triggered by **one or more** of the following:
 - Current pressure injury
 - Quadriplegia
 - Paraplegia
 - Total dependence with bed mobility
 - Comatose or persistent vegetative state
 - History of pressure injury within 1 year
 - Bed- and/or chairfast **and** cognition problems
 - Bed- and/or chairfast **and** incontinent of bladder or bowel most or all the time
 - Bed- and/or chairfast **and** insulin dependent diabetes mellitus (IDDM)
 - Hemiplegia **and** cognition problems **and** bladder or bowel incontinence
- 7. **When skin integrity concerns are identified outside of the CARE assessment process, the case manager must document the concern in CARE and initiate a referral to Nursing for evaluation.** Upon receipt of the referral, the Nurse will review the information, evaluate the reported concern, and provide clinical consultation, recommendations, and follow-up as appropriate to support the client's care plan and the prevention of further skin breakdown.



Nursing Services Involvement During Transitions of Care

Nursing Services may provide clinical consultation and expertise related to skin care and skin integrity during a client's transition from, or discharge by, a home health agency or previous health care provider.

This involvement supports continuity of care and ensures that home and community-based services are appropriately aligned with the client's ongoing health needs.

Nursing activities occur in collaboration with the case manager to confirm that the client's functional, health, and cognitive needs are met through coordinated service planning and delivery.

Services may include consultative support and, when indicated, a nursing assessment—such as the *Skin Observation Protocol (SOP)* to evaluate the adequacy of the service plan and interpret health-related, client-specific needs.

Note: Other resources may be available for AAA non-core clients. The referral criteria are the minimum set of criteria, as shown in the *Nursing Referral Indicators* screen of CARE, that you should use when considering a client for nursing services.

Examples of Nursing Services Involvement

Nursing Services may be engaged in the following circumstances:

- If a Nurse has an approved and documented reason, that prevents them from performing the SOP referral then an authorization can be sent to the RND or SN to complete the referral.
- A client receives **Private Duty Nursing (PDN)** and requires **nursing consultation** from HCS or DDA **Nurse Care Consultants (NCCs)**.
- A client resides in an **Enhanced Adult Residential Care (EARC)** or **Assisted Living (AL)** setting required to provide limited nursing services under **WAC 388-78A-2310**.
- The **primary care provider** is actively or recently involved in the client's health-related assessment or service planning.

Client Transfer and Referrals

Who Should I Refer the Case to?

** For HCS clients who were assessed in hospitals and skilled nursing facilities*

New HCS <i>in-home or residential</i>	New and ongoing DDA <i>in-home or residential</i>	Ongoing AAA <i>in-home</i>
HCS NCC (unless alternative local agreements allow you to refer it to the AAA)	Nursing Services resources. These include a AAA or a contracted agency or individual RN provider (DDA Policy 9.13)	AAA RN or LPN Case Manager or contractors



Transferring Clients

Note that for both HCS and DDA, local agreements with AAAs may require additional referral forms or communication. Common activities across both HCS and DDA are:

- Verify that the AAA, where your client is located, still has a DSHS contract for nursing services before transferring
- Nursing Referral Indicators in CARE are addressed.
- Skin Observation Protocol (SOP)

HCS to the AAA

- HCS staff must utilize HCS nursing resources **first**, before transferring the case (unless otherwise agreed to by the AAA).
- Complete the Case Transfer Form in Barcode:
 - Referring the case to the AAA for nursing services (per local agreement)
 - Transferring a case from one office to another (and nursing services have already been provided)
- As applicable, check the following boxes on the electronic Case Transfer form (if necessary, include additional information in the Comments space):
 - Nursing services
 - In-home nursing services review by AAA needed (NOTE: The AAA may assign referred cases to a case manager with a request for nursing consultation or to an AAA RN/case manager)
 - Nurse Delegation
- Local agreements may require additional referral forms or communication.

DDA Clients

Please refer to DDA Policy 9.13 for additional information on providing Nursing Services, including SOP. Use the DDA Nursing Services Referral Form (DSHS Form 13-911) to check:

- The type of Nursing Service activity(s) requested.
- The Nursing Referral or SOP reason(s) for referral; and
- Any special instructions or comments for the nurse.

The DDA Nursing Services Referral form can be faxed or emailed to the local NS resources, according to regional field office procedures and HIPAA compliance requirements (particularly when sent via email).

Nurse Delegators

In the situation where the Nurse is documented as unavailable and approval from supervisor is documented, case managers may refer the Nursing Trigger – Skin Observation Protocol, to any available Nurse Delegator, who will address *all* other nursing triggers at the same time. The timeframes for Nurse Triggered referrals can be found in this document under “Referral and Response Timeframes” (p.15). All NDs are held to the SOP policy timeframes. Reference: [Chapter 13 LTCM](#)

Contracted Skilled Nurses for SOP

In the situation where the Nurse is unavailable and approval from supervisor is documented, authorized staff may refer the Nursing Trigger – Skin Observation Protocol, to any available Skilled Nurse, who will address *all* other nursing triggers at the same time. The timeframes for Nurse Triggered referrals can be found in this document under “Referral and Response Timeframes” (p.15). All SNs are held to the SOP policy timeframes.

The case manager will send out the HCS/AAA Nursing Services Form: [HCS/AAA Nursing Services Referral Form \(#13-776\)](#)

Required Return Forms

Ensure the following forms are completed and uploaded to the proper resource in your office within the required timeframes:

- [Basic Skin Assessment \(13-780\)](#)
- [Pressure Injury Assessment and Documentation \(13-783\)](#) – (Form only needs to be filled out and returned when there is an actual pressure injury confirmed)

For DDA cases, refer to [DDA Policy 9.13](#) for Nurse Delegator referrals related to SOP.

Communication

When the protocol requires communication, verification, or information exchange with non-professional caregivers, and you are unable to contact the caregiver, try the following:

- Agency-Employed Caregiver:
Contact the home care agency supervisor or designated contact person.
- Individual Provider (IP) via CDWA:
Contact CDWA only to request that the IP reaches out to the case manager or nurse.
No client or case information should be shared directly with CDWA.

Ineligible Clients

Clients assessed in CARE who are determined ineligible for services or decline services may still trigger the Skin Observation Protocol (SOP).

In these cases, consult with your supervisor to determine the appropriate response, considering the client’s available caregiver support and health-related skin care needs based on identified high-risk indicators.

Check with your regional office or AAA for the action steps, if none are available, follow this general guideline below for the appropriate action.

- Consult your supervisor.



- Contact your designated SHPC trainer, or AAA trainer.
- If unresolved, contact the HQ Nursing Services Program Manager.
- See “SOP Visit Delayed” 24.25-27.

REFERRAL AND RESPONSE TIMEFRAMES

Service referral timeframes represent maximum allowable limits to ensure timely referral and response. In some cases, medical necessity may require a shortened timeframe.

Case managers and nursing professionals are responsible for evaluating each client’s individual situation and adjusting timeframes as needed to meet health and safety requirements.

- Applies to the **DSHS business week** (Monday–Friday, excluding State Holidays and weekends).
- **The day of assessment is day zero (0).**
- The **response clock** begins the **next business day** following the assessment visit.
- Example: *If assessment completed on Friday, two-business-day timeline begins on Monday.*
- Staff are collectively responsible for ensuring coverage and compliance within required
- timeframes.

What to do when SOP Triggers

Timeframe (maximum)	Required Action*
2 business days	Case Manager makes referral, if indicated
2 business days	Nurse confirms receipt of referral
5 business days	Nurse will review CARE Assessment and related documentation, reach out to client, family member, or POA/Guardian via telephone. If unable to make contact within the timeline, the nurse will document all efforts and barriers, inform the supervisor, case manager, and contact client as soon as possible
20 business days	Nurse will complete home visit, if necessary, and complete all documentation.
Total of 29 business days	

***Case Managers:** Some referrals will require quicker response times, per SOP, and may need to be submitted on the day of the assessment.

***Nurses:** Some referrals will require quicker response times based on client situation and nursing judgement.



What to do when other Nursing Referrals are Triggered (excluding SOP)

Timeframe (maximum)	Required Action*
2 business days	Case Manager makes referral, if indicated.
2 business days	Nurse confirms receipt of referral
10 business days	Nurse will review CARE Assessment and related documents and reach out to client, family member, or POA/Guardian via telephone. If unable to make contact within the timeline, the nurse will document all efforts and barriers, inform the supervisor, case manager, and contact client as soon as possible
15 business days	Nurse will complete home visit, if necessary, and complete all documentation.
Total of 29 business days	

***Case Managers:** Use professional judgment to determine which triggered referrals need to be sent to a nurse or other professional.

***Nurses:** Evaluate referral and make further decisions using nursing judgement

DDA clients Use [DDA Policy 9.13](#)

Exceptions:

- Exceptions to the Nursing Services activity timeframes may occur only when:
 - The referral source requests a shorter or longer timeframe and provides justification.
 - The client requests a shorter or longer timeframe.
 - The client is not available for consultation or visit.
- If a planned activity timeframe is not met, the **reason for the delay** must be documented in the Service Episode Record (SER).
- If a referral is made to a nurse who does not have CARE access and a delay is reported, this must also be recorded in the SER, along with the plan for follow-up and resolution of identified care needs.

PERFORMING NURSING SERVICES ACTIVITIES

Skin Observation Protocol is not just pressure injury protocol. The skin is the largest organ in the body.

- How to identify skin concerns:
 - It is important that you ask your client about their skin and if they have any issues or concerns such as: Rashes, open areas, wounds, bruises, etc.
 - Ask about previous pressure injuries, surgical wounds, etc.



- Ask collateral contacts/caregivers about any skin concerns.
- Use the pressure injury staging cards for reference.
- After receiving a referral or authorization from the case manager, the Nurse must complete and document the following activities as appropriate:
 - Review the CARE assessment (if the contractor does not have CARE access, the case manager will provide all necessary documentation).
 - Conduct consultations (office, telephone, or electronic).
 - Conduct a home visit or observation, if required. Follow the SOP scenarios below 24.22.
 - Perform a nursing assessment or reassessment, if required.
 - Collaborate with the case manager to determine the frequency and scope of nursing service activities, based on the client's individual needs.

Nurse CARE Assessment Reviews

The nurse should review the CARE assessment, Service Summary, and any pertinent Service Episode Record entries to identify health-related concerns such as:

- Health conditions that are not addressed by service interventions.
- Unmet medical or functional needs.
- Client and/or caregiver education needs.
- Gaps in care or resource coordination.
- Examples of follow-up activities may include:
 - Consultation with a physician, home health provider, or pharmacy.
 - Providing education about available community resources.
 - Telephone consultation when the client's condition changes.
 - Discussion with the case manager regarding a referral to COPES/RCL Skilled Nursing, RND or Adult Day Health for unmet or intermittent skilled nursing needs.
- *Note:* If the CARE assessment was completed by a nurse or if the assigned case manager is a registered nurse, an additional nursing review is not required.

In the case of a referral to a Nurse that does not have access to CARE, the case manager sends SOP Referral Form [#13-776](#) with the following documents:

- Current CARE assessment
- Pertinent Service Summaries
- Release of Information form
- Any other necessary information for the assessment
- Use one form per pressure injury

Nurses without access to CARE fill out and return the following forms to the case manager:

- [FORM 13-780](#) – Nursing Services Basic Skin Assessment
- [FORM 13-783](#) - Pressure Injury Assessment and Documentation – This form only needs to be filled out if a pressure injury is found. Please use one form per pressure injury.

Consultations, Assessments, and Visits

Based on the CARE assessment review, the nurse may perform one or more of the following activities:

- Nursing assessment/reassessment conducted in person when required. If visit is required this will be made in person and if visit is not possible, the nurse must consult with their supervisor and document the reason and any alternative action.
- Instruction to clients and/or caregivers, preferably in person. If it is not possible, staff with a supervisor and document both the reason and the alternative teaching method used.
- Care coordination among interdisciplinary team members.
- Evaluation of health-related care needs impacting service planning.

For skin assessments, the nurse will conduct a focused nursing assessment of all skin areas, which may involve repositioning the client. The nurse will provide education or instruction to the client or caregiver based on referral indicators, identified problems, or service planning needs.

Nursing Process Standards

Per [WAC 246-840-700\(2\)\(a\)\(i\)\(A\)](#), the nursing process is a systematic, problem-solving approach aimed at achieving optimal client functioning and health. It includes:

- Assessment and analysis: The registered nurse collects and interprets objective and subjective data regarding the client's health status.
- Focused assessment: When indicated (e.g., SOP referrals), the nurse performs a focused assessment to gather relevant clinical information. "Nursing-focused assessment" (for Skin Observation Protocol) means a focused nursing assessment limited to the client's skin integrity risk and current skin condition, including collection and documentation of pertinent findings sufficient to identify areas of concern and guide timely nursing interventions and follow-up. [WAC 246-840](#), [RCW 18.79](#), [NCQAC Advisory Opinion NCAO 13.02](#).
- Coordination: The nurse coordinates with the case manager when CARE updates or additional referrals are required to meet immediate and ongoing client needs.

Nursing Activities **May Include Assessment or Instruction or any/all of the following:**

- Perform focused nursing assessment
- Vital signs are the responsibility of the nurse doing the SOP based on nursing judgment. If vital signs are deemed necessary by the nurse, then document in the nursing comment section in CARE. For contracted nurses document on form [13-780](#), the updated form will be available on or before June 2026.
- Conduct Skin Observation Protocol (SOP) assessments.
- Evaluate positioning and mobility in relation to skin care and comfort.
- Review medical and surgical history, treatments, and current status.
- Review physical systems relevant to the client's functional and cognitive abilities.
- Assess psychosocial, emotional, and cognitive factors affecting care.
- Conduct medication review and identify issues requiring follow-up.
- Identify unaddressed client problems and caregiver teaching needs.



- Provide clients with education and teaching as appropriate.

Follow LTC Manual Chapter 3 (Assessment and Care Planning) for CARE documentation standards.

Contracted nurses without CARE access (e.g., Nurse Delegators, Skilled Nurses, PDN) must use [WAC 246-840-700\(2\)\(a\)\(i\)\(A\)](#) to submit recommendations to the case manager for CARE updates.

Educating Clients and Providers

Nursing Services may include education on:

- Disease processes and symptom management aligned with the client's cognitive and functional ability.
- Pressure injury prevention and early detection.
- Medication purposes, side effects, and interactions.
- Behavioral strategies and non-pharmacological alternatives to restraints or psychotropic medications.
- Safety protocols and universal precautions.
- Health promotion and prevention strategies to support overall client wellness and independence.

Care and Resource Coordination

The nurse will:

- Coordinate with members of the client's healthcare team and assist with necessary referrals.
- Educate clients and caregivers about community programs and available support.
- Offer telephone consultation or follow-up assessments based on changes in health status.

Evaluating Health-Related Functional or Cognitive Needs

If health-related concerns affect service planning or delivery, the nurse will:

- Observe, monitor, and reassess the client as needed.
- Evaluate caregiver training needs when skill deficits are identified.
- Update the care plan based on new assessment information.
- Identify and recommend additional Nursing Services activities when indicated.

Prohibited Activities

Nurses performing consultation or assessment under this policy must not perform skilled treatment, except if client is in jeopardy or threat of requiring immediate emergency medical care until the first responders arrive. If necessary, the nurses can do basic wound re-covering, using client's supplies, after observation for client safety, and document the task and the reason for your involvement.



Skilled treatment includes any skilled task requiring authorization or supervision by a licensed practitioner, such as injections, lab draws and complex wound care. Clients requiring these services must be referred to a contracted skilled nurse, home health or other licensed providers.

Documenting Results of Nursing Services Activities

- All activities, CARE/CARE Assessment reviews, consultations, and visits, must be documented in CARE or in the client's record.
- Documentation is not optional – it is a required part of your professional practice and a condition of participation in State and Medicaid programs. All records are subject to audit and missing or incomplete documentation may result in audit findings and corrective action, including placement on a performance improvement plan.
- If a nurse does not have CARE access, documentation must be completed using Department-approved forms.
- Documentation Guidelines ([Chapter 3 LTC Manual](#))

Department-Approved Forms

- When referrals are sent outside the agency, the following Department-approved forms must be used for consistency and compliance:
 - [Nursing Services Basic Skin Assessment \(13-780\)](#)
 - [Pressure Injury Assessment and Documentation \(13-783\)](#)
 - Documentations for "Other Triggered Referrals" should be done on a separate document that is a complete and concise nursing note and returned with the forms above.
- All documentation and communication must comply with confidentiality and privacy laws (e.g., HIPAA), as well as AAA and DSHS contract requirements.
- All forms and requests sent via email must use secure transmission and include a signed [DSHS 14-012](#). (Consent for Release of Information) form.

HCS/AAA Skin Observation Protocol

When an SOP referral is triggered, the assessor determines whether the client has:

- Current Pressure Injury
- Treatment Plan, and:
- Who is providing the treatment, a professional/non-professional/informal support caregiver.

Depending on the SOP scenario, a referral is sent to the Nurse. The nurse documents the review, visit note (if applicable), and all findings. If no pressure injuries are observed, the case manager completes documentation per protocol.

Skin Observation Protocol Requirements



The Skin Observation Protocol (SOP) is a mandatory process that must be completed for every client who triggers a high-risk indicator for compromised skin integrity.

The protocol ensures that all required activities are completed based on the client's current skin condition and the presence or absence of a capable caregiver. An observation refers specifically to an in-person visit conducted by a qualified nursing professional to assess the client's skin integrity.

During an SOP visit **all pressure points must be observed and documented in your nursing note. This includes pressure points as well as observed pressure injuries. Example: All pressure points observed as clear and intact with no notable issues, except for sacral area has a 1.0 cm x 2.0 cm of redness with slight tenderness to touch, blanchable.**

Purpose of the Protocol

The SOP provides structured guidance for determining:

- Whether a nursing observation visit is required.
- What activities must be completed by the case manager and/or nursing staff.
- The corresponding documentation requirements for both case management and nursing personnel.
- Priority Triage
- A non-professional is considered an unlicensed individual.

Priority Triage Levels for SOP Referrals

Priority triage is used by case managers and Nursing Services to determine the urgency of response for referrals related to skin integrity and the Skin Observation Protocol (SOP). **Priority triage supports referral management and does not replace clinical judgment. The definitions below are a guideline to help the assessor determine the response timeline.**

High Priority

Used when there is a significant risk of rapid deterioration or potential for serious harm if not reviewed promptly. Examples may include suspected pressure injuries, open wounds, signs of infection, rapidly worsening skin breakdown, or reports of untreated or uncovered wounds. High-priority referrals should be reviewed by Nursing Services as soon as practicable.

Routine Priority

Used when a skin concern is present but does not indicate immediate risk to the client's health or safety. Examples may include new redness, early skin irritation, or non-urgent skin integrity concerns that require nursing consultation or guidance. These referrals are addressed within standard Nursing Services response timeframes.

Monitor / Follow-Up

Used when the referral is informational or when a concern is being monitored but does not currently require nursing consultation. The case manager may continue to monitor the situation and initiate a referral if conditions change or indicators are triggered.

Skin Observation Protocol Scenarios

SOP 1

Pressure Injury Present – No one is Providing Care

If a pressure injury is present and no treatment has been verified, the case manager must refer the client to nurse.

Case Manager Responsibilities:

- Refer to Nurse same day as assessment.
- Mark referral as High Priority Triage.
- Provide prevention education to the caregiver and client. (i.e. Pressure Injury Staging Cards, Patient Brochure, etc.)
- Document referral and all actions in CARE.
- Follow Nurse recommendations and update the care plan.

Nurse Responsibilities:

- Conduct an in-person visit.
- Assess all pressure points.
- Review treatment with the client.
- Determine if there is a treatment plan in place and who authorized it.
- Provide prevention education and materials to the client.
- Revise the care plan as needed.
- Document all findings and actions in CARE.

Timeframe

This is a priority for the Case Manager and the Nurse. Case Manager must send referral same day as assessment and nurse puts this referral to the top of triage list and moves timeline up based on situation.

SOP 2

Pressure Injury Present – Non-Professional Providing Care

Case Manager Responsibilities

- The case manager must:
 - Send Nurse referral same day as assessment.
 - Indicate High Priority Triage in the referral.
 - Document referral and supporting information in CARE.

- Follow up on Nurse recommendations and ensure the CARE assessment meets SOP QA standards.

Nurse Responsibilities

- The nurse must:
 - Conduct an in-person visit.
 - Assess all pressure points.
 - Review treatment being provided by the caregiver.
 - Determine if there is a treatment plan in place and who authorized it.
 - Provide prevention education and materials to the caregiver and client.
 - Revise the care plan as needed.
 - Document all findings and actions in CARE.

Timeframe

This is a priority for the Case Manager and the Nurse. Case Manager must send referral same day as assessment and Nurse puts this referral to the top of triage list and moves timeline up based on situation.

SOP 3

Pressure Injury Present – Professional Providing Treatment

When a licensed healthcare professional is actively providing treatment for a pressure injury, the case manager or nurse must verify the care plan.

Case Manager Responsibilities:

- The case manager:
 - Verify and document with the health care professional that a treatment plan is in place.
 - Confirm the client has been observed by the HCP within the last seven days prior to assessment or according to the treatment plan timeline.
 - Verify that all pressure points are being monitored.
 - Request notification when treatment for the pressure injury is discontinued.
 - Document all verification and communication in CARE.

Timeframe

Communication with the HCP must occur as soon as possible, but no later than five business days.

Exception –

A nurse referral is required if:

- The healthcare professional does not have a treatment plan in place, or
- The client has not been seen for follow-up treatment.

- When this occurs, the nurse must perform a skin assessment and update CARE accordingly.

Note: The activities in this section of the protocol also apply to clients being assessed for in-home or residential services while receiving care from professionals in a hospital or skilled nursing facility (SNF). The Skin Observation Protocol must be completed for clients who are in a hospital or SNF at the time of the CARE assessment triggering the protocol.

SOP 4

Pressure Injury Unknown – Client Declines Skin Observation

When a client declines observation of pressure points and a caregiver is not verifying skin integrity by checking all the pressure points, preventative action must be taken.

Required Actions:

- The case manager or nurse must:
 - Explore the reason for the client's refusal.
 - Offer alternative ways to verify skin condition when possible.
 - Provide education using pressure injury prevention materials.
 - Consult with a supervisor and determine appropriate follow-up action.
 - Document the client's refusal and all actions taken in CARE.

Skin observation must not be completed if the client refuses consent.

SOP 5

No Pressure Injury – Non-Professional with Prevention Plan

When a caregiver is checking pressure points and skin integrity, there is no pressure injury, plus prevention measures are in place:

Case Manager Responsibilities:

- Verify and document source that all pressure points have been checked within the last seven days prior to assessment.
 - Confirm prevention measures are adequate.
 - Review pressure injury educational materials with the client or caregiver.
 - Update the care plan if needed.
 - Document all actions in CARE.

A nurse referral is not required unless prevention activities are not occurring.

SOP 6



No Pressure Injury – Professional Providing Preventative Care

When a licensed professional is providing preventative care:

- **Case Manager Responsibilities:**
 - Verify and document with the healthcare professional (HCP) the treatment plan, appointment schedule, confirmation of client attending appointments, last seen in office, ask HCP to notify case manager if client discharged.
 - Provide HCP with any concerns.
 - Document verification and provider contact information in CARE.

Timeframe

Verification with HCP must occur within 5 business days of assessment.

Reporting of possible skin issue or pressure injury – Outside of assessment

When a concern about skin integrity is reported by a client, caregiver or other party to the case manager outside the assessment, preventative action must be taken.

Case Manager Responsibilities:

- Gather detailed information about the reported concern.
- Determine if the situation appears urgent or life-threatening.
- Refer to Nurse same day as discovery.
- Document all information in CARE.

Nurse Responsibilities:

The Nurse will determine whether an in-person visit is required and will:

- Assess the client's skin condition.
- Provide education and prevention planning.
- Revise the care plan if needed.
- Document all actions in CARE.

Timeframe

CM referral same day as report and Nurse puts this referral to the top of triage list and moves timeline up based on situation.

SOP Visit Delayed

- Nursing and case management staff should anticipate barriers to Skin Observation Protocol (SOP) visits and plan to ensure a caregiver, assistant, or family member is available to assist the client as needed.



- All activities—including discussions, attempted contacts, and decisions—must be clearly documented.
- A skin observation visit may be delayed only when one or more of the following conditions exist:
 - Unsafe Conditions:
 - The environment poses a safety risk (e.g. threatening animals, sexually inappropriate or aggressive behavior).
 - If client or household member is under isolation precautions or quarantined for active infectious disease, please use appropriate PPE. Check with your supervisor and the Infection Preventionist Nurse at HQ (nursingservices@dshs.wa.gov) before entering.
 - Unsanitary Conditions
 - The environment is unhygienic (e.g., soiling, contamination) and no caregiver is available to assist.
 - Physical or Logistical Barriers
 - The client's condition makes observation difficult (e.g., immobility, need for assistance with positioning or transfers).
 - The client lacks consistent housing or support.
 - The client is in pain, and no caregiver is present to assist.
 - **Client Refusal or Provider Barrier**
 - The client refuses skin observation and has an unreliable provider who will not allow access, and/or refuses services related to skin integrity.
 - a) When any of the above circumstances apply, staff must:
 - 1) Discuss other possible resources or approaches with a supervisor within one (1) working day and follow normal case management response times based on that consultation.
 - 2) Reschedule the observation within two (2) business days.
 - 3) Follow all relevant LTC Manual Chapter 3 timeframes.
 - 4) Refer to Adult Protective Services (APS), Child Protective Services (CPS), or the Centralized Reporting Unit (CRU) if abuse, neglect, or self-neglect is suspected.
 - 5) Document all activities, arrangements, referrals, and discussions.

Client is Cognitively Intact but Declines Observation

- If a cognitively intact client declines skin observation and there is evidence of potential skin breakdown (e.g., odor, staining, or visible skin issues). Staff must determine the appropriate actions (and in which order) they should proceed dependent on the situation:
 - Call 911 if emergency medical care is required.
 - Refer to APS, CPS, or CRU as required under [RCW 74.34](#) if neglect or abuse is suspected.
 - If the case manager is not a nurse, make an immediate referral to nurse for an observation visit.
 - Verify and document completion of the observation visit.
 - Inform HCP of client's refusal for skin assessment.
 - HCP may want to create a referral for Home Health or have clients come into office for visit.
 - Educate the caregiver by reviewing the service plan section on skin care and pressure injury.
 - Identify someone (e.g., caregiver, family) to observe the client's skin and all pressure points.
 - Gather collateral information from family, caregivers, and health professionals.



- Explore alternative support, including residential care, new caregivers, or community
- Coordinate discussion with all involved parties and establish clear criteria for service continuation or termination (per *Challenging Cases Protocol*).
- Document all activities and communications.
- Reference **LTC Manual Chapter 5 – Case Management and Challenging Cases Protocol**; cases may remain open to active case management as needed.
- If you are in doubt, please contact supervisor.

Client is Cognitively Impaired (CPS > 3) and Declines Once

- When a cognitively impaired client declines observation one time or expresses mild resistance:
 - Re-request permission to use skilled interview and assessment techniques.
 - Ensure the client understands the request to the greatest extent possible.
 - If a legal representative exists, contact them for assistance in obtaining consent.
 - Document all efforts, discussions, and outcomes.

Client is Cognitively Impaired (CPS > 3) and Repeatedly Refuses Observation

- If the client consistently refuses observation and:
 - The skin condition over pressure points is unknown.
 - The provider restricts access to others; and/or
 - The client refuses services related to skin integrity, then staff must:
 - Follow the Challenging Cases Protocol (*LTC Manual Chapter 5*).
 - Consult with a supervisor regarding additional service options.
 - Offer alternative services (e.g., new provider, residential care, or modified service delivery).
 - Use skilled communication techniques, such as motivational interviewing to understand the reason for refusal.
 - Refer to APS, CPS, or CRU as required under RCW 74.34 if abuse or neglect is suspected.
 - Refer to 911, emergency services, or a Designated Crisis Responder (DCR) if the situation involves imminent risk or involuntary treatment concerns.
 - If there are questions regarding guardianship, capacity, or DPOA, consult with a supervisor, who may need to escalate further for answers.
 - Document all actions, decisions, and conversations.

Cultural or Gender-Based Barriers

- If the client meets the highest risk indicators, and observation cannot be completed due to cultural or gender factors:
 - Document all activities and discussions.
 - Consult with a supervisor immediately to identify a reasonable and respectful solution, ensuring that it is:
 - Timely.
 - Culturally and professionally appropriate; and
 - Results in skin observation being completed and documented by an appropriate individual.



Reporting Requirements-As much notice as possible will be given with the specific request.

Additional Nursing Services program data may be requested for program management purposes, including:

- Strategic planning and quality improvement.
- Program utilization and evaluation; and
- Coordination of long-term care activities with other state agencies providing Medicaid-funded care.

Additional Nursing Services Available

Mental Health Nurse

Purpose and Role

The Mental Health Nurse (MHN) provides specialized nursing consultation and clinical guidance for clients with behavioral and mental health complexities within Home and Community Services (HCS) and Area Agencies on Aging (AAA). The MHN role strengthens Nursing Services by integrating behavioral health expertise into nursing assessment, care planning, consultation, and interdisciplinary coordination.

Identification and Referral

Clients requiring MHN consultation may be identified through hospital discharge planning, Regional Complex Case Staffing, Headquarters (HQ) Complex Case Staffing, or Nursing Services Case Review. Referral for MHN consultation should occur when a client presents with behavioral health complexity, transition risk, or medication-related concerns that require nursing judgment beyond standard case management.

The pathway for the referral is to start with your regional complex staffing and once all recommendations from the regional staffing have been completed and there is still no clear path to a transition, the next steps would be:

- If the concern is strictly clinical/nursing or falls under the MHN consultation you can contact the Nurse Case Review team at – nursingservices@dshs.wa.gov to get on the schedule. Please fill out the Nurse Case Referral Form link below.
- If you need help other than nursing, alert your regional contact to bring the case to HQ for Complex Case Staffing. Please update the regional staffing form with any new information and send to your regional lead requesting staffing with the Complex Case Team.
- Case Managers may submit referrals using the [Complex Case Staffing Referral Form](#) for HQ staffing.
- Nursing Care Consultants (NCCs) may submit referrals using the [Nurse Case Review Referral Form](#) (13-960).



The MHN conducts a comprehensive clinical review of the CARE assessment. Nursing judgment is applied to determine impact on client safety and stability.

Consultation and Collaboration

The MHN consults and collaborates with interdisciplinary teams including case managers, physicians, psychiatrists, social workers, and hospital staff. Activities include case staffing, discharge planning, nurse-to-nurse consultation, and development of recommendations for behavioral strategies, medication monitoring, and service planning. Recommendations are communicated to the case manager for consideration and inclusion into the Plan of Care as appropriate.

Documentation

All MHN activities must be documented in the Service Episode Record (SER) within CARE, including nursing clinical findings, nursing judgment, and recommendations.

Complex Behavioral Review

MHN provides support to the Case Managers when guidance with decision-making is requested for nursing judgement with behavioral complexities.

A complex behavioral client is an individual whose behaviors present safety or care challenges due to the interaction of medical, psychological, and environmental factors requiring mental health nursing judgment.

Indicators include restraint use, frequent PRN psychotropic use, aggression, suicidal or homicidal ideation, hallucinations, self-injury, medication non-adherence, and behaviors impacting safety or care delivery, along with other clinically relevant indicators that may reflect changes in risk or functioning.

- The Process
 - Referral
 - Clinical Review
 - Interdisciplinary Consultation
 - Recommendations
 - Care Plan Integration
 - Follow-Up and Monitoring

Urgency and Response

Recommended referrals follow standard timelines. Response prioritization aligns with risk level.



For more information about this program including contact information, please click on this link: [HCLA Mental Health Nursing Program Flyer.pdf](#)

Contracted Skilled Nursing

This program provides direct skilled nursing tasks to clients. Examples may include administration of medications and injections, sterile catheter changes and bowel programs that cannot be nurse delegated.

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: Reference [Chapter 7D](#) in the LTCM.

- 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](#).

ETP

This ETP process establishes a consistent process for requesting, reviewing, and approving additional service units that exceed system limitations in CARE.



ETP instructions for additional units that exceed service limits and system parameters must be approved through the process below prior to approval/authorization or payment.

- CM/Nurse may enter an ETP through the ETR/ETP screen in CARE. Fill out all information in detail to avoid delays.
- Notify the Nursing Services Program Manager via email (nursingservices@dshs.wa.gov) once the ETP has been submitted in CARE.
- Once the ETP process has been approved by the PM the additional units can be authorized.

Resources

- [Preventing Pressure Injuries, A Patient's guide to Prevention- 2024](#)
- [NPIAP Staging Card for Lightly Pigmented Skin](#)
- [NPIAP Staging Card for Darkly Pigmented Skin](#)

LTCM Chapters

- **Skilled Nursing:** COPES Waiver Skilled Nursing – [Chapter 7D](#)
- **Nurse Delegation:** [Chapter 13](#)
- **Private Duty Nursing:** [Chapter 25](#)
- **Adult Day Health:** [Chapter 12](#)

Related WACs and RCWs

- | | |
|---|------------------------------------|
| • WAC 388-106-0300 (1 - 11) | COPES – own home |
| • WAC 388-106-0305 (6) | COPES – residential facility |
| • WAC 246-840 | PRACTICAL AND REGISTERED NURSING |
| • RCW 74.09.520(2)(b) and (c) | MA service and funding limitations |
| • RCW 18.79 | NURSING CARE |
| • WAC 388-106-0200 (3) | MPC Services |

Standard of Nursing Conduct/Nurse Practice

Everyone, upon entering the practice of nursing, assumes a measure of responsibility and trust and the corresponding obligation to adhere to standards of nursing practice and follow best practice. You are individually responsible and accountable for the quality and timeliness of nursing service you provide to clients.

- | | |
|-----------------------------------|--|
| • 18.79 RCW | Nurse Practice Act |
| • 18.130 RCW | Uniform Disciplinary Act |
| • WAC 246-840-700 | Standards of nursing conduct or practice |
| • WAC 246-840-710 | Violations of standards of nursing conduct or practice |

- [NCAO 13.02](#) NCQAC ADVISORY OPINION – SCOPE OF PRACTICE RN-LPN

Acronyms

AAA	Area Agency on Aging
ADL	Activities of Daily Living
AL	Assisted Living
APS	Adult Protective Services
CARE	Comprehensive Assessment and Reporting Evaluation
CDWA	Consumer Direct of Washington
CFC	Community First Choice
COPEs	Community Options Program Entry System
CM	Case Manager
CPS	Cognitive Performance Scale (when used with “score”) or Child Protective Services
CRM	Case Resource Manager
CRU	Complaint Resolution Unit
DDA	Developmental Disabilities Agency
EARC	Enhanced Adult Residential Care
HCP	Health Care Provider
HCLA	Home and Community Living Administration
HCS	Home and Community Services
HIPAA	Health Insurance Portability and Accountability Act
IP	Individual Provider
MPC	Medicaid Personal Care
NCC	Nurse Community Consultant
PDN	Private Duty Nursing
POA	Power of Attorney
RNCM	AAA - Registered Nurse Case Manager
RNC	AAA - Registered Nurse Consultant
RND	RN Delegator
SOP	Skin Observation Protocol
UTI	Urinary Tract Infection
WPC	Waiver Personal Care Revision History

DATE	MADE BY	CHANGE(S)	MB #

Private Duty Nursing (PDN)

Chapter 25 describes the Private Duty Nursing (PDN) policies and procedures eligibility requirements, how to determine and document need for PDN, and how to authorize services.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Kaila O'Dell, BSN, RN, Private Duty Nursing Program Manager, HCS

360.725.3549

privatedutynursing@dshs.wa.gov

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BACKGROUND

Purpose

Private Duty Nursing (PDN) is a program that provides in-home or Adult Family Home based skilled nursing care to Medicaid clients 18 years of age and over who would otherwise be served in a Medicaid Medical Institution (MMI). Home and Community Services (HCS) is responsible for this service. PDN is an alternative to institutional care and is the program of last resort.

The purpose of PDN is to:

- Provide community-based alternatives to institutional care for clients who have complex medical needs and require skilled nursing care on a continuous and daily basis that can be provided safely outside of an institutional setting.
- Support the client, client family, formal and informal supports, who are responsible for assuming a portion of care above the approved amount of PDN hours.

The NCC case manager must:

- Ensure that applicants submit a Medicaid application, if not already a Medicaid recipient. Coordinate the financial eligibility process on behalf of the applicant.
- Determine eligibility through the CARE assessment, review of [Skilled Nursing Task Log](#) (SNTL), review of medical record, and other documentation to support client's medical care needs. WAC 388-106-1010 (3, 2b)
- Contact the client or client representative within two (2) business days of receiving referral. WAC 388-106-1010
- Assist the client with finding a PDN provider and ensure that the provider is contracted.
- Utilizing CARE tool, develop a plan of care specific to the client. WAC 388-106-1010 (3)
- Authorize services (i.e. determine the number of hours, consider ETRs, authorize in ProviderOne, and send the Planned Action Notice).
- Provide ongoing case management. PDN clients are not transferred to the AAA.

ELIGIBILITY

Clients must meet medical, financial, and program eligibility requirements. Financial and program eligibility may be completed concurrently. However, **PDN cannot begin until financial eligibility is established** ([WAC 388-106-1010](#)). If a client is assessed for Nurse Delegation and is determined eligible, they may refuse Delegation, but this does not make the client eligible for PDN.

HCS Clients Nurse Care Consultants (NCCs) determines eligibility. WAC 388-106-1010 (2b)

DDA Clients Nursing Care Consultant determines eligibility (clients age 18+) and/or refers to HCS for eligibility determination for clients age 18+ if they no longer meet DDA criteria.

Staff Case Management Responsibilities

HCS Clients Nurse Care Consultants (NCCs) are responsible for case management.

DDA Clients Case Resource Manager and the Nursing Care Consultants (NCC) are collaboratively responsible.

Financial Eligibility

HCS clients The HCS financial worker calculates client responsibility toward the cost of care.
DDA clients The DDA LTC specialty team calculates client responsibility toward the cost of care.

Verify that the client meets financial eligibility requirements, which means the client is receiving Categorically Needy (CN), Alternate Benefit Plan (ABP) or Medically Needy (MN). If the client is in an adult family home, they pay room and board. If the client is on a Home and Community Based (HCB) Waiver, they may pay participation toward personal care depending on their income. The combination of participation, room and board, and third-party resource is called “client responsibility”.

Table 25.1 Financial Requirements

PROGRAM	PARTICIPATES TOWARDS	NOTES
CFC + CORE Waiver or CFC + Basic Plus In-Home	Eligible for HCB waiver services	Income cannot be above the Medicaid Special Income Level (SIL). The Medicaid SIL is 300% of the federal benefit rate (FBR).
CFC + COPES	Eligible for HCB waiver services.	Income can't be above the monthly state NF rate plus the medically needy income level.
CFC Only	Client pays toward AFH room and board	A client cannot receive PDN in any other residential setting. A CFC only client is receiving CN or ABP scope of care.
MN - Regular	Spend down required, can use PDN to meet	MN and PDN services <u>cannot</u> be authorized until spend down is met and case shows active in ACES online.

Please note: MPC eligibility does not meet Nursing Facility Level of CARE

Functional Eligibility (Initial determination and Ongoing Eligibility Determination)

You must complete a face-to-face initial CARE assessment, a face-to-face annual CARE assessment, any significant change assessments, and a six-month desk review. The NCC will have two (2) working days from the date the referral was received to contact the client. If the client is unreachable after two (2) days of documented consecutive attempts, then the NCC will follow process of sending out 10-day letter to client/authorized representative. NCC will also escalate to supervisor.

Assessment and the [Skilled Nursing Task Log](#) (SNTL) and review of medical records, and/or additional documentation to support clients medical care needs:

1. Requires care in a hospital or meets Nursing Facility Level of Care; **and**
2. Has unmet skilled nursing needs that cannot be met in a less costly program or least restrictive environment; **and**
3. Is unable to have their care tasks provided through nurse delegation, COPES Skilled Nursing, or self-directed care; **and**
4. Has a complex medical need that requires 4 (four) or more continuous hours of skilled nursing care and observation which can be *safely* provided outside an institution (for PDN AFH the client must meet this as well as require at least 8 hours of PDN care to qualify for all-inclusive PDN rate); **and**
5. Is technology-dependent daily (See Table 25.2)
6. Requires skilled nursing care that is medically necessary, as defined by the client's physician; **and**
7. Can supervise the care provider(s) or has a guardian who is authorized and able to supervise care or has a DPOA who is able to supervise for In-Home services, has family or other appropriate; **and**
8. For In-Home services, has family or other appropriate supports who assume a portion of the care, not be nurse delegated; **and**
9. Does not have other resources or means for providing this service.

Note: The need for a nursing assessment does not qualify a person for PDN

Table 25.2 Functional Requirements for Technology-Dependent PDN Clients

SKILLED TASK	DESCRIPTION
A. Mechanical Ventilation	The client requires the use of <i>mechanical ventilation</i> , which takes over the active breathing due to your inability to breathe on your own due to injury or illness. A <i>tracheal tube</i> is in place and is hooked up to a ventilator that pumps air into your lungs; <i>OR</i>
B. Complex respiratory support	The client requires <u>two</u> of the following treatment needs: i. Postural drainage and chest percussion; <i>OR</i> ii. Application of respiratory vests; <i>OR</i> iii. Nebulizer treatments with or without medications; <i>OR</i> iv. Intermittent Positive Pressure Breathing; <i>OR</i> v. O2 saturation with treatment decisions dependent on the results; <i>OR</i> vi. Tracheostomy <u>and</u>

	The client's treatment needs must be assessed and provided by an RN/LPN. <u>and</u> The client's treatment needs <i>cannot be nurse delegated or self-directed. If the task can be delegated, then the client is ineligible for PDN.</i>
C. Intravenous/parenteral administration of multiple medications	The client requires intravenous/parenteral administration of multiple medications and care is occurring on a continuing or frequent basis or:
D. Intravenous administration of nutritional substances.	The client requires intravenous administration of nutritional substances, and care is occurring on a continuing or frequent basis.

Primary Care Provider (PCP) Approval

PCP's medical orders can either be obtained by the NCC or the PDN Contractor but is necessary for the PDN Contractor to use the PCP's medical orders to develop a person-centered Care Plan. DSHS Form 15-594 is available for PDN Contractor's to use to document a person-centered Care Plan but is not a required form. The NCC approves the PDN Contractor's Care Plan after it has been completed, reviewed, and signed by the Primary Care Physician.

1. A primary care provider needs to document.
 - The client's medical stability.
 - Orders for medical services.
 - Approval of the PDN provider's plan of care; and
 - The client's appropriateness for PDN care.

And

 - Primary Care Provider must approve the PDN's Care Plan (388-106-1046 (3).) This must be completed *initially* and reviewed and signed by the Primary Care Provider at least every six (6) months.
2. NCCs must approve the PDN's care plan (WAC 388-106-1010 (3) h(ii).)

CHOOSING A PDN PROVIDER

You may need to help clients choose their PDN provider. The PDN provider must have a PDN contract with the state and must be a(n):

- Home Health Agency licensed in WA State (WAC 388-106-1025); or
- Independent RN provider or an LPN under the supervision of an RN with a contract with the Medicaid agency to provide PDN services (WAC 388-106-1040); or



- Adult Family Home that is RN-owned and operated (WAC 388-106-1045); or
- Adult Family Home (AFH) – Adhere to [WAC 388-106-1046](#) with a PDN Contract. To determine if AFH has an appropriately amended contract for PDN.

To determine if a PDN provider has a State contract visit: <http://adsaweb/hcs/sua/displayACDPDN.asp>
<https://fortress.wa.gov/dshs/adsaapps/Professional/ND/PDN.aspx>

Contracting with a PDN Provider

If a Home Health Agency, Adult Family Home, or individual nurse (RN or LPN with RN supervision with a DSHS PDN Contract), wishes to contract with the state to provide PDN services, they should contact the PDN Program Manager at privatedutynursing@dshs.wa.gov.

A signed contract **must** be in place before PDN services can begin.

A PDN contract status will be visible from the PDN website: [Private Duty Nursing | DSHS \(wa.gov\)](#) either from the hyperlink, List of Contracted Providers, [Find Private Duty Nurses \(wa.gov\)](#) or Adult Family Home Locator, [AFH Facility Search \(wa.gov\)](#). Please note that it is the PDN contracted providers choice if they do not want their information listed.

AUTHORIZING PDN SERVICES

Authorizing PDN Hours

1. Maximum hours that can be authorized without an ETR depend on the client's place of residence.
 - a. Private Home At least four (4) and up to sixteen (16) hours per day of PDN RN/LPN
 - b. AFH Up to eight (8) hours of PDN per day or the PDN All-Inclusive Daily Rate, for example, if a client does not require (8) hours of PDN per day based on the SNTL, then the client would not qualify for PDN All-Inclusive Daily Rate. The NCC will be responsible for reviewing the SNTL and make the appropriate determination. If the client does not meet the minimum requirements for the PDN all-inclusive rate, then the NCC would authorize the amount of daily hours of PDN assessed under (8) eight.
2. For clients receiving PDN and CFC or CFC+COPES personal care you must deduct the PDN hours from the hours that the CARE assessment generates per WAC 388-106-0130 (6)(e).
 - a. For example: If the CARE assessment generates 344 hours, and per NCC assessment of SNTL with/without additional documentation determines 10 hours of PDN is needed daily, then the NCC would take 344 hours and subtract 310 hours of PDN (10 hours a day x 31 days a month = 310 hours) and would get 34 hours that can be utilized for personal care.
3. If the overall hours needed exceed the remaining number of hours CARE generates after PDN hours have been deducted, the client is not eligible for any additional CFC or CFC+COPES personal care hours without an ETR.

- a. For example: CARE assessment generates 344 hours, and per NCC assessment of SNTL determines client requires 16 hours of PDN and requires either additional PDN or IP hours above 344 then; PDN clients who are on a waiver program must receive a monthly ancillary service to remain eligible for the waiver.
4. For clients receiving only PDN in in-home setting, they are eligible for between four (4) to sixteen (16) hours of nursing services/day. The number of PDN hours they are eligible for between 4 to 16 hours will be determined by the NCC after reviewing the SNTL.

Requesting an ETR

1. You will need to request an ETR ([WAC 388-440-0001](https://www.wa.gov/legislative/rulemaking/wac3884400001)) if:
 - A client resides in a private home and the NCC determines that the client requires both PDN and CFC or CFC+COPES hours. PDN hours must be deducted from the CARE generated hours; If hours needed exceed the remaining hours after PDN hours have been deducted an ETR is needed. This ETR, "Type," should be noted in CARE as **Personal Care ETR** and sent to the **ETR committee**, who will then staff with the PDN PM manager to determine outcome and hours.
 - A client resides in a private home, and the NCC determines that the client requires more than 16 hours of PDN from an RN/LPN per day. This ETR, "Type," should be noted in CARE as a **PDN ETR** and sent in CARE to the **PDN PM**.
If a client resides in a private home and needs **both** a) greater than 16 hours PDN and b) additional CFC+COPES hours. There will need to be **two ETR's** for the client; one ETR for the PDN hours and send to the **PDN PM** and one for the care hours and send to the **ETR Committee** to be reviewed with the PDN PM.
2. Send the [Skilled Nursing Task Logs](#) to privatedutynursing@dshs.wa.gov anytime an ETR is being requested.

Authorizing Payment

Payments for PDN services are authorized through ProviderOne:

- Complete the P1 authorization for HCS and DDA using CARE service codes T1000 with service code modifier: **TD** (RN Hourly Rate) **TE** (LPN Hourly Rate)
- AFH All-Inclusive Daily/Specialty Rate use T1020 without any modifiers.
- Holiday Rates use service code T1000 with modifier, TV:
- **Individual:** T1000, TD, TV (RN) T1000, TE, TV (LPN)
- **Agency:** T1000, TD, TV (RN) T1000, TE, TV (LPN)
- **Paid holidays are limited to:**
 - (1) The first day of January (New Year's Day);
 - (2) The third Monday of January (Martin Luther King, Jr.'s birthday);
 - (3) The third Monday of February (Presidents' Day);

- (4) The last Monday of May (Memorial Day);
- (5) The nineteenth day of June (Juneteenth);
- (6) The fourth day of July (Independence Day);
- (7) The first Monday in September (Labor Day);
- (8) The eleventh day of November (Veterans Day);
- (9) The fourth Thursday in November (Thanksgiving Day);
- (10) The Friday immediately following the fourth Thursday in November (Native American Heritage Day); and
- (11) The twenty-fifth day of December (Christmas Day).

- Use the [ProviderOne Billing Manual](#) for direction on how to complete authorization.
- Clients do not need to participate toward the cost of PDN services (PDN is a Medicaid

Note: Clients receiving PDN services are subject to estate recovery, depending on when they received services and their age.

State Plan-covered service).

- Apply participation if the client is also receiving personal care (e.g., CCFC+COPES).
- For HCS clients, financial staff will determine whether the PDN client has countable income above the Medically Needy Income Level (MNIL) and is required to participate toward the cost of COPES care.
- Inform the client that they may pay for any supplemental services not covered in the CARE plan.
- NCC to complete authorizations in CARE using service codes T1000 for in-home settings.

Notifying the Client of Services

When hours of PDN services are initiated or changed, you must send your client the Planned Action Notice (PAN) that will be generated in CARE.

DETERMINING PDN HOURS FOR A CLIENT (INITIAL OR REASSESSMENT)

To determine how many hours to authorize for PDN:

1. Review the completed [Skilled Nursing Task Log](#) (SNTL) and any additional authorized medical records to *determine* the **number of PDN hours** the client requires as well as **client eligibility for PDN services**.
 - a. If reauthorizing PDN hours for a subsequent 6-month period, the SNTL must be completed at least 7 days *prior* to the desk review or face-to-face assessment. In addition, if the client has a change of condition and changes to care need assessment completed, the NCC must obtain a new 7 day look back of SNTL.
 - b. Each new assessment/re-assessment must be conducted by utilizing the SNTL to determine eligibility and hours. For example: if a previous SNTL shows more PDN hours per NCC determination and upon reassessment by the NCC, the SNTL shows less hours are needed then the NCC will make the necessary changes. The NCC will also ensure ETR requirements are

completed to include supporting data and documentation. For example, justification, alternatives explored, etc.

PDN hours are determined based on SNTL assessment and determination. If a client previously had an ETR or additional hours, this is not a justification to continue. Each PDN client assessment will be independent of one another. The assessment will be based on clients PDN care needs and should be reflected in the SNTL.

2. Utilize informal supports in conjunction with PDN and CFC or CFC+COPEs services. The NCC **must:**
 1. Determine availability of informal/unpaid supports and other non-department paid resources. Identify that informal supports are based on voluntary actions and are available if the source is willing and able to continue them.
 2. Complete a CARE assessment annually and conduct six-month desk reviews. The annual CARE assessment **must** be a face-to-face interview with the client. The review must also be completed more frequently if the client's medical condition or situation changes.
Note: In order to meet the initial assessment timeframes outlined in [Chapter 3](#), a minimum of 1 week of [PDN Skilled Nursing Task Logs](#) must be completed to determine eligibility for PDN and to move the assessment to current. For annual assessments, PDN SNTL should be completed by the Provider and returned to the NCC for review prior to the face-to-face assessment and/or desk reviews.
 3. Determine that care needs cannot be met through other programs.
 4. Review the PDN service provider's plan of care, which must be updated and submitted every six months or more often if the client's medical condition changes to:
 - i. Reassess the client's medical eligibility; **and**
 - ii. Review the number of PDN hours the client needs; **and**
 - iii. Ensure that the physician has reviewed and signed orders and the provider's plan of care.
 5. Update authorizations in CARE and notify the client in writing regarding the outcome of your determination via a Planned Action Notice (PAN). PANs must be issued any time the Department approves, denies, increases, or reduces a client's benefit package.
Note: The 14-225 is one of many forms that needs to be signed at each face-to-face assessment regardless of the service.

DEVELOPING THE PLAN OF CARE

HCS clients NCC develops the Plan of Care utilizing CARE assessment.

DDA clients NCC and the Case Manager develop the Plan of Care collaboratively.

Whoever develops the Plan of Care is responsible to meet with the PDN client (and family or guardian) and provide them a copy of the Service Summary and Planned Action Notice/Personal Care Results.

When the NCC develops the plan, they **must:**

1. Consider the client's quality of life as well as overall cost effectiveness and long-range costs.

1. Consider PDN AFH for those clients whose PDN costs will exceed the cost of 16 hours of Private Duty Nursing per day.
2. Utilize informal supports in the development of plan of care. Family members may provide skilled care tasks as well as provide any additional hours of care needed above that of PDN hour determination.
3. Include detailed schedules of all formal and informal providers. **Do not** schedule a PDN provider and an IP, personal aide, or home care agency to provide services at the same time. Services may not be duplicated.
4. Evaluate clients who share a household to see whether they could be served by one PDN provider at the same time.
6. Utilize LPN services instead of RN services when appropriate. If a private LPN is going to be contracted, they must have oversight by an RN per the Nurse Practice Act [WAC 246-840-705](#)
7. Document the **four (4) continuous hours of skilled nursing** from the Skilled Nursing Task Log (SNTL) as required for program eligibility and in the comment box on the *Treatment* screen or *Indicators* screen in CARE.
8. Provide the [SNTL](#) forms to the PDN provider. You must review the completed SNTLs to determine the number of PDN hours the client requires.
9. The SNTL, medical provider's plan of care, client medical record, CARE assessment and any additional medical information about client should all align to provide accurate information about the client's care needs. If there are questions the NCC, PDN provider, and medical provider will work together to ensure plan of care and CARE assessment aligns.

RESOURCES

Related WACs

WAC 388-106-1000	What is the intent of WAC 388-106-1000 through 388-106-1055?
WAC 388-106-1005	What Services may I receive under Private Duty Nursing (PDN)?
WAC 388-106-1010	Am I eligible for Medicaid-funded Private Duty Nursing services?
WAC 388-106-1020	How do I pay for my PDN services?
WAC 388-106-1025	Who can provide my PDN services?
WAC 388-106-1030	Are there limitations or other requirements for PDN?
WAC 388-106-1035	What requirements must a home health agency meet in order to provide and get paid for my PDN?
WAC 388-106-1040 and WAC 246-840-705	What requirements must a private duty RN, or LPN under the supervision of an RN, meet in order to provide and get paid for my PDN services?
WAC 388-106-1045	When may I receive Private Duty Nursing (PDN) services in a contracted PDN adult family home (AFH)?
WAC 388-106-1046	When may an Adult Family Home (AFH) be paid an all-inclusive daily rate for Private Duty Nursing (PDN) services

WAC 388-106-1047	What is included in the all-inclusive daily rate payment to the Adult Family Home (AFH) providing Private Duty Nursing (PDN) services?
WAC 388-106-1050	May I receive other long-term care services in addition to PDN?
WAC 388-106-1055	Can I choose to self-direct my care if I receive PDN services?
WAC 388-440-0001	Exceptions to the Rule (ETR)

Forms

[PDN Skilled Nursing Task Log \(SNTL\)](#)

[Form 15-594 PDN Care Plan](#)

Acronyms in this Chapter

ABP	Alternative Benefit Plan
AFH	Adult Family Home
ALTSA	Aging and Long-Term Support Administration
CARE	Comprehensive Assessment and Reporting Evaluation
CFC	Community First Choice
CN	Categorically Needy
COPES	Community Options Program Entry System
DDA	Developmental Disabilities Administration
ETR	Exception to Rule
FBR	Federal Benefit Rate
HCB Waiver	Home and Community Based Waiver
HCS	Home and Community Services, Aging Long Term Support Administration
IP	Individual Provider
MMI	Medicaid Medical Institution
MNIL	Medically Needy Income Level
MPC	Medicaid Personal Care
NF	Nursing Facility
PAN	Planned Action Notices
PDN	Private Duty Nursing
SER	Service Episode Records
SIL	Special Income Letter
SNTL	Skilled Nursing Task Log



REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
10/2024	Kaila O'Dell		
12/29/2021	Kaila O'Dell		
3/4/2019	Whitney Hightower		
6/21/2018	Jevahly Wark		
12/2015		This information not tracked at this time of this revision.	

Administrative Hearings

The purpose of this chapter is to ensure that all persons have the right to apply for Long-term Care (LTC) services administered by the department and to:

- a) Have their financial and functional program eligibility correctly determined by the department; and
- b) Appeal any decision made by the department which they perceive as adversely impacting the authorization or delivery of LTC services, including approvals and increases.

Vendors have the right to an administrative hearing when the department determines that a vendor was overpaid by the department for either goods or services, or both and issues notice of the overpayment. RCW 43.20B.675, 43.20B.010 and RCW 41.05A.170.

Department staff has information about the administrative hearing process and the department's role in an administrative hearing.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Kim Averill	Administrative Hearing Program Manager 360.725.3223	kimberly.averill@dshs.wa.gov
Tania Gariano	HCS Administrative Hearing Specialist/Financial 509.846.8636	tania.gariano@dshs.wa.gov
Vicky Gawlik	Adult Protective Services 360.725.2615	vicky.gawlick@dshs.wa.gov

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BACKGROUND

The administrative hearing process allows individuals the right to challenge a government action to verify it was valid and based on laws and rules. It is a legal proceeding but is designed to be user friendly for appellants who represent themselves (not attorneys) with relaxed rules of evidence and procedure.

In 2011 the Health Care Authority (HCA) became the single state agency for Medicaid. This means DSHS is a designee of the HCA for managing some Medicaid benefits and represents HCA in hearings that relate to Medicaid. DSHS is the single state agency for Temporary Assistance for Needy Families and Basic Food.

RIGHTS TO AN ADMINISTRATIVE HEARING

Clients and vendors have a right to an administrative hearing only when entitled by law and when aggrieved by a department decision/action.

1. **Clients** have a right to a hearing:
 - a) For any action indicated on the Planned Action Notice (PAN) including, but not limited to approval, denial, reduction, or termination of services or eligibility;
 - b) When the department determines a client received a benefit or more benefit than they were eligible for, and an overpayment notice was issued; and
 - c) When the total number of in-home personal care hours or New Freedom budget being received is reduced because of a reduction or termination in the number of in-home personal care hours approved as an exception to rule¹ or the residential payment rate that was approved as an ETR is reduced or terminated.
2. **Vendors** have a right to a hearing when the department determines they were overpaid for goods and/or services provided to department clients on or after July 1, 1998², and notice of OP is provided to the vendor.

Resources:

RCW 74.09.741 Right to an Administrative Hearing (HCA).

RCW 74.02.080 Right to an Administrative Hearing (DSHS).

WAC 182-526-0085 Determining if a hearing right exists.

WAC 388-71-0562 Home Care Agency's Right to an Administrative Hearing.

WAC 388-115-0562 Consumer Directed Employer's Right to an Administrative Hearing.

WAC 388-106-1315 Hearing Rights for an ETR.

¹ There is no appeal right for a denial of an initial ETR request.

² In 1998 the legislature enacted RCW 43.20B.675, which requires the department to offer a "formal uniform appeal process" to vendors including the right to an adjudicative proceeding, which is governed by the Administrative Procedure Act and department rules.



REQUESTING AN ADMINISTRATIVE HEARING

Hearing requests must be made within a specific timeframe. See timeframes and deadlines for specifics.

1. A client may request a hearing in any of the following ways:
 - a) Verbal request. Department staff must notify the Office of Administrative Hearings (OAH) IMMEDIATELY³ of any verbal request from the client, preferably in writing. These requests can be entered into the Administrative Hearing Control System (AHCS) in Barcode by any staff with access to Barcode. Enter the hearing request in the client's own words, email it, print and fax or mail to OAH.
 - b) Written request (of any kind). Department staff must notify OAH IMMEDIATELY⁴ of any written request that doesn't go directly to OAH.
 - c) The Request for Hearing form that accompanies every PAN. This form can be completed by the client and mailed or faxed to OAH. The client may also ask department staff to help them complete and submit the hearing request to OAH.
 - d) Per the instructions on the Client Overpayment Notice to request a hearing for an overpayment issue.

2. Vendors may request a hearing related to an overpayment by using the instructions on the Vendor Overpayment Notice.

Resources

WAC 182-526-0095 How to Request a Hearing

WAC 182-526-0025 Use and Location of Office of Administrative Hearing (OAH)

³ Not to exceed two calendar days.

⁴ Not to exceed two calendar days.

NOTICES- SEE CHAPTER 27 “NOTICES”

When a client applies for or gets benefits, the department is required to send notice to alert clients about the decisions made about their benefits. Notices are the crux of the department’s case in an administrative hearing and should accurately represent the action that was taken by the department, including the supporting authorities for the action. If the notice is fatally deficient, the department may lose the case on inadequate notice. Notices may be amended up to and during the hearing in most instances⁵.

CASE MANAGER ROLE

1. The case manager remains responsible for case management activities, including completing an accurate assessment to determine correct eligibility.
2. In addition, the case manager:
 - a) Notifies the client, informally over the phone or in person, AND in writing using the automated PAN, when the department takes an action affecting the client’s services.
 - b) Attempts to resolve any issues expressed by the client when they don’t agree with the decision/action the department is taking. This includes but is not limited to:
 - i. Reviewing the assessment with the client to ensure accuracy and to explain the assessment process and the CARE tool.
 - ii. Gathering additional supporting information from collateral contacts including other health care professionals, when applicable.
 - iii. Exploring alternatives to help resolve issues like:
 - (1) Evaluating whether the client needs a reassessment and completing one if appropriate;
 - (2) Checking the availability and suitability of programs or services which may be offered by other community social service agencies or informal supports; and
 - (3) Assessing whether a request for an ETR is applicable.

⁵ **WAC 182-526-0260 Amending the health care authority or managed care organization notice.**

(1) The administrative law judge (ALJ) must allow the health care authority (HCA), HCA’s authorized agent, or a managed care organization (MCO) to amend (change) the notice of an action before or during the hearing to match the evidence and facts.

(2) HCA, HCA’s authorized agent, or MCO must put the change in writing and deliver a copy to the ALJ and all parties.

(3) The ALJ must offer to continue (postpone) the hearing to give the parties more time to prepare or present evidence or argument if there is a substantive change from the earlier notice.

(4) If the ALJ grants a continuance, the office of administrative hearings must serve a new hearing notice at least fourteen calendar days before the hearing date.



- c) If the client does not agree with a decision made by the department and a resolution cannot be reached, explains to the client that an administrative hearing may be requested.
- d) Informs the client that he or she will get continued benefits if they do not agree with a decision for a reduction or termination of services, if a hearing is requested before the effective date and pending the outcome of the hearing, unless they request not to receive them.
- e) Notifies the client that up to 60-days of continued benefits may have to be repaid if the department prevails in the hearing.
- f) Notifies the financial worker of continued benefits.
- g) Documents the communications with the client in SER including that the administrative hearing process was explained to the client and the client's decision about whether to request a hearing, if known.
Include the details about the hearing issue(s) and attempts made to resolve the issue(s).
- h) Assists the client to request a hearing, as needed, when the client chooses to make a formal request, by using the Administrative Hearing Control System⁶. Submits the request immediately to the local OAH field office.
- i) Notifies the local AHC of the verbal or written request for a hearing, and provides the AHC with the client's:
 - i. Name,
 - ii. ACES # and ProviderOne #.
 - iii. Date of request, and
 - iv. Administrative hearing issue.
- j) When informed that a formal notice of an administrative hearing is received, documents the:
 - i. Date of the request, and
 - ii. Date of the hearing.
- k) Provides the AHC with any physical records or other information that the AHC can't electronically access that would help the AHC decide if the department's decision/action was accurate.
- l) Provides the AHC with any additional information that will assist in the AHC's preparation for the hearing.
- m) Participates in the prehearing process, if requested by the AHC.
- n) Participates in the hearing as a witness for the department if requested by the AHC⁷.

For local OAH contacts use WAC 182-526-0025 or the OAH website or send requests to:
Office of Administrative Hearings (OAH)
PO Box 42489 Olympia, WA 98504-2489

Note: 182-526-0155

An appellant may represent themselves, or may be represented by a lawyer or paralegal, or by a relative, friend, or any other person of his or her choice, other than the department.

⁶ The AHCS does not link to OAH, so after a request is completed in the AHCS, it must still be sent to OAH.

⁷ HCS or AAA staff may not represent the appellant in an administrative hearing. Consult with program managers for any exceptions to DSHS staff representing the client. A case manager may be subpoenaed to testify as a witness for the appellant.



- o) Documents in the SER when the client withdraws an Administrative Hearing request, and includes the date and reason. Notifies the AHC so that a formal request for withdrawal can be made with the client, AHC, and OAH.
4. For vendor overpayment hearings, OFR notifies the vendor in writing using the Provider Overpayment Notice when there is an overpayment. The case manager follows the same basic process about providing documents and information to the AHC and participating in the hearing as indicated above for client.

It is assumed that vendors do not require the same degree of assistance as that of a client, and it is not the expectation that case manager or Administrative hearing coordinators provide it.

ADMINISTRATIVE HEARING COORDINATOR ROLE

The AHC represents the department (and HCA) in all activities related to the hearing request. The AHC is responsible to know the laws and rules, the facts of the case they are presenting, and be able to apply the law and rules to the facts in the appeal.

The AHC:

1. Receives notice of the administrative hearing request from the Case Manager or OAH and documents all hearing related activities and hearing related information in the Administrative Hearing Control System (AHCS) in Barcode.
2. Uses the AHCS system to track all hearing related activities, document witness names, exhibits, and the hearing report.

The Administrative Hearing Control System (AHCS) is a subsystem in Barcode used by AHCs to help in the tracking of cases for Administrative Hearings, printing DSHS forms, and keeping track of hearing statistics for both client and vendor hearings. Using the AHCS is mandatory for AHCs.

Functionality of the AHCS includes but is not limited to:

- Daily Hearing Schedule reports and prehearing and hearing calendars;
 - Availability to print hearing related forms like hearing withdrawals, AH Report template, Dismissal Order template, etc.
 - Tracking hearing events including dates, witnesses, the hearing issue and outcomes; and
 - Statistic Reports including appealed cases, pending cases, dockets with continuances, closes cases, dockets by program, etc.
3. Notifies the social worker/case manager and the CMs supervisor of the administrative hearing request and discusses the case with worker(s) involved and their supervisors, as appropriate.
 4. Requests the case record and all applicable documents.



5. Reviews the records including but not limited to the CARE assessment and the PAN to ensure accuracy. If any errors are found they should be corrected at this time. Notices may be corrected at any time up to and through the hearing, depending on the type of error on the notice.
6. Reviews the HCS/AAA case to determine whether the department/agency made the correct decision/action.
7. Makes other contacts/reviews other information, as necessary, to determine and make a recommendation about the department/agency position. If the department/agency made an error in its decision or action:
 - a. The decision/action is corrected;
 - b. The appellant/appellant representative is contacted; and
 - c. The hearing request is withdrawn at the applicant/client request if the issue is sufficiently resolved, and the client agrees with this step. This can be done in writing or by calling OAH with the appellant/appellant representative. This may require a written follow up letter requesting that the administrative hearing be withdrawn, by the client, depending on local OAH procedures.
 - d. If the action has been reversed and the client does not want to withdraw their request for hearing, the AHC will request a motion to dismiss the case. There is no right to a hearing without an action.
8. If the appellant wishes to continue with the hearing, the AHC is required to initiate the prehearing meeting. The AHC contacts the client⁸ and:
 - a. Reviews the administrative hearing process and the role of the AHC.
 - b. Describes both the informal and formal prehearing process and its purpose.
 - c. Asks about the need for an interpreter, or other auxiliary aids (Administrative Policy No. 7.02 Equal Access to Services for Individuals with Disabilities) and informs OAH.
 - d. Determines whether the appellant has legal or other representation, and if requested, may refer the appellant to legal resources.
 - e. Informs the client that he or she will get continued benefits, when applicable⁹, pending the outcome of the hearing, unless he or she requests not to receive them.
 - f. Informs the client that up to 60-days of continued benefits must be repaid if the outcome of the administrative hearing is in favor of the department.
 - g. Clarifies the issues surrounding the hearing and attempts to resolve them outside of the hearing process whenever possible.
9. Discusses the issues with department/agency administration or HQ Program Management staff and requests the assistance of the Assistant Attorney General's office (AAG) by contacting the HQ Program Manager(s) or requests assistance of AAA legal counsel if needed.

⁸ The AHC does not have the same responsibilities to assist the IP through the Administrative hearing process.

⁹ And if the client requests the hearing before the effective date of the notice.



10. Participates in the formal prehearing conference, if scheduled by OAH, or requests a prehearing conference from OAH when needed.
 11. Acts as the contact person between OAH and the department, appellant, appellant legal representative or other person representing the appellant;
 12. Develops the theory of the case and prepares the administrative hearing Report, DSHS 09-354 in the AHCS. This is a required document for all administrative hearings.
 13. Notifies the department's witnesses of the date of the hearing, when they are required to be present, and helps prepare the witnesses for the hearing.
This includes reviewing with the witness:
 - a) The hearing issue
 - b) The types of questions that may be asked by the AHC, appellant, and ALJ
 - c) The exhibits that will be referenced that the witness may be asked to talk about during the hearing
- In addition, to increase the comfort of the witness, the AHC practices with the witness, emphasizes confidence and truthfulness and provides encouragement and support¹⁰. The AHC should never give the answers to the witness for the questions they plan to ask or tell them what to say. The AHC should only coach the witness so they are prepared.
14. Gathers exhibits and reviews what documents are available to present and support the department's case.
 15. Provides the administrative hearing packet, including exhibits to OAH and to the appellant, at least five days prior to the hearing and includes the appellant in any "substantive" communications with OAH. The AHC must not participate in any *ex parte*¹¹ communications.
 16. Arranges for the location (room) of the hearing, if applicable (OAH may make these arrangements). Most hearings take place via phone.
 17. Presents the department's case to the ALJ and appellant at the hearing including opening and closing statements to clarify and summarize the issues and arguments, and facilitates witness testimony and cross examination. Opening and closing statements should be a summary of the department's position and should not be a reading of the administrative hearing report.
 18. Reviews the ALJ's decision and informs the case manager and supervisor. If the department/action is not upheld, the department must implement the order by the end of the month the order was received and the AHC must decide whether to request a review of the

¹⁰ Remember that the AHC may ask for a short recess. This may be an effective tool if the agency witness is anxious or scared and this is interfering with testimony. The witness will have to answer any question that has been asked before a recess will be granted but may benefit from this to break to compose themselves.

¹¹ See definition section



initial order to the Board of Appeals. In order to make this decision the AHC may consult with the social worker/case manager, supervisor, administrator/director, AAA attorneys, and with HQ Program Manager who may request consultation with the AAG's office.

Consultation with HQ is especially important when the initial decision, or a belief that a later decision by the Board of Appeals (BOA), may set a precedent that would have far reaching and/or long-term effects on eligibility, rules, policies, and costs, especially if the AHC anticipates the appellant could move the case through to Superior Court. The importance is to ensure a complete and accurate record and to get legal advice as appropriate.

If the department's position is upheld and the client received continued benefits, the AHC must notify the case manager who will terminate continued benefits and initiate the overpayment when appropriate.

19. Advises the client of the appeals process to BOA, as appropriate.
20. When known, refers the case to the HQ Program Manager if the appellant loses the BOA review and decides to appeal to Superior Court. HQ staff will coordinate with the AAG's office, which represents the department/agency in Superior Court¹².
21. Documents the actions in the AHCS in Barcode and files documents into the AH file. Sends the client hearing file to Document Management Services (DMS) for imaging when the hearing process is complete, (provider OP hearings are documented in the AHCS but not sent to DMS).

CONTINUED BENEFITS

Whenever the Department notifies a client that his or her benefits will be reduced or terminated, federal law allows the recipient to maintain benefits at the prior level if the recipient appeals the decision by requesting an administrative hearing prior to the appeal by/effective date on the PAN.

1. Clients automatically receive continued benefits if the appeal is requested prior to the appeal by date¹³ on the PAN, unless they request not to receive them.
2. Continued benefits are in the amount indicated by the assessment under appeal, unless less benefit is requested by the client. They are authorized on the first day after the request for appeal. If the ALJ reduces or terminates benefits, the initial order takes effect at the end of the month during which OAH mailed the initial order, even if the client requests an appeal through the Board of Appeals.
3. If the ALJ reduces or terminates benefits, the first 60-days of continued benefits, starting on the date of the request for hearing from OAH, are subject to an overpayment and the department

¹² Also known as Judicial Review.

¹³ For each Service on a PAN the date the client must appeal by, to receive continued benefits, is printed in the notice. For example: "To keep your services from being reduced until a hearing decision is made, you must appeal by 12/13/2019, and "If you appeal by 12/13/2019, we assume you want your services to stay the same until the hearing decision".

sends the overpayment to Office of Financial Recovery (OFR) if appropriate¹⁴. The recoverable funds that may be collected on the overpayment are from the effective date on the PAN out 60-days from the request of the hearing from OAH¹⁵.

4. The overpayment is based on the additional benefit the client received over and above the amount required by the initial order. The order should state the effective date of the reduction or termination and the amount the client is eligible to receive.
5. If the client requests an appeal of the initial decision with BOA, there will not be any collection action from OFR until the BOA decision is reached.
6. Vendors do not receive continued benefits.
7. If the department prevails at the hearing, continued benefits stop at the end of the month the hearing decision is mailed. The department must complete an overpayment, when appropriate. See the Overpayment section for more information.

Resources

WAC 182-504-0130 Continued Coverage Pending an Appeal.

388-458-0040(5) What happens if I ask for a hearing before a change happens?

TIMEFRAMES AND DEADLINES

1. PANs must be sent to the client immediately after completing the assessment and must provide at least 10-days' notice before the effective date¹⁶ of the action for services. For client services, the PAN in CARE automatically provides for at least 10-days' notice, using the ten-to-the-end policy.
2. If a request is received by OAH before the appeal by date on the PAN, the client receives continued service benefits, unless he or she requests not to receive them.
3. OAH must receive an appeal within 90-days¹⁷ of the date the client receives the PAN.
4. Request for correction of clerical errors on initial orders must be received on or before the tenth calendar day after the order was served.
5. BOA must receive the request for review within 21 calendar days from the mail date stamped on the initial decision from OAH and should:
 - a. Identify the parts of the initial order with which the department disagrees.

¹⁴ There may be certain situations where a client may have the kind of income that can't be garnished. The department must continue to submit the overpayment to OFR and OFR will determine whether or not the overpayment gets processed. Examples of income that may not be garnished may include: Income from Social Security, SSI, veteran's benefits, or retirement pensions, IRAs or 401(k) s.

¹⁵ For example:

- Date of the Notice is February 2nd.
- The appeal by date is February 29th.
- Effective date of reduction is March 1st.
- OAH receives the hearing request on February 8th.
- Continued benefits start on March 1st.
- The department prevails at the hearing that takes place in May.
- The overpayment clock begins on February 8th because that's when OAH received the request.
- 60 days is February 8th – April 7th.
- The department would collect from March 1st-April 7th (only 38 days).

¹⁶ See Notices (5) for exceptions.

¹⁷ Except in cases where good cause has been determined for a state only program, per RCW 74.08.080 and 74.09.741 effective 7/2023



- b. Identify arguments/evidence as to why the department believes the ALJ's decision was in error.
 - c. Send a copy of the review request to the other parties.
 - d. Direct Appeals to:
 - Board of Appeals
 - PO Box 45803
 - Olympia, WA. 98504-5803
- 6. Request for reconsideration must be received by BOA within 10 calendar days from the date stamped on the Review Decision or Order.
- 7. Superior Court must receive the request for review FROM THE APPELLANT (the department has no rights for this review) within 30-days from the date stamped on the review decision or order from BOA.

Resources

WAC 182-518-0025 Washington apple health- Notice Requirements
WAC 182-504-0130 Continued Coverage Pending an Appeal
WAC 182-526-0110 Process After a Hearing is Requested
WAC 182-526-0550 Deadline for Requesting a Corrected Initial Order
WAC 182-526-0560 Review of an Initial Order by a Review Judge
WAC 182-526-0575 How to Request Review of an Initial Order
WAC 182-526-0605-0620 Reconsideration
WAC 182-526-0650 Service of Petition for Judicial Review

HEARING DECISIONS AND FINAL ORDERS

1. An Initial Order becomes a final order at 5 pm on the 21st calendar day after OAH serves the initial order unless:
 - a. There is a request for a review of the initial order made to BOA.
 - b. There is a request for an extension that is granted.
 - c. Any party files a late request for review which is accepted¹⁸.
2. When you receive a final order you must:
 - a. Follow the judge's order.
 - b. Contact HQ program management staff for consultation if needed.

Resources

WAC 182-526-0525 When an Initial Order Becomes Final

COMPONENTS OF THE ADMINISTRATIVE HEARING PROCESS

1. A **prehearing meeting** is an informal discussion with the appellant. The ALJ is not present. Prehearing meetings are required, by policy, for the AHC but the appellant can refuse to participate in a prehearing meeting. Although the prehearing meeting is voluntary for the appellant, it must be offered to every appellant as early in the hearing process as possible. It can be held by phone, in person, or by other correspondence. Prehearing meetings can be used to:
 - a. Identify or clarify the issue(s) for the hearing and resolution where possible.
 - b. Explain the department's decision to the appellant by reviewing the rules (WAC) the department relied on when making the decision being appealed.
 - c. Arrange to give or receive documents as proposed exhibits including: additional medical documents from the appellant, documents or other evidence the department relied on when making the decision being appealed, etc.
 - d. Answer the appellant's questions about the hearing process and rules that apply.
 - e. Attempt to resolve the dispute through agreement and assist with the withdrawal of the hearing at the appellant's request.
 - f. Advise the appellant about possible free legal help at: 1-888-201-1014.
 - g. Discuss a request for a continuance, if necessary. If both parties are in agreement, call OAH together to request additional time to get more information, clarify issues, correct misunderstandings, make agreements, etc.
2. A formal **prehearing conference** with OAH may be requested if needed and is not already scheduled. A prehearing conference is generally required for overpayment hearings. If a prehearing conference is requested and granted (the ALJ must grant a request if it is filed with OAH at least 7 business days before a scheduled hearing date), all parties must attend. The

¹⁸ Good cause must be established for a late request to be accepted. The department should instead request an extension of the timeframe, before the deadline, if more time is needed.

conference is scheduled by OAH and usually takes place by phone. The prehearing conference can be used to:

- a. Simplify the issues. The department should be prepared to discuss the hearing issues.
 - b. Set the date, time, and place of the hearing.
 - c. Identify accommodation/safety issues.
 - d. Set a deadline to exchange witness lists and exhibits (which must not be less than five days before the hearing). Be prepared to know how many witnesses you expect to call and days you expect to need for the hearing.
 - e. Set deadlines for motions (“briefing” and “argument” deadlines).
 - f. Schedule additional prehearing conferences.
 - g. Discuss procedural matters.
 - h. Distribute written testimony and exhibits to the parties before the hearing.
 - i. Discuss other matters that may aid in the disposition or settlement of the proceeding.
 - j. Request a continuance if necessary.
 - k. Ask for a motion briefing schedule if wanting to file a motion.
3. A **hearing** is where the AHC, appellant, and witnesses come together with the ALJ, frequently by phone¹⁹, to present the issues being appealed. The AHC may:
- a. Present an opening statement that states the issue and briefly summarized the evidence that will be presented at the hearing.
 - b. Offer evidence to support the department’s decision such as exhibits and witness testimony and may question the witnesses presented by the other parties.
 - c. Give closing arguments where the facts presented at the hearing are applied to law. The ALJ or the appellant may also ask questions and the appellant may offer exhibits to support his or her position.

Resources

WAC 182-526-0175 Prehearing Meetings
WAC182-526-0195 Prehearing Conference

Most Social Services and Financial hearings fall under the HCA hearing rules: 182-526

HCA Hearings (WAC 182-526) include:

- Social Services Hearings- Services.
- Financial Hearings

DSHS Hearings (WAC 388-02) include:

- Food Stamps

RESOURCES

WACs and RCWs

WAC 182-526 Administrative Hearing Rules for Medical Services Programs (HCA)

RCW 34.05.410-34.05.494 General requirements for Administrative Hearings

RCW 74.09.741 Right to an Administrative Hearing (HCA)

RCW 74.02.080 Right to an Administrative Hearing (DSHS)

WAC 388-106 Long-Term Care Services

WAC 388-71 Home and Community Services and Programs

¹⁹ The hearing may also be in person or some parties may be in-person and some by phone.

Glossary

WORD	DEFINITION
Administrative Hearing Coordinator (AHC)	An employee of the department who represents the department in all activities related to administrative hearings. The AHC is also the Health Care Authority hearing representative, or authorized agent of HCA, for certain HCA hearings
Administrative Law Judge (ALJ)	An impartial decision-maker who is an attorney and presides at an administrative hearing. The Office of Administrative Hearings (OAH), which is a state agency, employs the ALJs. ALJs are not department employees or department representatives
Appellant	Term used for the client/rep or provider during the hearing process.
Board of Appeals (BOA)	An entity from HCA and DSHS responsible for reviewing the decisions issued by the ALJs as part of the appeals process. BOA review judges are attorneys who have the authority to review hearing records and initial orders for legal or factual errors. After their review, these judges enter final orders.
Client	For the purposes of this chapter, means an individual, who may also be the appellant, applying for Medicaid services (applicant) or an individual receiving Medicaid services. This also includes the client's chosen representative
Continued Benefits	When a Medicaid recipient's benefits are reduced or terminated by the department, and the recipient is able to maintain benefits at the prior level, if the recipient appeals the decision by requesting an administrative hearing with OAH by the appeal date on the notice.
Department	DSHS, Home and Community Services (HCS) and the Area Agencies on Aging (AAA) or their subcontracted entities. It also means Health Care Authority (HCA) because HCS and AAA staff represents HCA in most social services administrative hearings.
Department of Health (DOH)	A state agency separate from DSHS.
Exception to Rule (ETR)	Means an approved amount beyond the maximum hours/budget/daily rate generated by CARE when a client's situation differs from the majority. See 388-440-0001 for specifics.
Ex Parte Communication	Occurs when a party to a case, or someone involved with party, talks or writes to or otherwise communicates directly with the judge about the issues in the case without the other parties' knowledge.
Health Care Authority (HCA)	The single state agency responsible for overseeing Washington Apple Health (Medicaid), as well as other health care programs. HCS and AAA staff represents HCA in most social services hearings.
Office of Administrative Hearings (OAH)	A state agency that is independent from DSHS and HCA, which handles appeals of DSHS and HCA actions

Planned Action Notice (PAN)	A written form of communication used to notify clients of decisions about services and of the right to appeal that decision. It is the legal document/Notice that provides the client with the department's eligibility decision or decision about services and the authority that allows the department to take the action.
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REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
11/21/2022	Nina Banken	Updated contact information under "Ask the Expert"	
5/20/2025	Stacy Graff	- Corrected minor typos - Removed all references to Individual Providers because of the implementation of the Consumer Directed Employer (CDE). Clients no longer have a right to an Administrative Hearing regarding their choice of provider. IPs no longer have an administrative hearing related to training/certification and will not receive department issued overpayment notices that are for dates of payment after the transition to the CDE. The CDE has a grievance process for clients and providers. - Updated contact information under "Ask the Expert". - Added "email" as an option to notify OAH of a hearing request. - Removed IP Planned Action and Stop Work Notice information due to the transition to the CDE. - Added "This is a required document for all administrative hearings" re: administrative hearing report. - Added information in footnote 13 about requesting a recess during the hearing if needed. - Clarified in footnotes that a request to Superior Court is also known as Judicial Review. - Removed most of the duplicative information about notices that can be found in chapter 27.	



		• Added footnote 17 about changes to statute related to hearing request timeframes for state only programs where good cause is shown. • Other minor wording changes add for clarification.	
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Notices

The purpose of this chapter is to provide requirements and policy regarding Planned Action Notices (PANs) and other notices for client services.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Kim Averill Administrative Hearing Program Manager
360.725.3223 kimberly.averill@dshs.wa.gov

For specific program questions about PANs, contact the Program Manager who manages that program.

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BACKGROUND

Providing appropriate notice to clients and providers, prior to taking action in most instances, is a due process requirement and required by statute/rule. While this chapter will not cover program specific notices, it covers general information about notice requirements that can be applied to particular situations.

GENERAL NOTICE INFORMATION

In general, notices to clients must include the following, when applicable.

1. **Action taken by the department-** the action the department took that impacted the client's benefit.
2. **Reason for the action-** the reason the department took the action.
3. **Legal authority-** specific rule, Washington Administrative Code (WAC); law/statute, Revised Code of Washington (RCW); or Code of Federal Regulation (CFR) that supports the agency action.
4. **Date of notice-** date the notice is completed and mailed.
5. **Effective date-** date the action takes effect.
6. **Contact information-** department representative's name and contact information.
7. **Information about hearing rights-** when applicable, information in the notice informing the recipient about their hearing rights.
8. **Information about continued benefits-** when applicable, information in the notice informing the recipient about continued benefits.

Important: Planned Action Notices generated in CARE include some auto-populated fields, including WAC citations. Ensure this information is correct and applicable. Modify info as necessary before sending.



CLIENT SERVICES PAN

This section describes the requirements and policy direction for completing PANs related to client services.

Notice requirements

When a client applies for or receives benefits, the department is required to send timely written notice in the client's primary language, when the department takes an action that impacts the client's benefits.

1. Action

Examples of Actions taken by the department include approvals, increases, withdrawals, denials, reductions, terminations, and changes. Choose the **Action on the PAN** that most accurately reflects what the department is doing related to the client's benefits.

Use this table to assist you in selecting the correct Action.

ACTION	USE WHEN	10 to the END?
APPROVED (includes renewals and changes)	- Initial eligibility decisions - Continued eligibility/services when there is no change - A change in services from one program to another, e.g. MPC to CFC - Adding a service	n/a
INCREASED	Services/rate increase	n/a
WITHDRAWN	Requests for services that are withdrawn by the client after the assessment and before services start. <i>The department does not complete withdrawal PANs for actions or changes the department is taking.</i>	n/a
DENIED	- Initial functional ineligibility - Not eligible for requested service/program and services were never initiated or authorized.	n/a
REDUCED	Services/program/hours/rate reduced	Yes
TERMINATED	- If a service/program has been initiated and authorized, select "Terminated." - Use when client requests termination.	Yes



2. Reason

Select the reason that most accurately fits your situation. Reasons may include functionally eligible, not functionally eligible, not financially eligible, change of functional impairment, change in unmet need level, etc.

TIP: select “other” and add a brief, plain talk, explanation for unusual situations.

3. Legal authority

Include the specific WAC, RCW, or CFR that supports the action the agency took. WAC should be used first whenever possible. WACs related to LTC Services can be found in [Chapter 388-106](#)

4. Date of notice

This is the date the notice is completed and mailed. This date is auto populated when the PAN is finalized in CARE.

TIP: finalize and mail PAN on the same day. The day of mailing begins the count for 10 to the end, continued benefits, and hearing deadlines.

5. Effective date

This is the date the action takes effect. If a client is no longer functionally eligible for in-home care services, the services will be terminated on the effective date. This means the client will no longer receive services on or after that date. The Effective date auto-populates for reductions and terminations.

Important: To edit the effective date to allow more time for **translations**, complete an amended PAN. An amended PAN is currently the only way to edit the dates on a reduction or termination PAN.

TIP: the end date of the authorization is one day before the effective date.

6. Contact information

The case manager’s name and contact information is auto populated into the PAN from CARE.

7. Hearing rights

Clients have a right to a hearing when “aggrieved” by an agency decision. There must be an “action” to trigger a right to hearing. However, if a client asks for a hearing, regardless of whether the department made a decision or took an action, the department must assist the client in filing for an



administrative hearing with the Office of Administrative Hearings (see chapter 26). In these cases, the department's Administrative Hearing Coordinator will argue that the client does not have a right to a hearing. The local grievance policy should also be discussed with the client.

Clients have 90-days to appeal the department's action, unless good cause is demonstrated per RCW 74.09.741, which may allow more than 90 days in some situations. Information about how to request a hearing and a Request for Hearing Form is included on each Service PAN printed from CARE.

8. Continued Benefits

Continued benefits allow a client to continue receiving services at their prior level while they wait for the outcome of their hearing.

For service reductions and terminations, a client is automatically entitled to continued benefits if they request a hearing by the

Appeal-by-date (at least one day before the effective date on the PAN). A client can request not to receive continued benefits.

Grievance Process:

Each office has a written grievance policy and procedure. In situations where a client does not have a right to a hearing, he or she should be informed of the local grievance process. This may meet the client's needs outside of the hearing process.

- The appeal by date is auto populated.
- If the effective date on the PAN is August 1st, the appeal-by-date is July 31st.
- Client must ask for a hearing by July 31st to be eligible for continued benefits.

Continuation of benefits terminates immediately if Office of Administrative Hearings (OAH) rules in favor of the department in the Initial Order. Client may be subject to an overpayment for the first 60-days of continued benefits if OAH rules in favor of the department.

NOTICE TIMEFRAMES

PANs should be completed and sent immediately after completing an assessment. 10-to-the-end policies, continued benefits, and hearing rights all offer clients protections and options if they disagree with a department decision.

1.Reductions and Termination:

When an Annual or Significant Change CARE assessment results in a **decrease** in residential rate or a **termination** of a service, the department must provide clients with at least 10-days' notice prior to implementing the reduction or termination. This is called the **10-to-the-end policy**.

The reduction or termination becomes effective the first day of the following month that the PAN was finalized and sent to the client.



When a PAN is finalized with more than 10 days in the month, the dates would line up like this:

PAN finalized	7/10/2024
Date of Notice	7/10/2024
Appeal-by-Date	7/31/2024
Current Auth End Date	7/31/2024
Effective date	8/1/2024

When there are less than 10 days between the Date of Notice and the last day of the month, the effective date is the first day of the following month. This means the client will have more than 10 days notice.

When the PAN is finalized with less than 10 days left in the month, the dates would line up like this:

PAN finalized	7/23/2024
Date of Notice	7/23/2024
Appeal-by-Date	8/31/2024
Current Auth End Date	8/31/2024
Effective Date	9/1/2024

Exceptions to 10 to the End

Refer to [WAC 182-518-0025](#) for certain exceptions to the 10-day notice requirements including incarceration, returned mail, death, receipt of Medicaid from another state, etc.

If your client becomes incarcerated and you learn client will be incarcerated 30 days or more you can issue a PAN with an effective date that same day. You do not need to give 10 days notice.

2. Denials

When a client is found not to be eligible for services, send a denial-of-service PAN. The effective date is auto populated and is the same as the date of notice.

- The 10-to-the-end policy does not apply to denials.
- Denial PANs have no appeal-by-date because continued benefits are not relevant. A client will still have a right to request a hearing.



3. Approvals and Increases:

When an assessment results in the approval of a new service, increase in residential rate or in-home hours, or other service, the department IS required to send client notice of their benefits, but 10 days advanced notice is not required.

- Approval and increase PANs have no appeal-by-date because continued benefits are not relevant. Clients will continue to have a right to request a hearing.
- The effective date can be the beginning of the following month or immediately if needed (upon completion of the new assessment and client approval).
- If authorizing services mid-month, follow the instructions in the [SSAM 3.0](#) to ensure authorizations are done correctly.
- For mid-month hours *increase*, reflect all CARE-generated hours on the PAN for personal care. The effective date should match the date that the assessment was moved to current to reflect the date that the increase in benefit/change in eligibility took effect.

4. Service Changes

A PAN must be sent any time there is a change in the amount or type of benefits or services.

If a client is moving from one care setting to another, such as in home to a residential setting or vice versa, send a PAN noting the termination of in-home care and the approval of residential setting.

A PAN is also required if a client is moving from one residential setting to another such as AFH to ALF.

5. Correcting Errors

A PAN may be corrected up to the point of an administrative hearing (see [WAC 388-02-0260](#)).



OTHER CLIENT NOTICES

This section describes the policy direction for completing other types of notices.

1. When a client cannot be reached to complete the intake process

When a client makes a request for in-home services or services in a residential facility and the department is unable to reach the client to complete the intake process, send a [HCS - 10 Day Form Letter Intake](#) requesting contact within 10-days so the intake process can be completed. A PAN is not required.

2. When a client cannot be reached to schedule an assessment

When a client makes a request for in-home services or services in a residential facility and the department is unable to reach the client to schedule an assessment, send a [HCS - 10 Day Form Letter Assessor](#) requesting contact within 10-days so an assessment may be scheduled. A PAN is not required.

3. Notice of Decision on Request for an In-Home Personal Care Exception to Rule

Refer to LTC manual [Chapter 3.pdf](#), Exception to Rule (ETR) process for information on this type of notice.



4. When a client becomes financially ineligible for LTC services

When a client is or becomes **financially ineligible**, HCS financial staff *may* send the required notice to the client, depending upon the ACES coverage group the client is on and the LTC program/service the client is receiving. The financial notice includes the required information, including hearing rights.

When financial sends notice to a client, a SS PAN is not required and should not be sent¹.

Use this table to determine when a SS PAN is required when a client is financially ineligible.	
Program	Send PAN?
MPC	Yes
Fast Track	Yes
MCS	Yes
MAGI based	YES ²
HWD	In home-YES, Residential-No
CFC Classic	NO
CFC + Waiver	NO
Waiver (COPEs or New Freedom)	NO
RCL	NO
PACE	NO
Non-Citizen Program (45 slot)	NO

¹ If a financial notice and a SS PAN are sent on the same action, the client will be given hearing rights in both instances for the same issue.

² The Health Care Authority (HCA) sends notices to clients about their WA Apple Health benefits, but the notice does not include information about LTC services. CMs receive a H002 tickler in Barcode to alert them that a MAGI client's benefits may be changing. Please refer to MB 16-050 for more information.



RESOURCES

Related WACs and RCWs

RCW 74.09.741	Adjudicative Proceedings
eCFR :: 42 CFR 431.206	Informing applicants and Beneficiaries
WAC 388-458	Notices to Clients
WAC 388-02-0260:	May the Department Amend a Notice?
WAC 182-518	WASHINGTON APPLE HEALTH—LETTERS AND NOTICES
WAC 388-106	Long Term Care Services
WAC 388-71	Home and Community Services and Programs
RCW 43.20B.675	Vendor overpayments—Goods or services provided on or after July 1, 1998—Notice—Adjudicative proceeding—Enforcement—Collection—Rules.
RCW 43.20B.010	Definitions (overpayments)
42 CFR § 433.304	Definitions (overpayments)

Other Resources

Social Service Authorization Manual	Payment Issues
Chapter 3.pdf	notices for ETR's

Where to find Notice documents

Client Services PAN	CARE
10-Day Form Letter – Intake	In Translated Docs
10-Day Form Letter- Assessment	In Translated Docs



Notice of Decision on Request for an In-Home CARE
 Personal Care Exception to Rule #05-246

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
3/27/2023	Stacy Graff	Removed references and sections that were related to contracted Individual Providers including: rejection of client choice of provider PAN, IP PANs, Stop Work Notices, IP payments and overpayments.	
4/1/2025	Kim Averill	Updated new DSHS logo and formatting Added spacing to page 2, General Notice information Minor wording and formatting changes to PAN action table pg 3 Reworded section on continued benefits Reworded section on 10 to the end Minor wording changes in section covering client PANs Deleted some text boxes and replaced with plain text to improve readability of page. Added more resource links in resource table	
11/14/2025	Kim Averill	Corrected chart on page 3 to show 10 to the end doesn't apply to denials	
3/31/2026	Kim Averill	Added information and reference about good cause/RCW 74.09.741 on page 5 Added information about PAN's when there is a mid month hours increase to page 7. Added information about PAN's when there is a service change, page 7. Added information about correcting PANs, page 7. Corrected links to 10 day letters for intake and assessor, pages 7 and 8. Corrected link to ch3 ETR process, page 8. Corrected links under resources, page 10.	

CHAPTER 27: Notices
Long-Term Care Manual



7/13/2026	Kim Averill	Added note about due process on page 2. Added info about PANs when a client becomes incarcerated on page 6. Updated link to SSAM on page 7. Updated information about PANs for service changes on page 7.	
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Medicaid Fraud

The purpose of this chapter is to provide instruction and information to staff regarding suspected fraud, waste and abuse in Medicaid-funded programs.

Adult Protective Services staff please refer to Chapter 6 of the Long-Term Care Manual for instructions on reporting fraud.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Cheryl Timmons Program Integrity Manager
360.725.2530 cheryl.timmons2@dshs.wa.gov

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BACKGROUND

Federal regulation requires the Department to have methods and criteria to identify suspected fraud cases, procedures regarding investigation of these cases, and processes for referring suspected fraud cases to law enforcement officials.

When a complaint alleging Medicaid fraud is received, federal rules require the completion of a preliminary determination on whether there is sufficient basis to warrant a full investigation. Because direct line field staff in HCS, DDA and AAA offices conduct case management activities and are often the level of staff receiving this information, the preliminary determination is conducted at this level. If the preliminary results give staff reason to believe that an incident of fraud, waste or abuse has occurred, a referral for full investigation should be made to DSHS ALTSA/DDA Headquarters (HQ) for routing to the Medicaid Fraud Control Unit for their review and evaluation.

The Medicaid Fraud Control Unit (MFCU) conducts criminal and civil investigation and prosecution of health care provider fraud committed against the State of Washington's Medicaid program. MFCU also monitors complaints of resident abuse or neglect in Medicaid funded nursing homes, adult family homes and assisted living providers.

The guidance contained in this chapter is based on federal requirements, training materials offered by MFCU, and a collection of practices from field and headquarters program staff. Since this guidance document cannot cover or predict every possible fraud scheme or scenario, this information is presented as a resource to assist staff at reporting agencies when allegations of potential fraud are made, and to better understand the federal reporting requirements associated with Medicaid providers. HCS Headquarters program staff are available for consultation as requested.

Most Medicaid providers are honest, hardworking individuals and agency staff who provide high quality care that enables individuals to continue living in their own home and communities. However, a few individuals attempt to be paid for services they did not provide, for services that the client is not eligible to receive, or by other fraudulent schemes. By identifying provider fraud, we ensure a high-quality provider base to support vulnerable consumers and that taxpayer dollars are used accountably.

PRELIMINARY ACTION STEPS

If a fraud referral is going to be completed do not submit an ARF (Adjustment Request Form). No overpayments can be processed while a fraud referral is active.

If a referral is accepted by Medicaid Fraud Control Unit (MFCU), they will recover any overpayment due.

Case Managers and social services workers are at the front lines of the fight against provider fraud and are in a critical position to identify instances of suspected provider fraud. Reporting agency field staff have the most knowledge of a client/provider situation and are often the point of entry for awareness of



any suspicious acts. Field staff at AAA/HCS/DDA offices may receive information regarding a client or provider's actions that may indicate program rules are not being followed in multiple ways, such as:

- Tip received from an anonymous phone call or letter,
- Observation during regular case management activities,
- Contact by another interested party, or
- Information found in a report or data review.

CDE will also submit fraud referrals to DSHS. The referral will be shared with the local office staff as an FYI. If the Individual Provider is working for other clients, headquarters staff will work with CDE and local office staff to determine if Good Cause Applies (see page 5).

However, before a referral is made to the Medicaid Fraud Control Unit for potential investigation of a provider's actions, a preliminary review must be conducted at the field level or by CDE. This preliminary review contains action steps that are required to establish the credibility of the claim and to determine whether or not field staff or CDE believe behavior which rises to the level of fraud may be involved.

Professional judgment should be applied on a case-by-case basis to determine what steps are appropriate, as all situations are unique. Some steps to take as part of a preliminary review to determine the credibility of the allegation may include the following (if there is any concern that any of these actions might have an unintended influence on a subsequent investigation, contact the Program Integrity Manager for guidance):

- Talk to the client
- Talk to other involved parties
- Request and review the provider's timesheets/records of services provided. For CDE employees HQ staff will request shift details from CDE,
- Review and confirm the care plan and compare to what is being delivered
- Review invoices, staff logs, etc.
- Review the provider's contract file for any relevant documentation
- Gather documentation such as SER notes and/or provider education that occurred prior to current incident
- Consult with supervisor about possible actions before a referral is made, such as:
 - Increased monitoring of services
 - Unscheduled home/office visits (depending on provider type)
 - Conversations with provider regarding the allegation, with appropriate level of detail and reference to program rules (i.e. a reminder not to claim hours while a client is hospitalized).

Allegations are considered credible when they have "indicia of reliability" (see Glossary) or indicators of probability. Examples of some indicators that support the conclusion that the allegation may be true include, but are not limited to:

- Admission/confession to fraud activities,
- Supporting documentation,
- Verification by two or more sources,
- Clear patterns of misconduct,



- Continued misconduct after education on contract requirements (which should be documented in the contract file by the staff person who provided the notification),
- Any internal communications expressing concern about a provider's actions or conduct,
- History of multiple billing "errors", which result in a loss to the Medicaid program,
- A lack of reasonable legitimate explanation, etc.

It should be clear that the act under review is not accidental or inadvertent and is action by design. At the very least, it requires an intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit or payment, where the provider has made a knowing false statement. Not every overpayment is fraud, especially where an incident can be attributed to a mistake made by the provider.

If there is no pattern or history of behavior that persists over time, many times the most appropriate administrative remedy is to write an overpayment. When a pattern seems apparent, document the activity and corrective discussion with the provider, as well as any notification that was provided to correct the situation.

This documentation should be made in either the client's SER or the provider's contract file, whichever is most appropriate for the situation. If the behavior occurs again, this information will strengthen a referral as it will help establish a pattern of behavior as well as possible intent of the provider. Field staff should staff concerns with supervisors as appropriate.

Field staff should submit the referral package (see [Provider Fraud Referral Policy & Process](#) section for detailed instructions, page 9) with information and supporting documentation that addresses the allegations to the greatest extent possible. See also the Medicaid Provider Fraud Referral form (DSHS Form #12-210) and accompanying instructions for the specific information and required documentation. Following these instructions will provide assurance that quality referrals are submitted to MFCU for their evaluation and review. Be sure that all mandatory fields, those marked with an asterisk ("*"), are completed.

Examples of supporting documentation to submit with a completed referral form may include, but are not limited to:

- Provider Timesheets (if applicable) for a 3-6 month span, for the period of the identified concern,
 - For CDE employees HQ staff will request shift details from CDE,
- Documentation of any overpayment associated with the allegation,
- SER notes that document discussions with the provider regarding either the incident being investigated or any previous discussions with the provider on the same or similar topic,
- Name and contact information of any witness who would be contacted for more information during a full investigation. This could be the person who provided a tip to field staff, or someone who has additional information about the allegation or provider's actions,
- Documentation requested in the Provider Fraud referral form instructions, and
- Any other documents which support and substantiate the allegation.

PAYMENT SUSPENSION POLICY

In accordance with the Affordable Care Act (ACA) and federal regulation at 42 CFR 455.23, the State of Washington must ensure that federal funding is not provided to individuals or entities when there is a pending investigation of a credible allegation of fraud.

This means that system payments to a provider must be suspended when there is a credible allegation of fraud, unless Good Cause exists not to suspend payment. Terminating the provider's payment authorization is the equivalent of a payment suspension. If the payment is not suspended, or suspended only in part, federal rules require that a "good cause" exception must be documented.

- For referrals involving Individual Providers, the CDWA authorization does not need to be ended if CDWA confirms that a new Individual Provider will start serving the client.

Good Cause Exceptions

The federal rule allows that the reporting agency may find that good cause exists to:

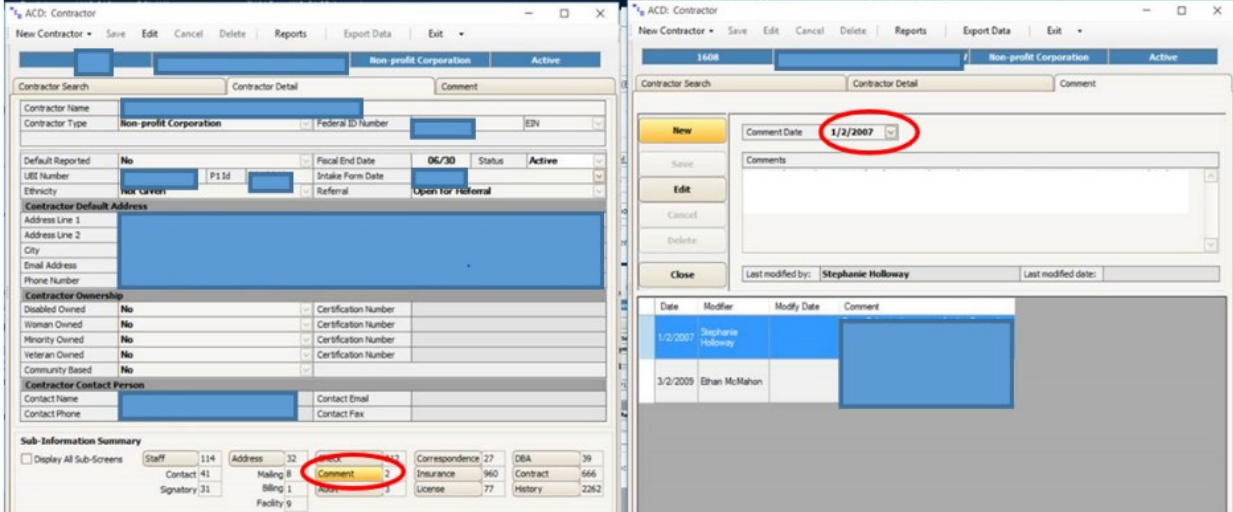
- Not suspend payments,
- Discontinue a payment suspension previously imposed, or
- Suspend payments only in part.

Documentation

If local office staff and CDE recommends that a Good Cause Exception based on client safety needs applies and is approved by DSHS HQ, the case manager (or designee) and CDE must ensure the applicable exception is documented, including the relevant facts, circumstances and any other information or supporting documentation to support the finding that a Good Cause Exception applies.

- For a provider with one or only a few clients, such as an Individual Provider, documentation of Good Cause Exception must be made in the client(s)'s SER.
- For Contracted DSHS providers a note in the provider's ACD contract file needs to be added to indicate that a referral was made, the date, a summary of the circumstances, and the Good Cause Exception that applies to the situation.
- For Contracted DSHS provider with several clients, such as an agency provider, documentation of Good Cause Exception must be made in the provider's contract file/ACD. Local or HQ Contract Staff may enter documentation of any monitoring action being considered and add a Comment to the provider's Contractor Profile in ACD to summarize all actions taken.

NOT Suspend Payment	Suspend Payment in PART
• Case manager must staff the case with Supervisor, considering all relevant factors and documentation to determine if a Good Cause Exception applies.	• The case manager who is making the referral must coordinate with the other case manager(s) of the provider's other clients to determine if there are any concerns regarding the provider. • The case manager must also staff the case with their Supervisor, considering all relevant factors and documentation to determine if a Good Cause Exception applies to suspend only in part.



Not Suspend Payment

If there is a good reason not to terminate the authorization of a provider (i.e. to allow a provider to continue working for the client) when a credible allegation of fraud is referred for potential investigation, this reason is called a Good Cause Exception and must be documented. **42 CFR §455.23** includes a provision for a good cause exception to not suspend payments. Allowable **Good Cause** reasons to either (1) NOT suspend payments, or (2) NOT continue a payment suspension previously imposed are:

Payment Not Suspended Due to Good Cause Exception

- MFCU (or other law enforcement agency) specifically requests that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
- Other available remedies implemented by the State more effectively or quickly protect Medicaid funds.
- Based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, the suspension should be removed.
- Client access to care would be jeopardized by a payment suspension because of either of the following: (please indicate)
 - (i) The individual or entity is the sole source of essential specialized services in a community.
 - (ii) The individual or entity serves a large number of clients within a federally designated medically underserved area.
- MFCU (or other law enforcement agency) declines to certify that this matter continues to be under investigation.
- Payment suspension is not in the best interests of the Medicaid program.

Suspend Payment Only in Part

The federal rule allows that the reporting agency may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part if there is a good reason to allow an individual or entity to continue working where there is an investigation of a credible allegation of fraud.

Suspending a payment only in part would be applicable when a provider has more than one client, the credible allegation of fraud is regarding only one client, and there are no issues with the remaining client(s). The applicable exceptions to suspend payment only in part are as follows:

Payment Suspended Only in Part Due to Good Cause Exception

- Client access to care would be jeopardized by a payment suspension in whole or part because of either of the following: (please indicate)
 - (i) The individual or entity is the sole source of essential specialized services in a community.
 - (ii) The individual or entity serves a large number of clients within a federally designated medically underserved area.
- The reporting agency determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that the previously imposed payment suspension should be imposed only in part.
- The credible allegation focuses solely and definitively on only a specific type of business area of a provider, and the reporting agency determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.
- MFCU (or other law enforcement agency) declines to certify that this matter continues to be under investigation.
- The reporting agency determines that payment suspension only in part is in the best interests of the Medicaid program.

If none of the exceptions apply, the payment authorization must be terminated when a provider fraud referral is submitted to MFCU. Notice to the provider regarding the termination of the payment authorization must be sent within five (5) of the termination date on the authorization, in accordance with the federal requirement at 42 CFR 455.23(b).

PROVIDER FRAUD REFERRAL POLICY AND PROCESS

Considerations Before a Referral is Made

A referral should contain sufficient information to support the Department's belief that an illegal act by a Medicaid provider has occurred. There is **no** "minimum dollar threshold" which must be met in order to make a provider fraud referral. If staff suspect a situation is Medicaid fraud, a referral should be made using the guidance presented in this chapter. Intake staff at the MFCU will review and evaluate cases referred by DSHS and make a determination to accept a case for further investigation and potential



prosecution based on the information presented and their agency's criteria. Field staff should not "screen out" or decide not to make a referral based on an assumption that a case might not be accepted due to dollar value.

Before a provider fraud referral is submitted to HQ for referral to MFCU, the referring staff (i.e. case manager or contract manager) must staff the referral package with supervisor(s) and/or others per AAA or regional practice. This should include a review of the allegation circumstances, all relevant supporting information and documentation, and a determination regarding payment suspension, documenting good cause exception where applicable. Supervisor review should ensure all required components of the referral are met according to the referral form instructions, and to ensure appropriate professional judgment has been applied to the process.

Submitting the Medicaid Provider Fraud Referral Package

Complete the Medicaid Provider Fraud Referral form ([DSHS Form 12-210](#)) according to the form instructions, gather all appropriate documentation (see Preliminary Action Steps section), and submit this package to the email addresses listed in the table below. HQ program staff monitors the email inbox on a daily basis. **Reporting agency field staff should not make any provider fraud referrals directly to MFCU**, either via email, phone, or through the online complaint form. MFCU Intake Unit staff are available for consultation upon request, if field staff would like to consult regarding a case before considering it for referral.

For ALTSA Home & Community Services (HCS) Division Referrals	For Development Disabilities Administration (DDA) Referrals
Send referrals to this email address: ProviderFraudHCS@dshs.wa.gov	Send referrals to this email address: ProviderFraudDDA@dshs.wa.gov

HCS and DDA HQ program staff monitor the email Inbox regularly to receive referrals. These are reviewed for completeness and compliance with federal regulations, and then entered into a tracking system. Provider fraud referrals are reported to this centralized location for tracking purposes related to quality assurance and annual reporting. This process facilitates collaboration with Health Care Authority's Division of Program Integrity (DPI) and ensures a standardized reporting process is followed in order to meet mutual reporting requirements to federal authorizing entities.

HCS and DDA HQ program staff will forward the completed referral package along with any supporting documentation to the appropriate investigating entity, MFCU and/or the DSHS Office of Fraud and Accountability (OFA), as appropriate. HQ program staff will monitor, track, and report on the follow-up provided by the fraud investigators, as well as communicate with case managers and field staff as needed on a case-by-case basis.

Notices to Client and Provider

Send the appropriate notice to the Client and provider according to current practice and policy. Include WAC and CFR citations from the Resources section at the end of this chapter, as applicable, as well as any other applicable WACs which support the action being taken.

- If the provider is an IP, the Consumer Directed Employer will provide notice to their employee.

Payment authorization to provider should be end dated according to the Payment Suspension section, unless a Good Cause Exception applies. When a fraud referral is made, terminate payment to the provider immediately and according to the Payment Suspension section, unless a Good Cause Exception applies, or client selects another CDE IP. Contact the provider about the termination and send written notice within five (5) days of the termination date on the authorization. Contact the client for care planning purposes and send a PAN.

- If the provider is an IP, the Consumer Directed Employer will provide notice to their employee

Documentation of Referral

The referring field staff must ensure the provider fraud referral is documented, including the date of referral, relevant facts, circumstances and any other information or supporting documentation.

- For a provider with one or only a few clients, such as an Individual Provider employed CDE, document the referral in the client(s)'s SER.
- For a provider with several clients, such as an agency provider, a notation in the provider's contract file must be added to document the date of referral, relevant facts, a summary of the circumstances, and any contract or monitoring action being considered. Add a Comment to the provider's Contractor Profile in ACD to summarize all actions taken.

FULL INVESTIGATION

Cases that are accepted by MFCU for investigation will be assigned to a MFCU Investigator, who may contact field staff to request cooperation and records related to the provider being investigated. An investigation will continue until the appropriate legal action is initiated, or the case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse. A matter may also be resolved between the agency and the provider through other means, such as a warning notice to the provider, assessing an overpayment, terminating the provider's contract, or other sanctions as appropriate.

HCS and AAA field staff and case management staff as well as HQ program staff will cooperate fully with the investigatory and prosecutorial activities of the MFCU to the extent allowed by law and rule. This includes providing access to records or information kept by the reporting agency as well as making records and/or reports available upon request. An example of records which may be requested include a copy of the provider contract and any documents signed by the provider at contracting indicating awareness of and willingness to comply with program policies.



Further, DSHS and its contractors will cooperate with Health Care Authority staff with regard to the prevention and detection of fraud, waste and abuse as outlined in the Cooperative Agreement between DSHS and HCA, and by extension through the Memorandum of Understanding between MFCU and HCA.

WHEN A REFERRAL IS NOT ACCEPTED BY MFCU

When a referral is screened out or declined by MFCU, field staff will receive notification from either HCS/DDA program staff or from MFCU staff directly. Field staff may then decide to resume payment to a provider for either the same client or a different client. For agency providers, this may mean that a previously imposed payment suspension in part would be ended. Before resuming payment or ending any payment suspension consider if a Character, Competence & Suitability Review is appropriate.

- For an agency provider, please reference Policy & Procedure Manual for AAA Operations, Chapter 6: Interlocal Agreements, Subcontracts and Grievances for guidance related to contract monitoring activities.
- Staff with case management supervisor to ensure awareness of prior referral activity.
- Document CCS results in provider's contract folder and add a Comment to the provider's Contractor Profile in ACD with the CCS results and any monitoring activities or report(s).
- CDE will perform CCS as appropriate for their employees.

CONTRACT TERMINATION

According to DSHS Central Contract and Legal Services (CCLS), termination of a contract for default means a contractor is not in compliance with the expectations or requirements of the contract. Requests for termination for default must be staffed with a supervisor, then submitted to the Contracts Unit for routing to CCLS who makes the final review and determination of default.

The reporting agency may determine that a provider's contract should be terminated as the result of the actions or activities that gave rise to the provider fraud referral. Please refer to information presented in other chapters of the LTC Manual regarding contract termination processes, such as Chapters 3 and 5, or AAA Policy and Procedure Manual, Chapter 6.

Contract terminations resulting from a Medicaid Provider Fraud Referral are an annual reporting requirement to HCA and CMS, so this information is collected on the Medicaid Provider Fraud Referral form as well as through follow up with case management staff by HQ program staff. Reporting agency staff should respond promptly to any inquiry made by HQ program staff about planned contract action following a provider fraud referral.

REPORTING CLIENT FRAUD

The Office of Fraud and Accountability (OFA), an office within DSHS, investigates Medicaid client fraud. MFCU and OFA may collaborate on investigations that may involve both a client and a provider. When an intake report, tip received, or investigation indicates that a client may have committed fraud involving Medicaid funds, suspected client fraud should be reported to OFA using the Fraud Early Detection (FRED) process through Barcode. Some DSHS staff may not have access to Barcode. If this is

the case, the referring worker should complete the [DSHS 12-209 Client Fraud Report](#) form and send via email to the correct email addresses listed above.

RESOURCES

Related WACs and RCWs

WAC 388-71-0540 – 388-71-0561	Home and Community Services and Programs
RCW 74.66 74.67 9A.56.030 9A.56.020(b) (4) & (5)	Medicaid Fraud False Claims Act Medicaid Fraud Control Unit Theft, 1 st degree Theft by Deceptions
CFR 42 CFR §455.2 42 CFR §455.12- 42 CFR §455.17 42 CFR §455.21 42 CFR §455.23	Definitions Preliminary & Full Investigation Requirements Cooperation with State Medicaid Fraud Control Units Suspension of Payments and Good Cause Exception

Acronyms

AAA	Area Agency on Aging
ACA	Affordable Care Act
ACD	Agency Contracts Database
ALTSA	Aging and Long-Term Support Administration
APS	Adult Protection Services
CCLS	Central Contracts and Legal Services
CCS	Character, Competence and Suitability Review
CDE	Consumer Directed Employer entity.
CDWA	Consumer Direct Care Network of Washington, the contracted CDE entity
CMS	Centers for Medicare and Medicaid Services
DDA	Development Disabilities Administration
DPI	Division of Program Integrity within Health Care Authority
DSHS	Department of Social and Health Services
FRED	Fraud Early Detection with OFA
HCA	Health Care Authority
HQ	DSHS ALTSA & DDA Headquarters
LTC Manual	Long Term Care Manual
MFCU/MFCD	Medicaid Fraud Control Unit/Division
OFA	Office of Fraud and Accountability
PAN	Planned Action Notice
SER	Service Episode Record
The Department	Department of Social and Health Services

Glossary

For purposes of Medicaid Fraud, and according to 42 CFR 455.2, the following definitions apply:

WORD	DEFINITION
Abuse	(meaning for this term as it is used within this chapter and <u>not as it applies to Adult Protective Services investigations</u>) means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
Credible allegation of fraud	Is an allegation which has been verified by the reporting agency (see definition below), received from any source, such as complaints received or observations during case management. Other sources could be patterns identified through report review or provider audits, information resulting from civil cases, or law enforcement investigations. Allegations are considered to be credible when they have “indicia of reliability” (see definition below) and the reporting agency (see definition below) has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
Fraud	Means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
Indicia of reliability	Are signs, indicators or circumstances, which tend to show or indicate that something is probable.
Reporting agency	Refers to DSHS (also referenced within this chapter as “the Department”) or any contracted AAA entity. This could mean any HCS, DDA, or AAA office.
Waste	Is defined as any activity that uses resources but creates no value. While all fraud is waste, not all waste is fraud. Waste is inefficiency that may be, for example, a medically unnecessary service, inefficient delivery of care, inflated prices, or excess administrative costs.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
11/2/20229/2/2026	Cheryl Timmons	Updated language of Good Cause process and added language to include CDE providers	n/a
01/06/2025	Cheryl Timmons	Added language about overpayments, made some grammar changes.	



APPENDIX

- [12-210](#) Provider Fraud Referral Form,
- [12-209](#) Client Fraud Referral Form,
- [FRED](#) link in Barcode (screenshot),
- [Provider Fraud Fact Sheet](#) – November 2014
- [H17-023](#) (Amended 5/22/2017)

Roads to Community Living

Washington State's Money Follows the Person Project

The Purpose of this chapter is to educate staff about Roads to Community Living (RCL), what benefits the program has offered to participants and to provide instruction on how to utilize the services through the close of the project.



Ask an Expert

If you have questions or need clarification about the content in this chapter, please contact:

Julie Cope	Project Director for Roads to Community Living
360.725.2529	julie.cope@dshs.wa.gov

If you have questions regarding RCL for HCS, please contact:

RCL General Inbox	DSHSALTSARCLReferrals@dshs.wa.gov
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Rebecca Kaiser	R1 RCL Enrollment Specialist
564.669.1282	rebecca.kaiser@dshs.wa.gov

Amanda Speck	R2 RCL Enrollment Specialist
360.870.6309	amanda.speck@dshs.wa.gov

Desiree Vallejo	R3 RCL Enrollment Specialist
360.890.2210	desiree.vallejo@dshs.wa.gov

Samantha Dunham	RCL Data and Quality Manager
509.309.9435	samantha.dunham@dshs.wa.gov

Cassie Pizano	RCL Technology Supports Specialist
564.669.8871	cassie.pizano@dshs.wa.gov

Jevahly Wark	NFCM Nurse Specialist
360.584.4318	Jevahly.Wark@dshs.wa.gov

Any questions regarding RCL for DDADDA can be directed to:
ddarclenrollmentintake@dshs.wa.gov

Melanie Ingram	Community Transitions Unit Manager
360.764.6915	melanie.ingram@dshs.wa.gov

Tom Farrow	RCL Grant & Enrollment Specialist
360.628.1818	tom.farrow@dshs.wa.gov

Ron Bryan

RCL Quality Improvement Specialist

360.791.6713

ronald.bryan@dshs.wa.gov

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WHAT IS THE ROADS TO COMMUNITY LIVING PROGRAM?

Roads to Community Living (RCL) is a statewide demonstration project funded by a federal “Money Follows the Person (MFP)” grant. The grant was received by Washington State from the federal Centers for Medicare and Medicaid Services (CMS). The purpose of the RCL demonstration project was to investigate what services and supports will successfully help people with complex, long-term care needs transition from an institution to a community setting.

Services and supports from the RCL demonstration project have proven successful and are being used to shape changes to Washington State’s long-term care system. This will result in more people with complex long-term care needs being able to remain independent or transition from institutional into community settings in Washington State.

The RCL demonstration project has received approval to extend new RCL enrollments through the end of **2028**; the last date for individuals to receive RCL services has also been extended through **12/31/2029**. All new HCLA RCL participants will be enrolled and managed by ALTSA HQ. RCL enrollment procedures for DDA remain unchanged. ALL RCL participants must be disenrolled by **12/31/2029**. The grant will be closed out with all expenditures finalized, reconciled, and submitted to CMS by **09/30/2031**.

As part of sustainability planning, demonstration and supplemental services that have proven to be useful will be added to the state plan and/or waiver. Those supplemental or demonstration services with low or no utilization will be allowed to sunset with the program. This process has already started and will continue. The goal is to ensure a seamless transition in Home and Community Based Services (HCBS) available in existing state plan and waiver programs once RCL is no longer available.

WHO IS ELIGIBLE FOR THE RCL PROJECT?

The RCL demonstration project will transition the last individual onto RCL services on 12/31/2027. The last date for individuals to receive RCL services is 12/31/2028 therefore all RCL participants must be disenrolled by that date. For those RCL participants who may be re-institutionalized during their 365 day post transition demonstration period, they will be allowed to finish the remainder of their 365 day demonstration period on or before the 12/31/2028 project end date. The grant will be closed out with all expenditures finalized, reconciled and submitted to CMS by 09/30/2031.

Individuals eligible for RCL are:

- People of any age with a continuous, qualified stay of **60 days or longer** in one or more qualified institutional setting (hospital, nursing home, RHC/ICF-ID) without a break in institutional care; OR
- Individuals in an inpatient psychiatric hospital with a continuous stay of **60 days or longer** who are 20 years or younger, or 65 and older. (**Note:** The RCL enroll disenroll Help screen in CARE provides a list of RCL qualified inpatient psychiatric settings.)

AND each of the following:

- Receiving Medicaid-paid inpatient services immediately prior to discharge, including most of the ACES N group, also known as MAGI (see exceptions below)
- Interested in moving to a qualified community setting which includes the following: DDADDA Group Home, In-Home, Assisted Living Facility (ALF), Adult Residential Care (ARC), and Enhanced Adult Residential Care (EARC);
- On the day of institutional transition to begin the 365-day demonstration year, RCL participants must be functionally and financially eligible for waiver or state plan services (or Fast Tracked).

Please note: Medicaid recipients receiving services through HCS may be fast-tracked into the program while institutionalized to allow them to access pre-transition services while pending LTSS financial eligibility. However, it's important to note that while participants can receive pre-transition services through the fast-track process, they must meet financial eligibility for waiver or state plan services on the day of institutional transition.

RCL services for individuals while institutionalized who plan to transition to an unqualified setting:

Individuals may enroll in RCL while institutionalized to access services for pre-transition support, even if they plan to transition to a setting that is not considered a qualified RCL setting after discharge. This ensures the use of federally funded RCL services rather than relying on state funded service packages (CTSS/WA Roads) if the individual meets RCL eligibility. RCL services may be used for individuals who are planning to transition from institutional care into:

- A designated Residential Support Waiver (RSW) setting
- An Enhanced Adult Residential Care - Specialized Dementia Care Program (SDCP)
- The Program of All-Inclusive Care for the Elderly (PACE).
- An Adult Family Home (see MB 026-008 for details)

Upon transition, the individual will need to be disenrolled from RCL, since ongoing RCL services cannot be provided in an unqualified setting. Please refer to the section [What is the process to disenroll an individual from RCL prior to discharge?](#) for detailed steps.

Individuals who are not eligible for RCL are:

- Individuals in the AO1, AO5, L04, L24, N20, N21 and N25 state funded non-citizens medical benefits.
- Individuals receiving a TSOA benefit (TO2). These individuals will need to apply for a Medicaid LTSS Program to facilitate an RCL Enrollment. Individuals must choose the program which is most appropriate to meet their needs.

Residents in inpatient psychiatric facilities of more than 16 beds which are primarily engaged in providing diagnosis and treatment of care to persons with behavioral health diagnoses aged 21-64 years may be excluded from enrollment onto the Roads to Community Living program. To confirm whether your client is eligible for RCL, please review the list in the RCL enroll disenroll Help screen in CARE or reach out to: DSHSALTSARCLReferrals@dshs.wa.gov.

How to request RCL Enrollment for a qualified individual

Individuals may enroll onto RCL for multiple demonstration periods when eligibility requirements are met. Create an email including the following client information:

- Client name
 - Client ACES ID
 - Estimated discharge date, if known
 - Expected community setting at discharge (this can be multiple settings for those who are entertaining dual track planning)
 - Indicate whether pre-transition services are anticipated
 - Qualified institutional name and admission date
 - Individual may be enrolled early for RCL, when the institutional stay is expected to exceed 60 days. Indicate this information in the email if requesting early enrollment.
 - Any requests for transition planning support (if needed)
- Send the email
 - For HCS clients send the email to: DSHSALTSARCLReferrals@dshs.wa.gov
 - For DDADDA client send the email to: DDARCLENROLLMENTINTAKE@DSHS.WA.GOV

After the RCL enrollment request is received and processed, an email reply will be sent with the RCL Participant form attached. The case manager provides a copy of this form to the client. HCS Headquarters staff will submit the form to DMS for HCS, and RMT for DDADDA. (Example of RCL participation form is located under the [Resources](#) section)



HCS and DDADDA Headquarters staff will complete RCL enrollment procedures, including adding the RCL RAC.

Once enrolled, RCL services can be utilized while institutionalized to assist the participant's transition to the community. RCL participants can continue utilizing RCL services for 365 days in the community with the first day beginning on day of discharge. The days used in the community are automatically tracked in the RCL enroll disenroll screen in CARE. See [Authorizing RCL services for HCS clients](#) for more information.

WHAT SERVICES ARE OFFERED UNDER RCL?

Participants enrolled in this project have access to:

- All services currently available under the Medicaid State Plans: Medicaid Personal Care (MPC) and Community First Choice (CFC) and
- Home and Community Services (HCS) and Developmental Disability Administration (DDADDA) Medicaid waivers provided in in-home settings (such as COPES); and
- Additional services available through RCL that are above and beyond what is offered in any other state plan or waiver as [outlined below](#).

RCL project services are only available to the participant while in the institutional setting and during the project demonstration year (365 days after leaving the facility and residing in a community setting).

All RCL project services must be authorized by HCS, Area Agency on Aging (AAA), or DDADDA case managers.

For DDADDA: If the person is exiting an RHC, contact the RCL liaison in the DDADDA region where the person would like to live to determine what services are available.

WHAT ADDITIONAL SERVICES ARE AVAILABLE THROUGH RCL FOR HCLA CLIENTS?

In addition to qualified services that are also available through state plan and waiver services [e.g. personal care [Individual Provider (IP), CDWA, agency caregiver, and Assisted Living facility (ALF)], Nurse Delegation, Adult Day Health, etc.], the following services are available for RCL participants when indicated in the plan of care and authorized by the case manager. For those RCL participants who are on the Address Confidentiality Program, please refer to [Chapter 3: Assessment and Care Planning](#) for further information.

Client Training: Behavior Support Services: [H2019](#) (HCS Only)

Behavior Support services are for participants transitioning from institutional to community settings or requiring stabilization while residing in the community in instances where the authorized Medicaid benefit amount, duration or scope of service does not meet the individual's needs. This service may be helpful in situations where a client is struggling to keep caregivers due to the way they interact with others, or when they're not making progress toward their healthcare or transition goals. A change in health status or living situation may lead to emotional or behavioral shifts, like increased stress, frustration or withdrawal that begin to interfere with daily life. In other cases, tensions within the household or family system may be creating a stressful environment for the client. These are some examples where Behavior Support Services may help address underlying issues and improve stability.

Identifying a Behavior Support Provider:

Behavior Support Providers are contracted and monitored by the local Area Agency on Aging (AAA). To locate a Behavior Support Provider in the client's area, refer to the vendor/provider list maintained by that AAA. Once you identify a provider, reach out to them directly to confirm whether they currently have capacity to serve the individual.

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 again after the initial three-month (92 day) period has ended with a local ETR.

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.

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 purposed 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
- The assigned case manager sends the behavior support plan to DMS.

This service is also available through COPES. See [Chapter 7d: COPES](#) for more information.

Community Choice Guiding (CCG): SA263 (HCS Only)

Payment for specialty services which provides assistance and support to ensure the participant's successful transition to the community and/or maintenance of community living as authorized by HCS and/or AAA staff. CCG services may include, but are not limited to the following:

- Locating and arranging appropriate, accessible housing; including working with local housing authorities and other community resource providers. Assisting with subsidy applications, move-in logistics, and coordinating with other providers to promote housing stability.
- Supporting clients in setting housing goals, identifying preferences, and addressing barriers.
- Set up client's new home such as arranging lease documentation, arranging utility hook-ups or acquiring furnishings and household goods.
- Assist a client with touring Adult Family Homes (AFH) and Assist Living Facilities (ALF) to determine whether this setting is preferred by the client.
- Supporting the establishment of a network 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 any other involved parties.
- Assisting with filling out forms and obtaining needed documentation to aid in the client's successful transition from an institutional setting or stabilization within the community (forms may be related to Public Benefits, housing subsidy, lease agreements, etc.).
- Providing emergent assistance to avoid utility shut-off and/or eviction.
- Assisting client in developing a basic household budget.

NOTE: If the client needs additional assistance to manage their finances or learn independent living skills related to household management, consider authorizing [Client Training: Non-Medical](#) services.

- Assisting client with locating and arranging transportation resources to effectively connect with community and community resources. An example would be a one-time purchase and reimbursement of a bus pass.

NOTE: Transportation for medical appointments should be provided by existing non-emergency medical transportation benefits if the client is eligible.

- 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, housing budgeting, Durable Medical Equipment providers and other needs identified in the Plan of Care.
- 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.

NOTE: 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.

- Assisting to find a qualified caregiver. See additional information in COPES
- When determining whether to authorize a CCG to assist with identifying a client's preferred residential setting, please refer to [Transition Academy SharePoint](#) for additional guidance on the Room and Care residential search tool procedure.

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](#). See additional information in [Chapter 7d: COPES](#).

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. See additional Client Training information in [Chapter 7d: COPES](#).

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 CAREWeb.
 - a. Enter a brief comment for each treatment. Examples include:
 - i. Community Integration: CCG to assist with transitioning a client to the community OR CCG to assist with stabilizing client in the community.
 - ii. 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. Please check individual LTC Manual chapter for additional information.
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.

NOTE: Services such as pest eradication, janitorial services and packing/moving services must be performed by a contracted provider who holds 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](#)

Community Choice Guide Issuing Payment for AT Good [SA266](#)

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.

Based on a client's eligibility:

- The case manager will supply the detailed information for the covered assistive technology 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 assistive technology after it is verified the client received the good. Authorization for the good is under a separate service code and case managers will process the reimbursement(s) for assistive technology 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.

Note: See Resources section for the Community Choice Guide Activity Tracking form. For more information on how to authorize CCG services please refer to the [CCG Services SharePoint](#). For more information and guidance related to CCG services and authorization steps, please review [Chapter 7d - COPES](#).

Community Transition Services- Items: SA296

Items may include, but are not limited to:

- Goods necessary to establish a residence such as essential household items and furnishings.
- Goods needed to help stabilize community living for a client.
- This service code can be utilized at any time during the enrollment and transition period for community transition goods as identified in the CARE plan.
 - For AFH Settings reference WAC 388-76-10685, and for Assisted Living Settings reference WAC 388-78A-3011 which outline resident unit furnishings in these settings. In the event a residential setting indicates they are unable to provide the required furnishings as outlined in WAC, notify the provider of their requirements as outlined in WAC, and also submit a referral to Residential Care Services (RCS) Complaint Resolution Unit (CRU) to document the provider's inability to meet residential unit furnishings per WAC. Referrals can be made online [Residential Care Services Online Incident Reporting | DSHS \(wa.gov\)](#) or via phone at 1-800-562-6078.

See Which Program to Use: Transition and Sustainability Goods and Services in the [Appendix](#) as a 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/casher's check fee as part of a move-in cost (payment of first month's rent/deposit) is allowable.

Community Transition Services: SA297

Services include:

- Packing assistance
- Moving assistance
- Utility set up fees or deposits
- Non-recurring health and safety assurances such as pest eradication, allergen control and/or one time cleaning.
- Rental deposits (all pre-tenancy funds required can be bundled as one deposit, staying within the service code limit)
- Non-recurring rental insurance

See *Which Program to Use: Transition and Sustainability Goods and Services* in the [Appendix](#) as a reference guide.

NOTE: Services such as pest eradication, janitorial services and packing/moving services must be performed by a contracted provider who holds 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](#)

RCL Supplemental Goods & Services: SA295

For services and supports after the client transitions out of an approved institutional setting which supports community living, use the SA295 service code. This service code can be used for the purchase of necessary one-time goods or services where the authorized Medicaid scope of service does not meet the client's needs. This service code should also be used to reimburse a CCG for Trial Visits. Excluded are rental subsidies.

NOTE: A contract is not required if another payment mechanism is utilized.

Options include:

- Using a client services HCS P-Card (state issued credit card available to HCS HQ staff); or
- Authorizing a contracted provider to pay for rental deposits and community living set-up fees directly and be reimbursed (such as a CCG).

Unit compensation to the contracted provider for issuing or coordinating payment does not count towards the funding limits of SA295, SA296, and SA297.

Short-Term Rental Assistance

This supplemental service will cover up to 6 months of short-term rental assistance and associated utility expenses to bridge the gap between transition to the community and when federal, state, or local housing assistance is secured.

To access this resource, case managers will need to utilize the established process for the HCLA Bridge Subsidy as outlined in [Chapter 6a: ALTSA Subsidies & GOSH Services](#).

Motel Interim Stay for Transitions: [SA294 U1](#)

The Motel Interim Stay for Transitions (MIST) is a service to pay for a short-term motel/hotel stay offered to minimize the number of voucher/subsidy holding clients who discharge to and/or experience episodes of homelessness while in housing search. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for a 6-month period at a time. MIST currently cannot be offered to clients who do not have a housing subsidy/voucher in hand to utilize. Please Reference [Chapter 6b: Interim Housing Resources \(Motel Interim Stay for Transitions & Emergency Rental Assistance\)](#) for additional Housing Resource policy information.

Environmental Modifications- In Home: [S5165 UA](#)

Minor physical adaptations to an RCL participant's in home setting as authorized in the plan of care to increase health, welfare and safety and provide greater independence. Must be of direct medical or remedial benefit to the participant, including but not limited to:

- Installation of ramps and grab bars
- Widening of doorways
- Modification of bathroom facilities
- Installation of specialized electric or plumbing systems.
- Installation of Assistive Devices

Excluded are adaptations or improvements that are of general utility and are not of direct benefit to the individual (e.g., carpeting, roof repair, central air conditioning, etc.). See [General Utility modifications](#) for more information. Adaptations which add to the total square footage are also excluded.

Note: The [Housing Modification Property Release Agreement \(Form 27-147\)](#) is required for Environmental Modifications completed in residences which are not owned by the client. For more information see [Chapter 7d: COPES](#).

Environmental Modifications- Residential: [S5165 UB](#)

Minor physical adaptations to an RCL residential setting as authorized in a participant's plan of care to increase health, welfare and safety and provide greater independence. Must be of direct medical or remedial benefit to the participant, including but not limited to:

- Installation of ramps and grab bars
- Widening of doorways
- Modification of bathroom facilities
- Installation of specialized electric or plumbing systems.
- Excluded are adaptations or improvements that are of general utility and are not of direct benefit to the individual (e.g., carpeting, roof repair, central air conditioning, etc.). See [General Utility modifications](#) for more information. Adaptations which add to the total square footage are also excluded.

Environmental Modifications- General Utility Allowance: S5165 U3

Minor general utility adaptations to an RCL resident's home as authorized in a participant's plan of care to increase health, welfare and safety and provide greater independence. Must be of direct medical or remedial benefit to the participant, including but not limited to:

- replacing hot water heaters
- minor roof repairs
- repair of drywall
- Repairs to specialized electric or plumbing systems.

Note: The In home Environmental Adaptations General Utility and Repair [Property Release Agreement \(Form 27-147A\)](#) is required for clients who own their home or reside in a family owned home.

Pantry Stocking: SA420-U1

One-time, nonrecurring, setup expenses for necessary food items essential for basic living. These are pantry items necessary to help eligible clients transition from an institutional setting to an independent living setting. This is separate funding source than Community Transition Services (CTS): Goods and therefore is excluded from the CTS funding limits.

Allowable expenses are those necessary to enable a person to establish a basic household and stock their pantry with food goods that are essential for living in the community before food benefit is received or reinstated.

Federal approval requires that this service is limited to food items and pantry items only.

Assistive Technology (Non-CFC): SA075 U2

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.

AT Goods, including assistive equipment, are adaptive/assistive devices/items that increase a client's independence or substitutes for human assistance with an ADL, IADL, or health-related task.

The list of RCL AT covered goods is in alignment with the [CFC AT Covered Items List](#) and is updated in the CFC Chapter of the Long Term Care Manual (Chapter 7b). Further details, to include how to find and AT contracted provider, and limitations regarding this service, are located in the CFC Chapter.

Technology Support Consultation and Technical Assistance: H2014 U9

Technology Support Consultation and Technical Assistance services are for participants transitioning from an institutional stay to a community setting. Individuals statewide who want to transition to a community setting will have access to receiving Technology Consultation and Technical Assistance along with their Assistive Technology (AT) benefit.

Technology Support Consultation will identify AT that could provide solutions to potential barriers to discharge. The Assistive Technology Provider (ATP) will evaluate the client's environment and abilities and make referrals for appropriate assisted technology to the case manager. The use of Assisted Technology will support clients with ADL's and or IADL's to help client's community setting be more sustainable.

The participant will receive training and Technical Assistance from the ATP to support transition from the institutional setting to their community setting to ensure that they can use their AT to meet their needs.

To capture this in CARE, choose Other in the Treatments screen, indicate Assistive Technology Supports in the comments and assign to the Technology Support Services Provider in the Supports table.

For details on entering the CARE authorization and making the referral for this service, see [Desk Aid for Technology Support Consultation and Technical Assistance](#)

The Technology Provider will **develop a technology support plan during the consultation with client** and provide this to the case manager. The Assistive Technology Provider address things such as:

- Assessment of technology support environment and skill building strategies
- Technology support planning
- Recommendations for maximizing existing technology and incorporating additional technology resources to increase access, engagement, and utilization of assistive technology.
- Case consultation with case managers as well as client and formal or informal caregivers

- Coordinating the purchasing of Assistive Technology
- Installation of Assistive Technology devices and equipment
- Education and training on incorporating technology use directly with the client
- Education and training to DSHS staff regarding assistive device utilization, digital literacy, and functional limitation concerns
- Assistance considers site-specific circumstances and culture

For additional resources please see the [AT SharePoint](#) HCS SharePoint site.

Smart Care Device: SA077 U2

The Smart Care Device is a proactive AI device that interacts and engages with a client to provide support through proactive suggestions, cuing and reminders for ADL &/or IADL tasks or health-related activities, and accessing their community.

The Smart Care Device is available to clients receiving in-home care services on the Roads to Community Living (RCL) program. This service is also available through CFC – please reference [Chapter 7b](#) for information on authorizing this service through CFC.

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
- To make referral for ElliQ Smart Care Device, go to the [ElliQ DSHS Landing Page](#) to complete provider designation form. Once submitted a confirmation email will be sent to case manager email prompting Provider One Authorization.
- Under Treatments, choose “Technology Support Services” under programs. In the Provider field, choose “Other”. Include a short comment noting Smart Care Device, and Technology Support Consultations and Technical Assistance, if applicable.

Treatment
Technology Support Services

Received in the last 14 days? ☐ Yes ☒ No Need ☒ Yes ☐ No

Provider list

+	Provider	Frequency	
	Other	PRN (as needed)	

Comments
Smart Care Companion
Technology Support Consultation and Technical Assistance

- Update Provider one authorization in CARE to include rate and frequency of service.

ProviderOne Search

ID: 2319157 Provider name: ProviderOne P County: City: Provider type: Filter by service code Search ProviderOne X Clear

Select a provider

Provider name	ProviderOne ID	Business status
Intuition Robotics Inc	2319157	Active/Open

Smart Care Companion - Service fee SCDS

Line #	Service code	Service name
	SA077,U2	Smart Care Companion - Service fee

Start: 04/01/2025 End: 03/31/2026

of Units: 1 Unit type: Monthly

Rate: 99.00 Lookup rate Total: \$99.00

Business status: Approved Reason code:

- Complete PAN indicating Roads to Community Living (RCL) as program. In the service field choose Other HCS Services indicating Technology Support Services as the name of service.

PAN Services details

Related assessment: 04/30/2024 / Current / Initial Comparison assessment: No related assessment Contact worker: Pizano, Casandra

Created by: Pizano, Casandra

Services

Program	Service	Effective date	Action	Previous amount	New amount	Amount type	Frequency
Roads to Community Liv...	Technology Support Ser...	03/26/2025	Approved	0	99.00	Each	Per Month

Roads to Community Living (RCL) - Technology Support Services (Other) details

Action: Approved Effective date: 03/26/2025 Previous amount: 0 New amount: 99.00 Amount type: Each

Frequency: Per Month Reasons: Functionally Eligible

Authority: WAC 388-106-0255

Delete PAN Save PAN Finalize PAN Print PAN

- **Note:** Planned Action Notices (PAN) must be completed and provided to the participant and their representative when HCLA makes a decision regarding

eligibility, service, or denial/termination of a provider. The PAN includes information regarding the planned action and appeal rights.

For additional resources please see the [AT SharePoint](#), HCS SharePoint site.

Other services available under Roads to Community Living:

- Durable Medical Equipment (See [Blanket code](#) lists). When an RCL enrolled participant will benefit from an item of DME which must be provided as part of a transition plan prior to leaving the institutional setting, please reach out the RCL Enrollment specialist in your area for guidance. RCL programmatic flexibilities may allow for the procurement of the DME outside of the usual and traditional pathways as outlined in the 1915 (c) waiver requirements or through Apple Health benefits, however should not be used to supplant a Medicaid Benefit available through these state plan processes. [Spec. Medical Equipment Service/repair: K0739](#)
- [Non-Medical Equipment and Supplies: SA421](#)
- [Client Training Medical: H2014-UC](#)
- [Client Training Non-Medical: H2014-UD](#)
- [Non-Medical Transportation: T2003](#)
- [Technical Assistance: S5115-U6](#)
- [Wellness Education: SA080](#)
- [Home Delivered Meals: S5170](#)
- Private Duty Nursing In [Home: T1000](#)
- Specialized Goods/Services Purchasing Card: [SA638](#)
- Nurse Delegation: H2014 U5
- Skilled Nursing: T1002, T1003,
- Personal Care

Personal Care Service Codes	P1 Code
Personal Care In Home	T1019 U6
Personal Care Residential ARC	T1020 U2
Personal Care ARC Enhanced	T1020 U3
Assisted Living	T2031

- Personal Emergency Response System (PERS):

PERS Service Codes	P1 Code
PERS Installation Fee	S5160
PERS standard/basic unit	S5161
- Fall Detection add-on service (AT) to PERS standard/basic unit	S5161 – U1
- GPS add-on service (AT) to PERS standard/basic unit	S5161 – U2
- Medication Mgmt System add-on (AT) to PERS standard/basic unit	S5161 – U3

When in doubt, send questions and concerns to:

HCS: DSHSALTSARCLReferrals@dshs.wa.gov

DDADDA: ddarclenrollmentintake@dshs.wa.gov
HQ RCL Staff are happy to help!

Are all the RCL services available anywhere in the State of Washington?

Some services may be limited according to regional contracted provider availability. One of the goals of the RCL demonstration project is to help identify and expand contracted provider capacity and resource availability when the services and supports meet the RCL demonstration project criteria.

*If there is a specific client need for a contracted service provider that does not exist in their local area, notify the associated [Area Agency on Aging](#) contracts management and the [HCS Resource Support and Development](#) teams of this need.

Where may individuals receive services under RCL?

Places where individuals may receive services during the RCL 365 day post transition demonstration period are called qualified community settings. Qualified community settings under RCL include:

- The individual's owned or leased home or apartment (including Supported Living when the client holds the lease)
- A home or apartment owned or leased by the participant's family; or
- Assisted Living Facility (ALF), Adult Residential Care (ARC), and Enhanced Adult Residential Care (EARC).

AUTHORIZING RCL SERVICES FOR HCS CLIENTS

Once the HCS individual is enrolled in RCL on the RCL Enroll/Disenroll screen, the case worker may authorize pre-transition services while the participant is residing in the qualified institutional setting:

1. Have the individual or their representative complete the [Consent for Services \(DSHS 14-012\) form](#), Acknowledgement of Services (DSHS 14-225) form, and Rights and Responsibilities (DSHS 16-172) Form assisting as necessary.
2. Document in the CARE assessment, a SER and/or the Sustainability Goals screen in CARE the service(s) being authorized, and/or the items to be purchased,
3. Following all procedures in the [Social Services Authorization Manual](#), authorize necessary services. List all RCL services on the appropriate screen(s) in CARE. For example, if an individual is authorized RCL Client Training: Behavior Support services, "Client Training/Waiver" should be included in the Treatment screen, choosing the appropriate provider type and frequency on the Provider List. In the "Supports" screen connect this treatment to contracted Professional Support provider as a paid task.

For RCL services that do not have a distinct treatment, follow this guide as to which treatments to choose:

RCL Service	Treatment Screen
Community Choice Guiding	Community Integration
Community Transition Goods or Items (including One Time Pantry Stocking)	Community Transitions Goods or Items
Community Transition Services	Community Transition Services
Client Training: Behavior Support	Client Training/Waiver
Non-Medical Transportation	Non-medical transportation
Technology Support Consultation & Technical Assistance Smart Care Device	Technology Support Services
Short Term Rental Assistance (to include MIST)	Housing Subsidy

When the participant is approaching a transition date from a qualified institution:

1. Complete the CARE assessment including all transition services authorized and move it to current.
 - **Reminder:** an assessment can be moved to Current status with any authorized paid service. Many RCL participants receive a variety of services to support transition planning and these are authorized prior to personal care starting.
2. Ensure all services and identified equipment are delivered and in place at the time of transition.
3. Send care planning documentation to the participant and any individuals involved in care planning, as necessary, per instructions in [Chapter 3: Assessment and Care Planning](#).
4. Follow instructions as outlined in the LTC Manual to obtain approval on the plan of care, send all required documents/forms to the individual/representatives and providers, and complete required documentation of these activities.

Tip: As a best practice, it is helpful for the individual to visit their new setting prior to transition to determine if additional supports or services will be needed. Additional equipment may be identified, or it could be as simple as rearranging items for easier access to prevent falls.

For example, if a person is returning to their own home after a hip replacement, they may need items in the kitchen moved to a new place so they can reach them without falling when they are home alone (for example, pots and pans that are kept in a low cabinet may need to be relocated). This could include a home evaluation by OT/PT or a home visit with a CCG or other contracted provider.

Upon confirmation of participant's transition from the institution:

Update the following fields on the RCL Enroll/Disenroll screen in CARE:

1. Enter the discharge date in the “Actual discharge date” field (this must match the discharge date on the NFCM/Acute Care hospital/State hospital screen).
 - Please note: The individual’s 365-day demonstration year clock does not begin until this field is complete.

Note: If an individual transitions to an RCL unqualified setting (AFH, RSW, PACE, SDCP, etc.) they will need to be disenrolled, and a different program will need to be started the day of discharge. The *Actual Discharge Date* field will be left blank. To disenroll, follow instructions within the section: [What is the process to disenroll an individual from RCL prior to discharge?](#)

2. The “Projected end date” field will populate with an auto calculated RCL year-end date,

Discharge detail

Actual discharge date	Projected end date	Days left on RCL	Discharge to
06/22/2022	06/21/2023	331	Assisted Living (EARC, AL, ARC) ▼

3. Discharged To (setting type).

Discharge to

Home (owned or leased by individual or family) ▼

Apartment (individual lease, lockable access, etc.)

Assisted Living (AL, ARC, EARC)

DDCS Group Home (Child Staffed, GH/GTH, etc.)

Home (owned or leased by individual or family)

4. Indicate whether or not the participant is receiving HCLA Housing resources as part of their transition plan
 - Review LTC Manual [Chapter 6a-d: Housing Resources for HCLA Clients](#) for more information regarding HCLA Housing resources

Receiving ALTSA housing resource ?

Yes	No
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5. Indicate whether or not the participant is receiving managed Medicaid services (N series or enrolled with a Managed Care plan for apple health benefits).
 - Review LTC Manual [Chapter 22: Managed Care](#) for more information regarding managed Medicaid services



Is client managed medicaid ?

Yes

No

6. Create a new entry on the Contact Details screen with updated address information.
7. On the Care Plan screen, ensure “Roads to Community Living” is the selected program in the “Client chosen program” field.
8. Update the RCL RAC end date. Ensure the RCL RAC end date matches the “Projected end date” field date from the RCL Enroll/Disenroll screen

RAC eligibility

RAC eligibility list					
	RAC	Start date	End Date	Override	
+	3100 - HCS Roads to Community Living	06/03/2022	06/21/2023	☐	

9. Using the [DSHS 14-443 form](#), notify the Public Benefits Specialist of the discharge date from the nursing facility/acute care hospital/psychiatric hospital and complete the RCL portions. The RCL start date is the date of discharge and the RCL end date is the projected end date as indicated on the RCL Enroll/disenroll screen. (Reminder the RCL 365 day end date needs to match the RCL RAC end date).
 - **Note:** For Managed Medicaid participants the RCL Demonstration period is documented in the client tab in Barcode under Customer Information Notes. See [Chapter 10: Nursing Facility Case Management and Relocation](#) for more information about the NFLOC screen in ProviderOne.

Important note: The case worker should closely monitor all financial letters during the 365 day RCL demonstration period. If the participant receives a termination letter, contact the financial worker immediately. *Eligibility should not be terminated due to changes in functional or financial status.*
Participants who were eligible for RCL at discharge are eligible for RCL until the end of their 365 day demonstration service year regardless of change in functional or financial status.

10. Create the authorization(s) and send a Planned Action Notice
 - **Note: Planned** Action Notices (PAN) must be completed and provided to the participant and/or their representative when HCLA takes an action that impacts the client’s benefits. The PAN includes information regarding the planned action and hearing rights.

Services								Add service
Program▲	Service	Effective date	Action	Previous amo...	New amount	Amount type	Frequency	
Roads to Community Living (RCL)	Assistive Technology - Annual limit	03/11/2025	Approved		1	Each	One-time	
Roads to Community Living (RCL)	Community Choice Guide	03/11/2025	Approved		160	Each	Per Month	
Roads to Community Living (RCL)	Community Transition Services	03/11/2025	Approved		1	Each	One-time	
Roads to Community Living (RCL)	Personal Care	03/11/2025	Approved		158	Hour(s)	Per Month	

11. As a best practice, it is highly recommended to schedule a joint case staffing between the case worker and AAA/Residential Care Case Manager to facilitate a smooth transition.
12. Transfer the case to the AAA or Residential Care Case Manager per local policy. Refer to existing [Case Transfer Guidelines](#) in Chapter 5 of the LTC Manual. Make sure to note on the Case Transfer form that the individual is an RCL participant and include the projected end date of their 365 day demonstration year as detailed on the RCL Enroll/Disenroll screen and as indicated on the RCL RAC screen.

When in doubt, send questions and concerns to:

HCS: DSHSALTSARCLReferrals@dshs.wa.gov

DDADDA: DDARCLENROLLMENTINTAKE@DSHS.WA.GOV

HQ RCL Staff are happy to help!

AUTHORIZING RCL SERVICES FOR DDADDA INDIVIDUALS

While the person is still in the institutional facility, the CRM shall:

Send enrollment referral to DDARCLENROLLMENTINTAKE@DSHS.WA.GOV

When the participant is approaching discharge from the facility, the DDADDA CRM shall:

- Complete the DDADDA assessment.
- Following all CARE notification protocols, distribute necessary assessment related documents (PAN, Service Summary, etc.).
- Notify the financial worker that the individual is an RCL participant on the RCL version of the DSHS 15-345 in Barcode and include the following:
 - a) The date of discharge from the institutional setting onto RCL services.
 - b) The setting that RCL services will take place (in-home, group home etc.).
 - c) The new address.
 - d) A request to complete the Authorized Representative (AREP) screen in ACES per normal procedures so the CRM can receive the financial letters.
 - e) A request that the financial worker open the RCL Program in ACES.

Upon confirmation of the participant's transition from the institution:

Update the following fields on the RCL Enroll/ Disenroll screen in CARE:

- Actual Discharge Date (this must also be updated on the NFCM screen if discharging from a nursing facility).
- Please note: The individual is not considered to be on their 365 day demonstration period until this field is complete.

- Discharged To (setting type).
- Receiving ALTSA Housing Resources- Indicate “yes/no” when asked if the participant is receiving an HCS housing resource. For DDADDA recipients, they will always choose “no.”
- Indicate if the participant is managed Medicaid (check in ACES or ProviderOne screen in CARE if you are unsure).
- Update the Contact Details screen with the current address information.
- Update the end date for the RCL RAC. The RCL end date is the Projected End Date listed on the RCL Enroll Disenroll screen which populates once the discharge date is entered.

Important note: The HCS/DDADDA case worker should closely monitor all financial letters during the 365 day RCL demonstration period. If the participant receives a termination letter, contact the financial worker immediately. *Eligibility should not be terminated due to changes in functional or financial status. **Participants who were eligible for RCL at discharge are eligible for RCL until the end of their 365 day demonstration service year regardless of change in functional or financial status.***

How much may I spend on RCL services?

RCL services can only be authorized for a **MAXIMUM of 365** days following discharge from an institutional setting. Services may be used during the demonstration year and are intended to be intensive, if needed, at the beginning of transition, and to lessen over time. Case managers must also plan for services which are necessary for maintenance of community living after the end of the 365 day period. You can find the RCL end date by checking the “Projected End Date” field on the RCL Enroll/Disenroll screen in CARE. This field auto-populates based once the *Actual Discharge Date* is entered.

Since one of the goals of the project is to promote flexibility and develop individualized and person-centered transition plans, spending guidelines **are dependent on the participant’s circumstances and needs**. (The DDADDA Assessment and rates calculator will be used to determine the funding available for individuals enrolled in RCL through DDADDA.)

When utilizing RCL Services:

- Document in the CARE Assessment, a SER or the Sustainability Goals screen:
 - How the services or supports being authorized are of direct benefit to the participant’s successful transition and community living.
 - Ensure authorized services are consistent with needs identified in the CARE assessment.
 - The process followed that demonstrates that any equipment purchased is in addition to that supplied by Medicare/Medicaid and does not replace it.

Follow all purchasing protocols as outlined in [Chapter 3: Assessment and Care Planning](#):

- Receipts for all purchases must be included in the participant’s electronic case record (ECR). Attach all receipts/bids to the [Social Services Invoice/Receipt Packet Cover \(02-615\)](#).

- The case manager must verify the participant received the goods purchased. This can be done by having the contracted provider, like a Community Choice Guide (CCG) verify or by contacting the client directly. The case manager must document the receipt of goods in a SER.
- Services can be reauthorized at the end of the Maximum Length of Service included on the [Service Code Data Sheet](#).
 - For example, if additional services are needed after authorizing Client Training: Behavior Support services for a three month period of time, three additional months may be authorized.
- Service maximums are cumulative for each service *per occurrence*. For example, if the service limit for a given code is \$5000, all the goods purchased over the maximum length of service per the Service Code Data Sheet cannot total more than \$5000 without an ETR during a transition. If the service is needed at a later date due to a different event, the service may be authorized again with the service limit available. See Service Code Data sheets for detailed information.

ETR Considerations Personal Care:

HQ ETRs will only be used for additional necessary personal care hours or daily residential rate.

Community Transition or Sustainability Services:

If authorizations for a necessary service/item exceed the maximum amount allowable, you must complete a local ETR prior to exceeding the maximum limit. Each region will use their local ETR process for RCL services.

Bathroom Equipment:

Follow all procedures to request bathroom equipment through the ETR process as outlined in the Social Services Authorization Manual. Please reference bathroom equipment ETR protocol in [Ch 7d: COPES](#).

[Chapter 3: Assessment and Care Planning](#) has detailed information on the Exception to Rule (ETR) Process.

WHAT ARE THE CASE WORKER'S RESPONSIBILITIES WITH THE RCL PROGRAM?

Once a participant is enrolled in the RCL program, the case worker provides primary case management, including the authorization of RCL services.

How often do I need to assess the participant?

As outlined in [Chapter 3: Assessment and Care Planning](#), the CM/CRM/CNC will use professional discretion to determine if an updated assessment is needed during the course of the client's 365 day

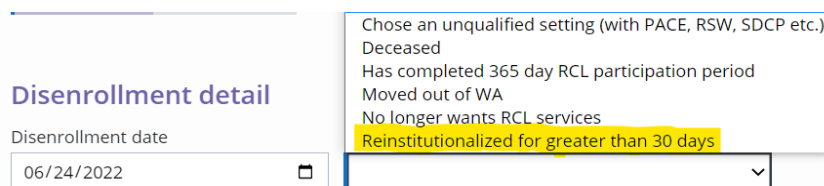
RCL service year. The Annual assessment will likely be completed within the RCL service year and likely will not correspond with the RCL end date. RCL will remain in place until the end date as indicated on the RCL Enroll/Disenroll screen in CARE. A general check in with the client within 60 days prior to the end of the RCL 365 day service year is recommended to plan for the transition onto waiver or state plan services when the RCL services end. See [Actions for HCS, AAA and DDADDA to prepare for the end of the RCL 365 day service period](#) section for more information.

If a participant is re-admitted into an institutional setting:

For nursing facility admissions, follow all protocols in the [Ch 10 Nursing Facility Case Management and Relocation](#) chapter (making sure to update the NFCM screen in CARE with the admit date and facility name).

If an RCL participant re-admits to an institutional setting (nursing facility, acute care hospital, State Psychiatric Hospital, residential habilitation center, etc.) after transitioning to the community, please note the following:

- For an institutional stay less than 30 days, do not disenroll the participant (the RCL 365 day service period continues uninterrupted) and **do not end date the RCL RAC**.
 - Keep services which will support the RCL enrollee's return to the community in place. This could include [Community Choice Guide](#) services and Client Training Services.
- For an institutional stay greater than 30 days, the participant must be disenrolled on the RCL enroll disenroll screen in CARE. Email the HQ RCL Policy Unit (HCS: DSHSALTSARCLReferrals@dshs.wa.gov or DDADDA: ddarclenrollmentintake@dshs.wa.gov), if needed, to assist with these steps:
 - a) **Record the Disenrollment Date and Reason**
 - i. The Disenrollment Date is the date of re-admission to the institution once the stay has extended beyond 30 days (backdating to accurately reflect the readmission date is acceptable).



- ii. Choose “Reinstitutionalized for greater than 30 days” in the Disenrollment Reason field of the RCL Enroll/ Disenroll screen in CARE.
 - iii. Choose from the drop down the reason the participant was reinstitutionalized.

Note: by entering the disenrollment due to “Reinstitutionalization for greater than 30 days”, the participant’s “RCL clock” is paused to ensure the participant utilizes their allotted 365 days in the community. Once re-enrolled and discharged, any days used prior to reinstitutionalization are counted and thus the clock continues. The RCL



Enroll/Disenroll screen accounts for prior days used and automatically updates the correct Projected end date on the RCL Enroll/Disenroll screen in CARE upon the next transition.

- b) **Re-Enroll the Client:** A client can be immediately re-enrolled to access RCL services to support their transition and return to the community. Re-Enrollment pauses the RCL “clock”, recalculating the Projected End Date by accounting for prior days used in the community on RCL. This will ensure the client can access the remainder of their RCL demonstration period. This process can be followed as needed throughout the participant’s RCL demonstration period until there is no time remaining on the RCL “clock”.

Note: For re-enrollment after disenrollment due to reinstitutionalization, a new 60-day length of stay is not required. A new Consent Form (DSHS 14-012) does not need to be signed by the individual.

Email the HQ RCL Policy Unit (HCS: DSHSALTSARCLReferrals@dshs.wa.gov or DDADDA: ddarclenrollmentintake@dshs.wa.gov), if needed, to assist with these re-enrollment steps:

- i. Prior to authorization any transition services, create a new enrollment on the RCL Enroll/Disenroll screen in CARE by clicking on the “plus (+)” button.
- ii. Enter the *Enrollment Date*. The Enrollment date can be as early as one day following the Disenrollment date if transition planning begins immediately, or it can be as late as the same day as the subsequent Actual Discharge Date if no transition services were utilized.
- iii. Select the *Institution Type* where the client is currently admitted. The *Admit Date* will auto-populate if the corresponding Nursing Facility Case Management, Acute Care Hospital or State Hospital Screen has been completed.
- iv. Enter the *Estimated Discharge Date* to indicate when the client is expected to transition back to the community. This date is an estimate and does not need to reflect the client’s actual discharge date.
- v. Complete SER note of the re-enrollment.

Upon transition, follow all other instructions [regarding transitioning from an institution](#) including entering all the required information on the Enrollment screen and NFCM screen (if applicable) in CARE.

When in doubt, send questions and concerns to:

HCS: DSHSALTSARCLReferrals@dshs.wa.gov
DDADDA: ddarclenrollmentintake@dshs.wa.gov

HQ RCL Staff are happy to help!

What is the procedure for RCL participants who have received services but who choose not to receive personal care services in the community?

In order for participants to remain on the RCL program for the full 365 days post institutional transition, they must accept an RCL paid service from the RCL community transition and sustainability package of services. For those HCS participants who choose to decline all paid services in addition to declining personal care services, follow the Termination of Services guidelines and procedures as outlined in [Chapter 5: Case Management](#). In addition, formally disenroll the participant from RCL by updating the RCL Enroll/Disenroll screen in CARE following all [disenrollment steps](#). DDADDA RCL participants will remain active on DDADDA caseload for the full 365 days and then transition to the non-paid services caseload after their demonstration year.

Can RCL participants choose not to participate in the RCL project?

HCS/AAA/DDADDA: Yes. When a participant or their representative wants to withdraw from the RCL project, work with the participant to resolve issues, if possible. If the participant still wishes to disenroll in RCL but wants to continue to receive state plan or waiver services, a CARE assessment and financial eligibility determination must be completed to establish the participant's eligibility for the appropriate Medicaid waiver or state plan program.

RCL services for all participants must end by day 366 (on or before day 365). At that time, they must be transitioned to the waiver or state plan services available to them based on their financial and functional eligibility.

Actions to prepare for the end of the RCL 365 day service period

The *Projected End Date* displayed on the RCL enroll disenroll screen in CARE indicates the end of the individual's RCL participation period. Approximately 60 days prior to the end of the individual's 365 day service year, the CM/CRM/CNC should check in with the RCL participant and ensure the client continues to be stable in their community setting. This is an important period of time to determine if the client is in need of any of the RCL package of services prior to the demonstration year ending. Does the client require an updated assessment? If so, follow usual assessment procedures. Ensure that any necessary steps are taken in order for the participant to maintain successful community living, including an evaluation of functional and financial program eligibility for services after the participant's 365 day demonstration period has expired. To complete RCL disenrollment steps at the end of the participation period, see [Individual has completed 365 days of RCL participation period](#).

NOTE: The assessment may be moved to Current prior to the end of the 365 day demonstration period. However, in order to maximize the enhanced match received for RCL services, end date the RCL RAC to match the Projected End Date on the RCL Enroll/Disenroll screen and open the new RAC identifying the on-going service program(s) starting the day after the RCL Projected End Date. The RCL RAC should be assigned for the maximum length of time based on the Projected End date which considers any disenrollments and re-enrollments which pushed the Projected End Date out beyond the original 365 days (you can use a custom tickler as a reminder to change the RAC at the appropriate time). When ending the RCL RAC and starting the on-going program(s) RAC mid-month, this action may require modifying/splitting of the service payment line, please review [P1 Social Services Manual](#) for procedure steps.

RCL DISENROLLMENT ACTIONS FOR HCS, AAA AND DDADDA

RCL disenrollment reasons:

An individual must be disenrolled from RCL for the following reasons:

- **Chose an unqualified setting (with AFH, PACE, RSW, SDGP, etc):** Select this reason when the individual transitions to any of the listed unqualified settings whether upon initial transition from the institution or at any point during their RCL participation period in the community.
 - If the individual is transitioning directly to an unqualified setting from an institution, refer to [What is the process of disenrolling an individual from RCL who is still in an institutional setting?](#) for disenrollment steps.
 - If the individual is currently living in the community and will be transitioning to an unqualified setting, see [Disenrollment when an individual has chosen an unqualified setting](#) for required steps.
- **Deceased:** Select this reason when the client has passed away.
 - If the individual passed away while in an institutional setting, refer to [What is the process of disenrolling an individual from RCL who is still in an institutional setting?](#) for disenrollment steps.
 - If the individual passed away while in the community, refer to [Disenrollment after an individual has passed away](#) for steps.
- **Has completed 365 day participation period:** Select this reason once a client has completed their 365-day participation period. The case manager will know when the client has completed their 365-day participation period by looking at the *Projected End Date* listed on the RCL enroll disenroll screen in CARE. The case manager will also receive Ticklers when the participant has 60,30 and 5 days left on their RCL participation period. When selecting this disenrollment reason, the disenrollment date should match the projected end date. There are several actions the case manager must complete before the participant's RCL participation period ends. See, [Actions to prepare for the end of the RCL 365 day service period](#).
 - For disenrollment steps, refer to [Disenrollment steps once an RCL participant has completed 365 day participation period](#).

- **Moved out of WA:** Select this reason if a client has moved out of Washington State. There are others states and territories that participate in the Money Follows the Person (MFP) federal demonstration program. Click [here](#) for a current list of MFP states/Project Directors. For disenrollment steps, refer to [Disenrollment when an individual who has moved out of WA](#).
- **No longer Medicaid eligible:** Select this reason if a client is no longer Medicaid eligible. This might include a client who is incarcerated and can no longer receive Medicaid. If a client is no longer financially eligible, please reach out to the HQ RCL team as there are specific financial eligibility considerations for RCL enrolled individuals. Refer to [Disenrollment when no Longer Medicaid Eligible](#) for disenrollment steps.
- **No longer wants RCL services:** Select this reason if an individual has chosen to stay long term in the institutional setting or if a client withdraws from all services after transition to the community.
 - If the client is remaining in the institutional setting, see [What is the process of disenrolling an individual from RCL who is still in an institutional setting?](#) for disenrollment steps.
 - If the client withdraws from all services after transition (within their RCL participation period), see [No longer wants RCL while living in community-based setting](#) for disenrollment steps.
- **Reinstitutionalized for greater than 30 days:** Select this reason when a client has been reinstitutionalized for more than 30 days. This will pause the “RCL clock” and allow the individual to continue to access RCL services to support a return to the community when a subsequent enrollment is made. Do not use this reason if the client has been reinstitutionalized for less than 30 days. For disenrollment steps, see [If a participant is re-admitted into an institutional setting](#).

Steps to disenroll a participant from RCL:

The actions required of the HCS, AAA, or DDADDA CM/CRM during disenrollment vary based on the reason for disenrollment. Detailed steps for each scenario are provided below.

Disenrollment when an individual has chosen an unqualified setting while in the community

Note: If an individual is being disenrolled from RCL because they are transitioning directly from an institutional setting into an unqualified setting, refer to [What is the process of disenrolling an individual from RCL who is still in an institutional setting?](#)

If an individual currently living in the community and has now chosen an unqualified RCL setting (AFH, PACE, RSW, SDCP, etc.), the CM/CRM must follow these steps:

1. End date of the RCL RAC (HCS 3100 or DDA 3701), for the date prior to the client converting to an unqualified RCL setting, and add the ongoing applicable state plan/waiver HCBS RAC the individual is eligible to receive based on functional and financial eligibility.

Note: For PACE, refer to LTC Manual [Chapter 29c: Program of All-Inclusive Care for the Elderly](#)



RAC eligibility					
RAC eligibility list			RAC Inclusions table		
	RAC	Start date	End Date	Override	
+	3032 - RSW - Expanded Community Services	02/18/2026	01/31/2027	☐	
	3101 - HCS-RCL Disenroll/No post-dischrg serv	01/20/2026	02/17/2026	☒	

2. Add the Disenrollment Date to the RCL Enroll/Disenroll screen in CARE. This date must match the RCL RAC end date.
3. Choose “Chose an unqualified setting (with PACE, RSW, SDCP, etc.)” as the Disenrollment Reason in CARE. **Note:** Although AFH is not listed, it is considered an unqualified setting.

Disenrollment detail

Disenrollment date

02/26/2026

Disenrollment reason

Chose an unqualified setting (with PACE, RSW, SDCP, etc.)

Chose an unqualified setting (with PACE, RSW, SDCP, etc.)

Deceased

Has completed 365 day RCL participation period

Moved out of WA

No longer Medicaid eligible

No longer wants RCL services

Reinstitutionalized for greater than 30 days

4. Follow instructions as outlined in [Chapter 3: Assessment and Care Planning](#) to obtain approval of the plan of care, send all required documents/forms to the individual, representatives and providers (including PANs), and complete required documentation of these activities.
5. For **Classic Medicaid participants**, Notify the PBS on a DSHS 14-443 (for HCS/AAA) or a DSHS 15-345 (for DDADDA) in Barcode and include:
 - a) The date of the disenrollment from RCL services.
 - b) The program the participant is functionally eligible for (state plan/Medicaid waiver), and this program start date.
 - c) The setting of the services (in-home, ALF, etc.).
 - d) Update the address, if necessary.

For individuals who are managed Medicaid and enrolled with a Managed Care Plan (also known as the MAGI, ABP or MCS group), additional steps must occur as part of transition planning for the end of the RCL 365 day service period.

- 90 days prior to the end of the 365 day demonstration year, begin pursuing a disability determination, if enrolling the individual onto a waiver program (i.e., COPES, New Freedom, Basic +, Core, Community Protection, or CIIBS) or prepare to transition the client to ABP-CFC only.
- 60 days prior to the end of the 365 day demonstration year: If the RCL client is utilizing waiver services or is wishing to access Waiver services after RCL expires, assist the client

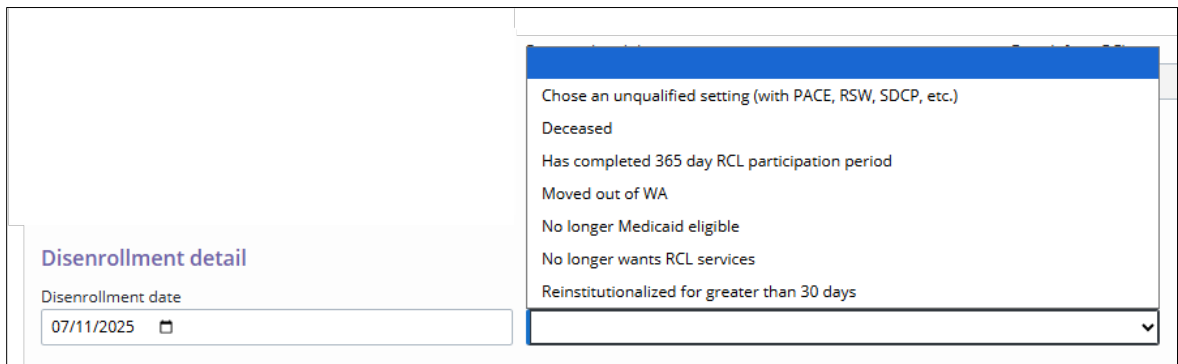
- with submitting a LTSS application for a financial determination of waiver services (i.e., COPES, New Freedom, Basic +, Core, Community Protection, or CIIBS).
- 30 days prior to the end of the 365-day service period, the case worker should review eligibility status with the Public Benefits Specialist.

Public Benefits Specialists must follow instructions as outlined in the [Apple Health Medicaid Manual](#).

Disenrollment after an individual has passed away

Note: If completing the disenrollment while the individual is still in the institutional setting, refer to [What is the process of disenrolling an individual from RCL who is still in an institutional setting?](#) for disenrollment steps.

1. End date the RCL RAC matching the date of death
2. Enter the same date for the *Disenrollment Date* on the RCL enroll/disenroll screen in CARE. **Do not enter an Actual Discharge Date.**
3. Select “Deceased” for the *Disenrollment Reason*



4. Follow the Termination of Services guidelines and procedures as outlined in [Chapter 5: Case Management](#).

Disenrolling steps once an RCL participant has completed 365 days of RCL participation period

Reminder: The Projected end date listed on the RCL Enroll/Disenroll screen in CARE indicates the end of the participant’s 365 day demonstration period.

1. Add the Disenrollment Date to the RCL Enroll/Disenroll screen in CARE. This date should match the Projected end date listed on the RCL Enroll/Disenroll screen.
 - **Note:** Case managers have flexibility in entering the RCL disenrollment date as the last day of the previous month. For example, if the Projected end date is 5/11/22, a case manager can enter a disenrollment date of 4/30/22. The RCL RAC must also reflect the same end date. The Disenrollment reason of “Has completed 365 day RCL participation period” is still chosen.

- A client's projected end date may extend beyond the current plan period. RCL should be maintained through the full projected end date, even when it overlaps with multiple plan periods.

2. Chooses "Has completed 365 day RCL participation period" as the Disenrollment Reason in CARE

Disenrollment detail

Disenrollment date	Disenrollment reason
05/11/2022	Has completed 365 day RCL participation peri ▼

3. Ensures the end date of the RCL RAC (HCS 3100 or DDA 3701) matches the Disenrollment Date and adds the on-going applicable state plan/waiver HCBS RAC the individual is eligible to receive based on functional and financial eligibility (see **Note** above).

RAC eligibility

RAC eligibility list

	RAC	Start date	End Date	Override	
	3051 - CFC -Residential	07/08/2022	05/31/2023	☐	
	3001 - COPES Waiver -residential	07/08/2022	05/31/2023	☐	
+	3100 - HCS Roads to Community Living	07/01/2021	07/07/2022	☐	

4. Follow instructions as outlined in [Chapter 3: Assessment and Care Planning](#) to obtain approval of the plan of care, send all required documents/forms to the individual, representatives and providers (including PANs), and complete required documentation of these activities.
5. For Classic Medicaid participants, Notify the PBS on a DSHS 14-443 (for HCS/AAA) or a DSHS 15-345 (for DDADDA) in Barcode and include:
 - e) The date of the disenrollment from RCL services.
 - f) The program the participant is functionally eligible for (state plan/Medicaid waiver), and this program start date.
 - g) The setting of the services (in-home, ALF, etc.).
 - h) Update the address, if necessary.

For individuals who are managed Medicaid and enrolled with a Managed Care Plan (also known as the MAGI, ABP or MCS group), additional steps must occur as part of transition planning for the end of the RCL 365 day service period.

- 90 days prior to the end of the 365 day demonstration year, begin pursuing a disability determination, if enrolling the individual onto a waiver program (i.e., COPES, New Freedom, Basic +, Core, Community Protection, or CIIBS) or prepare to transition the client to ABP-CFC only.
- 60 days prior to the end of the 365 day demonstration year: If the RCL client is utilizing waiver services or is wishing to access Waiver services after RCL expires, assist the client

with submitting a LTSS application for a financial determination of waiver services (i.e., COPES, New Freedom, Basic +, Core, Community Protection, or CIIBS).

- 30 days prior to the end of the 365-day service period, the case worker should review eligibility status with the Public Benefits Specialist.

Public Benefits Specialists must follow instructions as outlined in the [Apple Health Medicaid Manual](#).

When in doubt, send questions and concerns to:

HCS: DSHSALTSARCLReferrals@dshs.wa.gov

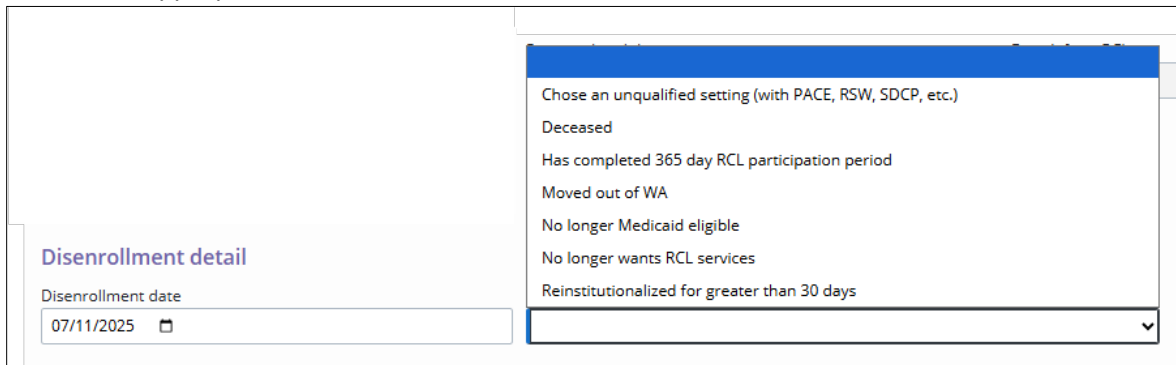
DDADDA: ddarclenrollmentintake@dshs.wa.gov

HQ RCL Staff are happy to help!

Disenrollment when an individual has moved out of WA

Note: If the individual moved out of Washington State directly from the institutional setting to a home and community-based setting, enter the **Actual Discharge Date** and additional fields that auto-populate in the RCL enroll/disenroll screen in CARE. If the individual is already living in the community, an *Actual Discharge Date* will have already been entered.

1. End date the RCL RAC to correspond with the date of move
2. Enter the same date for the *Disenrollment Date* on the RCL enroll/disenroll screen in CARE.
3. Choose the appropriate *Disenrollment Reason*



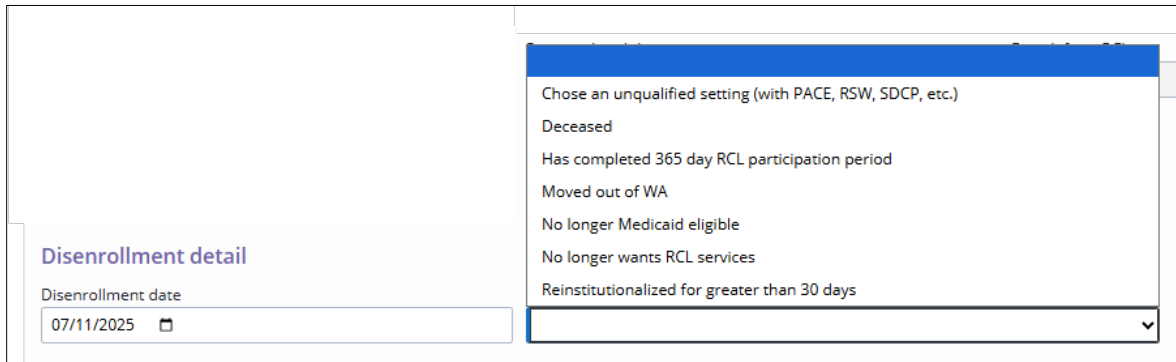
4. Follow the Termination of Services guidelines and procedures as outlined in [Chapter 5: Case Management](#).

Disenrollment when the individual is no longer Medicaid eligible

If the client is no longer Medicaid eligible and still in an institutional setting, refer to [What is the process of disenrolling an individual from RCL who is still in an institutional setting?](#) for disenrollment steps.

For a client living in a community-based setting who is no longer financially eligible, please email the HQ RCL Policy Unit as there are specific financial eligibility considerations for RCL enrolled individuals. Email HCS: DSHSALTSARCLReferrals@dshs.wa.gov or DDADDA: ddarclenrollmentintake@dshs.wa.gov.

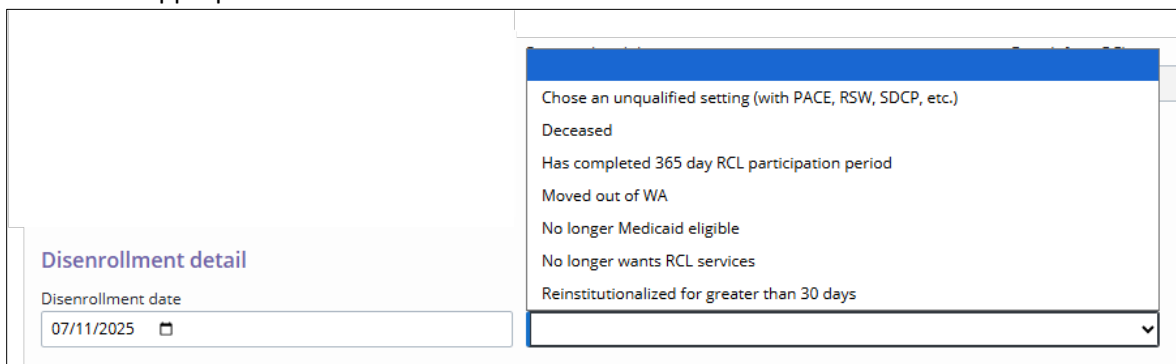
1. End date the RCL RAC to correspond with the date of move
2. Enter the same date for the *Disenrollment Date* on the RCL enroll/disenroll screen in CARE.
3. Choose the appropriate *Disenrollment Reason*



4. Follow the Termination of Services guidelines and procedures as outlined in [Chapter 5: Case Management](#).

Disenrolling an individual who no longer wants RCL services while in a community-based setting

1. End date the RCL RAC to correspond with the date of move
2. Enter the same date for the *Disenrollment Date* on the RCL enroll/disenroll screen in CARE.
3. Choose the appropriate *Disenrollment Reason*



4. Follow the Termination of Services guidelines and procedures as outlined in [Chapter 5: Case Management](#).

What is the process of disenrolling an individual from RCL who is still in an institutional setting?

If an individual no longer plans to transition on RCL, passes away prior to transition, or transitions directly to an RCL unqualified setting (AFH, RSW, SDCP, PACE, etc.) from the institution, the individual must be disenrolled from RCL and RAC changes are needed.

If the RCL enrolled individual is transitioning directly to an unqualified setting from the institution:

1. End date the RCL RAC one day prior to discharge. For example, if the date of discharge is 2/18/26, end date the RCL RAC 2/17/26.
2. Add the ongoing applicable state plan/waiver HCBS RAC the individual is eligible to receive based on functional and financial eligibility.

RAC eligibility

RAC eligibility list [RAC Inclusions table](#)

	RAC	Start date	End Date	Override	
+	3032 - RSW - Expanded Community Services	02/18/2026	01/31/2027	☐	
	3101 - HCS-RCL Disenroll/No post-dischrg serv	01/20/2026	02/17/2026	☒	

3. Enter the *Disenrollment Date* to the RCL Enroll/Disenroll screen in CARE. This date must match the RCL RAC end date. **Do not enter a date in the *Actual Discharge Date* field.**
4. Select “Chose an unqualified setting (with PACE, RSW, SDCP, etc.)” as the *Disenrollment Reason* in CARE.

Note: Although AFH is not listed, it is considered an unqualified setting.

Disenrollment detail

Disenrollment date: 02/26/2026

Disenrollment reason:

- Chose an unqualified setting (with PACE, RSW, SDCP, etc.)
- Chose an unqualified setting (with PACE, RSW, SDCP, etc.)
- Deceased
- Has completed 365 day RCL participation period
- Moved out of WA
- No longer Medicaid eligible
- No longer wants RCL services
- Reinstitutionalized for greater than 30 days

5. **For HCS clients:** Email DSHSALTSARCLReferrals@dshs.wa.gov to notify the HQ RCL Policy Unit of the disenrollment so RAC changes can be completed.
 - For HCS: RAC 3100 – HCS RCL Roads to Community Living must be replaced with 3101 – HCS-RCL Disenroll/No post-discharge services.
6. For DDADDA Clients: The DDADDA CRM will replace the RAC 3701 – DDA Roads to Community Living with 3702 DDA- RCL Disenroll/No post discharge services.
7. Follow instructions as outlined in [Chapter 3: Assessment and Care Planning](#) to obtain approval of the plan of care, send all required documents/forms to the individual, representatives and providers (including PANs), and complete required documentation of these activities.

Prior to discharge, if an individual has passed away or is no longer planning to transition to the community:

1. End date the RCL RAC.
2. Enter the *Disenrollment Date* on the RCL enroll disenroll screen using the same end date as the RCL RAC. **Do not enter a date in the *Actual Discharge Date* field.**

3. **For HCS clients:** Email DSHSALTSARCLReferrals@dshs.wa.gov to notify the HQ RCL Policy Unit of the disenrollment so RAC changes can be completed.
 - **For HCS:** RAC 3100 – HCS RCL Roads to Community Living must be replaced with 3101 – HCS-RCL Disenroll/No post-discharge services.
4. **For DDADDA clients:** The DDADDA CRM will replace the RAC 3701 – DDA Roads to Community Living with 3702 DDA- RCL Disenroll/No post discharge services.
5. Follow the Termination of Services guidelines and procedures as outlined in [Chapter 5: Case Management](#).

What about Contracting?

All LTC contracts are executed through the AAA unless other local agreements are in place that state otherwise. RCL services are contracted utilizing the same procedures as other client service contracts. Obtain a list of current contracted providers from your local AAA office. Notify your regional HCLA HQ Resource and Development team member and/or local AAA Contract Managers if you find there is a network capacity need for contracted providers in your area.

For DDADDA contracts, refer to the DDADDA RCL Coordinator with questions.

Note: In addition to specific contracted duties, each provider is responsible for reporting any instances of abuse, neglect, or exploitation of a vulnerable adult or child.

Note: All IPs must be currently employed with Consumer Direct Care Network (CDWA) before becoming a paid provider for a participant who is being served in the RCL project.

How is the project evaluated?

The Centers for Medicare and Medicaid Services (CMS) requires regular reports on RCL participants in their demonstration year. In addition, CMS evaluates grantees semi-annual reporting to monitor progress and identify challenges and improvement opportunities with participating state's MFP programs.

RESOURCES

Money Follows the Person Tribal Initiative

The [MFP Tribal Initiative](#) focuses on developing inclusive service contracts and engaging potential partners at the state, tribal and county levels for improved and culturally inclusive service delivery of ALTA services, including tribal contracted support services. The initiative's goals are to:

- Identify American Indians/Alaska Natives (AI/AN) who are living in institutions and assist them to return to their community of choice.

- Develop culturally inclusive service systems and providers to support American Indians/Alaska Natives once they returned to their communities.
- Support tribal contracts to provide long-term services and supports.

Information about the Money Follows the Person RCL Project

Public HCS website: [Roads to Community Living \(RCL\) | DSHS \(wa.gov\)](#)

Public DDADDA website: [Roads to Community Living | DSHS \(wa.gov\)](#)

Public TI website: [Money Follows the Person Tribal Initiative | DSHS \(wa.gov\)](#)

Federal website: [Money Follows the Person | Medicaid](#)

[WAC 388-106-0250-0265](#)

RCL Enrollment Form (managed by HCS HQ)

[RCL Enrollment Form](#)

Client Services Purchasing Card Process (HCS Only):

[HCS Purchasing Card](#)

DMS Packet Cover form:

[02-615 Social Services Packet Coversheet General Utility & Repair Allowance form:](#)

[Form 27-147 Community Choice Guide Activity Tracking Form:](#)

[CCG Activity Tracking Form - Instructions and Samples](#)

[CCG Activity Tracking Form MONTHLY](#)

[CCG Activity Tracking Form WEEKLY](#)

What Program to Use: Transition and Sustainability Goods and Services:

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

Technology Support Consultation and Technical Assistance Desk Aid:

[Desk Aid for Technology Support Consultation](#)

Smart Care Device Desk Aid:

[RCL Desk Aid for Smart Care Device](#)

[Smart Care Device Suitability Guide for ElliQ](#)

Non-Medical Transportation Request Process

[Non-Medical Transportation Request Process](#)

[Medstar Trip Request Form](#)

[Medstar Stretcher Transport Form](#)



HCS Decision Making for Transitions/Authorized Representative

[HCLA Power of Attorney vs. Uniform Guardianship](#) [HCLA How to Identify a Guardian](#) [HCS Decision Making for Transitions.pdf](#)

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
07/2026	Rebecca Kaiser Desiree Vallejo	- Updated all references of DDCS to DDA - Added reference to Room and Care procedure for CCG residential searches.	
05/2026	Samantha Dunham Desiree Vallejo Cassie Pizano	- Removed references to Adult Family Homes as RCL qualified settings. - Clarified the use of RCL services to support individuals who are still institutionalized but planning to transition to an RCL unqualified setting. - Clarified what CCGs are not permitted to do and outlined the steps for referring and authorizing CCG services. - Expanded the Client Training-Behavior Support service details to align with the COPES chapter. - Updated and added guidance on determining which program to use for transition and sustainability goods and services - Removed the Emergency Rental Assistance (ERA) section as it is no longer offered under RCL - Added details for the Pantry Stocking service - Added a link to desk aid for referring and authorizing Technology Support Consultation and Technical Assistance - Clarified disenrollment reasons and procedures - Updated Smart Care Device name and eligibility - Updated Assistive Technology (AT) section to align with CFC Chapter - Updated (RCL) Smart Care Device Desk Aid	
11/2025	Samantha Dunham Desiree Vallejo	- Updated CCG Service Codes descriptions & Tracking forms to be aligned with contract updates. - Updated to include all RCL services and added hyperlinks to Service Code Data Sheets - Clarified eligibility requirements for individuals in inpatient psychiatric hospitals	

6/2025	Samantha Dunham Cassie Pizano	• Updated all references of ALTSA to HCLA and DDA to DDA • Updated end dates of RCL demonstration project • RCL eligibility clarified to indicate 60 day stay can include multiple institutional settings • Clarified enrollment request instructions • Provided examples of client situations which Client Training: Behavior Support Services may be beneficial • Added clarification to Community Choice Guide (CCG) scope of work • Added clarification on next steps when disenrolling RCL participant due to completing 365 day demonstration period • Added clarification on next steps when client is reinstitutionalized • Updated disenrollment reasons to include “No Longer eligible for Medicaid” and updated RCL enroll/disenroll screen shot • Updated Smart Care Companion Desk Aid link	
03/2025	Samantha Dunham Cassie Pizano Desiree Vallejo	• Corrected end dates of RCL demonstration project • Added clarification regarding fast track and RCL • Added clarification on process to authorize Client Training: Behavior Support Services • Added clarification that Community Transition Services – Items does not permit payment of tips. • Added MIST information • Added Smart Care Companion service information • Added 14-225 and 16-472 as necessary forms to be completed upon authorizing RCL services for HCS clients • Updated treatment names for Community Transition Goods/Items, Community Transition Services and Short-Term Rental Assistance • Added the process to disenroll an individual from RCL prior to discharge • Added Money Follows the Person Tribal Initiative information and website • Updated PAN example	

10/2024	Samantha Dunham	• Provided clarification on RCL demonstration year and CARE Plan period misalignment. • Added Public RCL Website links for DDA and HCS	
7/2024	Samantha Dunham	• Revised the format of the chapter to outline eligibility prior to RCL service descriptions. • Provided clarification on concurrent authorization of SA263 and SA266. • Included RCL services PAN screen shot example. • Added CCG Activity Tracking form to Resources Section. The Form includes the option for providers to submit the form directly to the Imaging Unit via fax.	
4/2024	Julie Cope	• Included form of 27-147A for General Utility and Repair Allowance. • Added Description of Technology Support Consultation and Technical Assistance service (H2014 U9) • Added Service Code Data Sheet links for Pantry Stocking (SA420-U1) • Included additional direction for NFLOC communication for RCL enrolled participants of MAGI or MCS Medicaid programs into ProviderOne.	H24-018
11/2023	Amanda Speck	• Clarification on SA266 Purchasing and CCG reimbursement timeliness. • Included additional service information for: Trial Visits, Pantry Stocking & Non Medical Transportation • Amendment of SA297, SA296 and Environmental Modification service code purchase limits without ETR.	H23-090
08/2023	Stephanie VanPelt	• Added Emergency Rental Assistance information • Added P-card information and guide • Added Environmental Modification General Utility Allowance information • Updated RCL project dates • Updated DMS packet cover form 02-615	H23-071
09/2022	Stephanie VanPelt	Included RCL Referral shared email box Removed detailed description of RCL eligible settings. Updated RCL enrollment/disenrollment instructions to reflect CARE Web migration Aligned RCL case management and transfer procedures with the State Plan and Chapter 5.	H22-042
5/2022	Stephanie VanPelt	Extended RCL Project through 12/31/2026	H22-028

06/2021	Stephanie VanPelt	• Updated RCL qualified and unqualified community settings. • Updated RCL eligibility criteria from 90 days to 60 days continuous qualified institutional stay. • Addition of Residential Unit Furnishings WACs and guidance	H21-050
03/2021	Stephanie VanPelt	• The RCL project has been extended through 12/31/2022 • Updated language in the eligibility section to reference the state funded non-citizens medical benefit instead of the acronym AEM and updated language related to PACE program	H21-018
8/2020	Stephanie VanPelt	Updated RCL Expert Contact information Clarified Services available to RCL Participants Added CCG Tracking Forms in Resource Section	H20-031



Introduction to the Medicaid Transformation Project

This section will provide a brief overview of the 1115 Medicaid Transformation demonstration waiver often referred to as Medicaid Transformation Project (MTP) or MTP 2.0. Throughout this chapter it will be referred to as “MTP”. The primary focus in the chapter is on the Older and aging adults and family caregivers provision and the Housing & Employment provisions of MTP.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Resa Lee-Bell	1115 Waiver Program Manager 564.999.1287	Resa.Lee-Bell@dshs.wa.gov
Samantha Thurston	Housing Integration Unit Manager 564.200.2296	Samantha.Thurston1@dshs.wa.gov
Mike Corcoran	Employment Unit Manager 360.725.2614	Michael.Corcoran@dshs.wa.gov

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WHAT IS MTP?

MTP or Medicaid Transformation Project (aka MTP 2.0) is a five-year 1115 demonstration waiver with the Centers for Medicare and Medicaid Services (CMS) that provides up to \$1.1 billion federal investment. This funding is not a grant. The 1115 waiver allows the state to “waive” certain Medicaid requirements in order to test innovative, sustainable and systematic changes that will help improve the overall health of Washingtonians. During the five years of the waiver, the state must demonstrate that it will not spend more federal dollars on its Medicaid program than it would have spent without the waiver.

MTP 2.0 is part of the Health Care Authority’s (HCA) Healthier Washington Initiative. Over the next five years, the goals of the project are to:

- Expand coverage and access to care, ensuring that people can get the care they need.
- Advance whole-person primary, preventive, and home and community-based care.
- Accelerate care delivery and payment innovation focused on health-related social needs.

The current five-year period for this waiver began on July 1, 2023, and ends June 30, 2028.

WHAT ARE THE INITIATIVES UNDER MTP 2.0?

MTP 2.0 consists of seven provisions. They are as follows:

- **Older and Aging Adults and Family Caregivers:** supports Washington's aging population and family caregivers who provide care for their loved ones.
 - Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)
 - These programs will broaden the array of service options that enable individuals to remain at home and avoid or delay the need for more intensive care. The state has created a system of care focused on outcomes that support unpaid family caregivers in caring for loved ones, delay or avoid need for more intensive long-term services and supports (LTSS), create better linkages within the health care system, and continue its commitment to a robust LTSS system for those who need it.
 - Long-Term Services and Supports Presumptive Eligibility (LTSS PE)
 - This program is a package of services that provides individuals an opportunity for expedited access to specific home and community-based services in their own home and Medicaid medical coverage, for a limited time, while full functional and financial eligibility are being determined.
- **Housing and Employment:** Foundational Community Supports (FCS) provides supportive housing and supported employment services to our most vulnerable Medicaid beneficiaries. These services are designed to promote independence and recovery by helping participants find and maintain stable housing and employment.
 - Foundational Community Supports – Supported Employment
 - These services assist those individuals who want to work and meet FCS criteria. Supported Employment services are designed to be person-centered and offer individualized, one-to-one supports to individuals interested in employment in the community. FCS creates a system of



services which will provide pre-employment and post-employment services to an individual at any point in their pathway to employment. The services are not time-limited but are intended to support the individual for as long as there is an identified need. Individualized Supported Employment services include: identifying career and occupational targets, developing ongoing relationships with prospective employers, assisting with the interviewing and hiring process, benefit planning supports, and once hired, support with maintaining employment.

- Foundational Community Supports – Supportive Housing
 - Washington has offered Supportive Housing benefits through Foundational Community Supports since January 1, 2018. Supportive Housing provides dedicated housing support to people with complex needs wishing to live independently. The service provides wraparound support, which means facilitating cross sector coordination of all services the person needs and wants. Supportive Housing services may be an option for individuals who want to live independently and have a history of unsuccessful housing episodes without coordinated, focused support services. These specialty services provide assistance and support to aid an eligible individual in searching and finding housing (pre-tenancy services) and support an individual maintain their independent housing (ongoing tenancy support services).
- **Behavioral Health:** Washington State believes behavioral health—which includes care for our minds or bodies when substances are misused—is just as important as physical health care. Under the Medicaid Transformation Project (MTP) 2.0, these programs support individuals who are receiving services for substance use disorder (SUD) treatment or serious mental illness. MTP 2.0 also includes SUD and other behavioral health services for people in prisons and jails, with the goal of continued recovery once they reenter the community.
 - [SUD IMD program](#)
 - [Mental health IMD program](#)
 - [Contingency management for SUD treatment](#)
- **Reentry from a Carceral Setting:** Reentry services under MTP provides essential services for individuals leaving a state prison, county/city jail, or youth correctional facility.
- **Continuous Enrollment:** Includes continuous two components: Apple Health enrollment for children, ages 0 through 5 provides continued benefits for eligible children, ages 0 through the end of the month in which they turn 6 years old and Apple Health postpartum coverage expansion which provides continued benefits for individuals from the end of the pregnancy through 12 months of postpartum.
- **Health-Related Social Needs (HRSN):** HRSN is composed of 3 provisions: Community Hubs which focuses on community-based care coordination, including screening patients, determining patient needs, connecting patients to community organizations that can provide those needs, and more; Native Hubs which is a statewide network of Indian health care providers, tribal social service divisions, and Native-led, Native-serving organizations focused on whole-person care coordination; and Other HRSN services including nutrition, housing, rental subsidies, transportation, and other non-medical HRSN services that help a person live their healthiest life. Rental subsidies up to 6 months is a specific HRSN service for



individuals transitioning out of institutional care or congregate settings, such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), correctional facilities, and acute care hospitals, or Homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5, or Youth transitioning out of the child welfare system, including foster care. This program provides financial assistance to individuals at risk of homelessness so they can pay their rent and have stable housing.

- **HRSN System:** This program provides infrastructure investments to support the readiness for HRSN service delivery. Investments include technology, planning, workforce development, and convening.

The Older and Aging Adults and Family Caregivers as well as Housing and Employment programs are operated through Home and Community Services (HCS).

MTP RESOURCES

[MTP Community Workspace](#): the MTP SharePoint site that contains useful information, training videos, desk aids, and a Q & A forum called Conversation Cafe`.

[Health Care Authority's Healthier Washington Website](#)

[HCS MTP Intranet site](#)

[HCLA MTP Internet site](#)

Acronyms

MTP	Medicaid Transformation Project
CMS	Centers for Medicare and Medicaid Services
HCA	Health Care Authority
MAC	Medicaid Alternative Care
TSOA	Tailored Supports for Older Adults
LTSS PE	Long-Term Services and Supports Presumptive Eligibility
LTSS	Long-Term Services and Supports
FCS	Foundational Community Supports
HRSN	Health-Related Social Needs
IMDs	Institutions for Mental Diseases
HCS	Home and Community Services
CFR	Code of Federal Regulations
SUD	Substance Use Disorder
HCLA	Home and Community Living Administration



REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
November 2019	Debbie Johnson	Moved to new template	H19-0xx
May 2024	Resa Lee-Bell	Incorporated language from June 2023 CMS Approval/STC's	
April 2025	Resa Lee-Bell	Addition of Acronyms Style Formatting Update	
October 2025	Resa Lee-Bell	Rebranding Updates	

MAC & TSOA

Chapter 30b provides a description of Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) offered under the Older and Aging Adults and Family Caregivers provision of the 1115 Medicaid Transformation Demonstration waiver. These programs are intended to support unpaid family caregivers and their loved ones so they can remain in their chosen communities.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Resa Lee-Bell	1115 Waiver Program Manager 587.999.1287	Resa.Lee-Bell@dshs.wa.gov
Adrienne Cotton	MAC & TSOA Program Manager, State Unit on Aging 360.764.9077	Adrienne.Cotton@dshs.wa.gov

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BACKGROUND

The intent of the Older and Aging Adults and Family Caregivers provision under the Medicaid Transformation Project – 1115 Demonstration Waiver, is to expand care options for people, ages 55 and older, so they can stay at home and delay or avoid more intensive services, and providing assistance to unpaid family caregivers, ages 18 or older, who provide care for their loved ones. The MAC and TSOA programs are both found under the Older and Aging Adults and Family Caregiver’s section. These programs are helping change the Medicaid health care delivery system by:

- Providing additional options for people with long-term care needs.
- Increasing access to services for people on the cusp of poverty to reduce:
 - A potential health decline.
 - The need to move out of home.
 - The spending-down of limited resources.
- Slowing the growth trend of traditional Medicaid-funded services, including Medicaid long-term services and supports.
- Providing unpaid family caregivers with supports and knowledge to continue providing care while also taking care of themselves.
- Helping people remain at home for as long as possible, and to maintain independent living.

Both MAC and TSOA are mirrored after the state funded Family Caregiver Support Program (FCSP). FCSP which was established in 2000 and is available in every county in Washington. The FCSP program was developed with the concept that supporting unpaid family caregivers keeps Washington families together and means less people need expensive long-term care placement or services. If family caregivers become unavailable, it is likely that older adults would need to access more costly in-home and residential services. These caregivers need support to help prolong their ongoing caregiving activities as well as ensure their own mental and physical health stays intact while coping with related challenges. Research demonstrates that it is critical to understand how a caregiver is feeling about their role in order to better tailor support to their individual needs. The FCSP has shown that the majority of caregivers show significant improvements on key outcomes when their stresses and burdens are addressed.

For more information about the FCSP see [Chapter 17a](#) the LTC manual.

PROGRAM DESCRIPTION & ELIGIBILITY CRITERIA

The Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) fall under the Older and Aging Adults and Family Caregivers provision of the 1115 demonstration waiver. Eligibility for both programs is based on the care receiver, although services may be provided to both the care receiver and/or the unpaid caregiver. MAC provides support for unpaid family caregivers caring for Medicaid-eligible people who are not currently accessing Medicaid long-term services and supports such as Medicaid Personal Care (MPC), Community First Choice (CFC), and Community Options Program Entry System (COPES) programs. The unpaid family caregiver, who must be at least 18 years old, is the individual who provides care to their care receiver and does not receive direct, public, or private payment such as a wage for the caregiving services they provide. An unpaid family caregiver may be a

spouse/partner, adult child, other family member, a friend, or a neighbor and does not need to be a Washington State resident. The unpaid family caregiver and the care receiver are collectively referred to as the dyad.

TSOA serves individuals who are functionally eligible but not yet financially eligible for Medicaid or are receiving limited Medicaid coverage based upon a specific set of criteria (such as Medically Needy or Medicare Savings Program). Services under TSOA can support someone with an unpaid family caregiver (the dyad) or someone who does not have an unpaid family caregiver.

For more information about financial eligibility and ACES coverage groups for MAC and TSOA see the [MTP Community Workspace](#) on the ALTSA SharePoint site.

Both MAC and TSOA programs are designed to offer the right amount of services, at the right time in order to divert or delay the need for more comprehensive Medicaid long-term services and supports. Both programs are funded 100% by federal Medicaid dollars and offer the same services, with some exceptions. MAC and TSOA services can only be received by care receivers living in a private residence such as their own home, independent living, or another's home rather than a licensed residential facility (i.e., adult family home or assisted living facility).

A care receiver may have more than one caregiver. However, the care receiver only has one benefit amount (service dollars). The funds must be shared between the identified unpaid caregivers.

An unpaid caregiver may be supporting more than one care receiver. For example, an adult daughter may be providing care to both her mother and her father. In this situation, if both parents are enrolled in MAC or TSOA then each parent would have a separate benefit amount that could be used to support their daughter/unpaid caregiver.

There are also scenarios where a MAC or TSOA dyad caregiver is inquiring about being a TSOA individual. The below is a helpful chart on determining when caregivers can also be care receivers themselves and what necessary steps are required:

Program	Can CG be TSOA Ind?	MTP Exception to Rule (ETR) local required?
Caregiver (such as IP, home care agency or unpaid CG) for CFC/ COPES client	Y	N** Best practice is for MTP case worker to consult with CFC/COPES case worker to ensure there is a safe plan of care for both CFC/COPES client and TSOA Individual.
FCSP CG	Y*	Y**
MAC/TSOA CG	Y*	Y**

		Local ETR must be requested annually for dyad CG to be a TSOA individual.
*Things to Consider: Does the request make sense for the situation? What tasks is the CG doing and what tasks does the individual/CG need help with as a CR? **Why is the ETR needed? What makes this situation different from the majority? Is this a safe plan of care?		

MEDICAID ALTERNATIVE CARE (MAC)

MAC helps unpaid family caregivers provide high-quality care for their loved ones, while also tending to their own health and well-being. MAC serves dyads (care receiver and unpaid caregiver). Applicants may request services through either the AAA or HCS front door. An example of a dyad who may want to access MAC services is one who:

- Does not want or need a more comprehensive Medicaid LTSS program, or
- Doesn't want to risk estate recovery

To be eligible for MAC, the care receiver must meet **ALL** the following eligibility criteria:

- Be age 55 or older
- Live in their own home or another's home (not a licensed residential facility)
- Currently be enrolled on a Categorically Needy (CN) or Alternative Benefit Plan (ABP) Medicaid coverage group (Apple Health)
- Meet nursing facility level of care (NFLOC) but has chosen not to receive Medicaid long-term services and supports through the state's other programs.

There is no client participation/responsibility or estate recovery with MAC and TSOA programs.

TAILORED SUPPORTS FOR OLDER ADULTS (TSOA)

TSOA establishes a new eligibility category and benefit package for people who may need Medicaid long-term services and supports in the future. TSOA helps people and families avoid or delay impoverishment and the future need for Medicaid-funded services. TSOA serves dyads (care receivers and unpaid caregivers) as well as individuals who do not have an unpaid family caregiver. Dyads and individuals without an unpaid family caregiver may access services through either the AAA or the HCS front door. An example of an individual who may want to access TSOA services is one who:

- Does not want or need a more comprehensive Medicaid LTSS program,
- Doesn't want to risk estate recovery, and/or
- Feels that paying participation would cause an unsustainable financial hardship.
- May be over the resource limit for traditional Medicaid LTSS programs.

To be eligible for the TSOA program, whether for the dyad or an individual, the care receiver must meet **ALL** of the following eligibility criteria:

- Be age 55 or older
- Live in their own home or another's home (not a licensed residential facility)
- Be a US citizen or have eligible immigrant status
- Not currently be eligible for Categorically Needy (CN) or Alternative Benefit Plan (ABP) Medicaid coverage (Apple Health)
 - Note: TSOA applicants may be on a Medically Needy (MN) or Medicare Savings Program (MSP) ACES coverage group and still be financially eligible for TSOA. This coverage group only provides limited scope of Medicaid benefits from Health Care Authority (HCA).
- Meet nursing facility level of care (NFLOC)
- Meet financial requirements:
 - Income up to 400% of the Supplemental Security Income (SSI) Federal Benefit Rate per [WAC 182-513-1635](#)
 - Countable non-excluded resources are at or below the current monthly private nursing facility rate multiplied by six months for a single applicant or, for a married couple with a community spouse (CS), non-excluded resources are at or below a combination of the current monthly private nursing facility rate multiplied by six months plus the current state spousal resource standard for the spousal impoverishment protections community (SIPC) spouse. The state spousal resource standard may change annually on July 1st. Resource eligibility for TSOA is described under [WAC 182-513-1640](#), [WAC 182-513-1660](#), & [WAC 182-513-1640](#).
 - Standards chart can be found [here](#).

For MAC and TSOA care receivers, the nursing facility level of care (NFLOC) assessment and the financial eligibility review must be completed annually. Each NFLOC assessment completed post-presumptive eligibility, should be completed by AAA MTP staff and will not require confirmation by HCS staff. HCS financial staff (Public Benefit Specialists) will conduct the annual financial eligibility review.

INTAKE AND SERVICE DELIVERY FLOW

Intake and service delivery flow consists of taking a person through the process of accessing services. Medicaid Alternative Care (MAC) and Tailored Support for Older Adults (TSOA) programs may be requested through either the AAA or HCS front door. During the intake process, applicants are educated about the long-term services and supports provided by HCLA and the settings for which they are offered, including functional and basic financial eligibility criteria. Upon the applicant making an informed decision to receive either MAC or TSOA services; the MTP Presumptive Eligibility (PE) screening can be completed. If an applicant

MAC and TSOA service provision is unique: The AAA GetCare systems interface with the CARE system to ensure seamless service delivery flow.

chooses another service offered by HCLA ; the appropriate referral or intake can be completed. If the applicant indicates that HCLA LTSS are not needed or are declined; the applicant should be referred to alternative community resources, including other state or federal funded programs offered through the aging and disability network including Older Americans Act and Family Caregiver Support Program (FCSP).

The PE screening will be completed in either the GetCare or CARE systems. AAAs primarily use the GetCare systems. GetCare interfaces with CARE, TCARE, Barcode and ProviderOne (P1). PE screenings and confirmations completed by HCS are done in the CARE system.

Role of AAA and HCS staff

AAA MTP staff work in the GetCare system after having person-centered conversations with participants about available programs, services, settings and providers. If MAC or TSOA is the participant's program choice, AAA staff complete the following:

- Intake in GetCare
- Presumptive Eligibility (PE) assessments
- Annual Nursing Facility level of care assessments
- GetCare or TCARE® screenings
- GetCare or TCARE® assessments
- GetCare or TCARE® Care Plans
- Service enrollments and authorizations
- Eligibility notifications and other required notices to care receivers
- Obtain signatures on required DSHS forms (see Forms and Notices section)
- Voter Registration Assistance at intake during the Presumptive Eligibility screening, whenever the care receiver's home address changes, and during annual nursing facility level of care (NFLOC) assessments. Refer to MB [H18-030](#) for more information.
- On-going case management
- Administrative hearings, as necessary

Designated HCS MTP intake workers, using CARE, will also work with clients to conduct person-centered conversations about available programs, services, settings, and providers. If the MAC or TSOA program is selected by the participant, these designated workers will complete the following:

- Intake in CARE
- Presumptive eligibility screenings and initial functional eligibility (NFLOC) determinations
- Confirmation of initial functional eligibility (NFLOC) via review of the PE assessments completed by AAA workers in GetCare and sent to CARE via an interface.

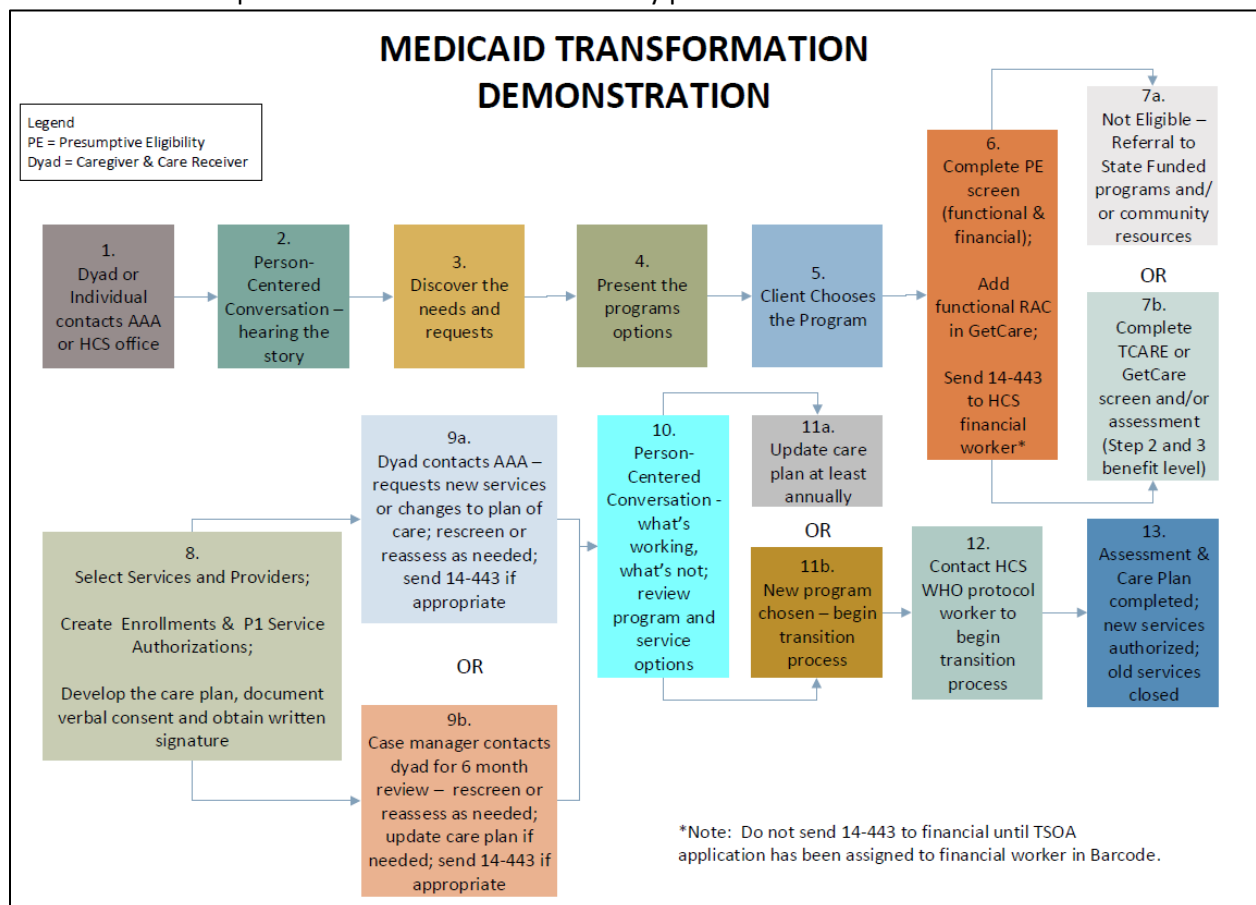
HCS Public Benefit Specialists (PBS)/financial workers will process TSOA applications and confirm financial eligibility for TSOA. Some MAC care receivers, if the applicant is eligible for Medicare or is age 65+, will also be managed by the HCS PBS. HCS PBS complete the annual financial eligibility reviews for the TSOA and MAC cases they oversee. MAC applicants and recipients, authorized under N-track or MAGI group of eligibility, are managed by the Health Care Authority (HCA). PBS utilize ACES, Barcode, AVS, Lexus Nexus Asset Reports, Employment Security Department Data, Washington State Pension

Data, Social Security Online Queries, as well as other additional systems to help determine financial eligibility for programs.

In order for certain tasks, such as full eligibility confirmation to be completed by HCS, information must be confidentially shared between AAA and HCS offices. Warm hand-off (WHO) protocols, developed between each AAA and their respective HCS partner, focus on confidential and quick communication so that participants receive seamless service provision. See the [Warm Hand-Off](#) section in this chapter for additional information.

Whether services are requested through the HCS or the AAA front door, HCS ensures the care receiver is assigned a ProviderOne (P1) ID number. HCS will match to existing records or links each new care receiver to the ProviderOne (P1) system. The P1 ID number is sent electronically from the care receiver's record in CARE to their record in GetCare. The P1 ID number allows AAA staff to create enrollments and service authorizations and send them to P1. P1 will then auto-generate authorization notices to the provider, the care receiver, and the caregiver. Once an authorization is accepted by P1 and the service is provided to the care receiver and/or unpaid caregiver, providers may submit a claim to P1 for payment against that specific authorization.

The chart below depicts the intake and service delivery process.



Community Living Connections - GetCare

Community Living Connections (CLC) GetCare is the client management information system used by AAAs to complete intakes, presumptive eligibility (PE) assessments, annual nursing facility level of care assessments, screenings and assessments, PE notices, MTP Service Notices, enrollments and authorizations.

GetCare is also used to create:

- Step 1 and 2 care plans for dyads and TSOA individuals, and
- Step 3 care plans for TSOA individuals.

GetCare is the system of record for care receivers enrolled in the MAC and TSOA programs.

For MAC and TSOA, System of Record means information provided through GetCare takes precedence over information from any other system involved in the service delivery flow with exception to social security numbers. P1 is the system of record for social security numbers.

TCARE®

TCARE® is the evidence-based assessment tool and information system used by the AAAs for completing:

- caregiver screens for Step 2 dyads,
- Step 3 care plans for dyads,
- assessments and consultation worksheets for Step 3 dyads.

Care plans for dyads at Step 1 and 2 and care plans for TSOA Individuals at Step 1, 2, and 3 are completed in GetCare. Care Plans for dyads at Step 3 are completed in TCARE.

CARE

Comprehensive Assessment Reporting and Evaluation, CARE, is the case management information system used by HCS to:

- complete intakes, presumptive eligibility screenings, and initial functional eligibility confirmations;
- obtain ProviderOne ID numbers for care receivers; and
- share information such as functional RACs and AAA staff information with ProviderOne.

ProviderOne

ProviderOne is Washington State's Medicaid Management Information System (MMIS) and is the system used by all Medicaid providers to submit claims to be paid for services provided. It is the system of record for care receiver's Social Security Number (SSN) as this systems interfaces with federal databases to confirm accuracy of SSNs.

ProviderOne “talks” to many different systems such as ACES, Barcode, Agency Contracts Database (ACD), CARE, and GetCare. If any of these systems are down (experiencing technical difficulties) updates from those systems to ProviderOne may be delayed. Some changes made in GetCare and CARE will be processed overnight and updated to the care receiver’s file in ProviderOne. For example, when the AAA staff, functional RAC, or RU change, the primary case manager and RU fields will be updated overnight for any authorization with current or future end dates.

All ProviderOne authorizations for payment are made under the Care Receiver’s ProviderOne ID in the Care Receiver’s GetCare profile.

Refer providers who want more information about ProviderOne (such as how to become a provider or how to get paid) to [HCA’s website](#) for social service providers.

Agency Contracts Database (ACD)

Medicaid-funded contracts, paid through ProviderOne, are stored in the statewide DSHS system called ACD. In order to validate social service authorizations for contracted services, and for payment to be processed through ProviderOne, a corresponding active contract must exist in ACD. An interface between ProviderOne and ACD will supply contract information for such validation. Once a contract goes into signed status in ACD, the contract and provider information automatically is sent to ProviderOne allowing for service authorizations and payments to be completed.

Automated Client Eligibility System (ACES) and Barcode

ACES is used by the State of Washington's Department of Social and Health Services and supports the operations of the department by integrating DSHS programs under a single, client-based, on-line system. The ACES system is a tool for determining program financial eligibility, issuing Medicaid benefits, management support, and sharing of data between agencies.

Barcode is an application with an array of workflow and document management functionality. It tracks case management contact information, communication with the public benefits specialist and financial eligibility determination and integrates this information with the ACES system.

TIVA2

TIVA2 (Tracking Incidents of Vulnerable Adults) is used by Adult Protective Services (APS) and Residential Care Services (RCS) to assist with tracking and trending critical allegations of abuse and neglect across settings, providers, and alleged perpetrators.

An outbound interface between TIVA2 and CARE identifies when a care receiver with an active MAC or TSOA RAC has been identified as an alleged victim in an APS or RCS intake and then CARE interfaces with GetCare to provide the MTP case manager notification via a message on the AAA staff’s GetCare

dashboard. Further information about the intake or outcome notice can be reviewed by clicking on the APS/RCS ribbon in the care receiver's record in GetCare.

Presenting Program Options

When individuals contact the AAA or HCS office for the first time or when individuals who are currently receiving services want to understand more about available programs, services and supports, it is important for AAA and HCS staff to facilitate a person-centered discussion. The full range of available programs, services, providers and settings should be presented, with enough information to allow people to understand options that best suit their needs.

The focus of this discussion should be an “important to, important for” approach, which is similar to motivational interviewing and other related approaches to person centered discussions.

The following tool was developed to help with understanding the program options available:

[Decision Tool for Program Options](#)

For more information about person centered conversations see the [MTP Community WorkSpace](#) on the ALTSA SharePoint site.

HCS and AAA staff must document in CARE – SER notes and in GetCare and TCARE® care plans that they have discussed all available program, setting, provider and service options such as FCSP, MAC, TSOA, MPC, CFC, COPES, New Freedom, nursing facility care, etc. with the care receiver prior to enrollment into a program. Below is a screen shot of the question in the GetCare care plan. The answers available in the drop-down list include “Yes”, “No”, and “Unknown”.

Has the case worker discussed with the client/rep all available programs, services, settings, and providers?	Yes
--	----------------------------------

Warm Hand-Off Standards & Protocols

The Warm Hand-Off (WHO) Protocol is the plan for how and when information and/or documents will be shared between AAA staff and HCS staff to ensure seamless and confidential service provision for clients of the MAC and TSOA programs.

In each program there is essential information, such as intakes, presumptive eligibility, P1 ID number and program start/end dates, which must be sent back and forth electronically between GetCare, CARE and Barcode. The Warm Hand-Off Protocol details how this sharing of documents and information is going to occur and within what timelines. The WHO protocol also requires names and contact information of lead staff at local HCS (social services and financial) and AAA offices to be known to each counterpart, providing a point person to ensure seamless service delivery for clients.

The WHO protocol also provides instruction for how information will be confidentially exchanged if usual ways of handing off cases are not operational. For example, when computers are down for a day and documents still need to be warmly handed off between AAA and HCS partners, or there is a delay in

determining final eligibility for a dyad. The contingency section in the WHO protocol details how data will be exchanged so that seamless service delivery is provided to clients.

In the evaluation section of the WHO protocol, each AAA and HCS partner provides a plan for how each area's respective WHO Protocol will be evaluated. For example, it should include details about how the plan will be reviewed to determine if it is working or needs modifications or updates. Also included is information about what systems will be put in place to ensure seamless and timely handoffs and how often the lead contact staff between offices will touch base to review whether the process is working as designed.

WHO Protocol Due Dates:

MAC/TSOA Hand-Offs	Work flow	Maximum # of days
NFLOC Prescreen Information for confirmation of NFLOC eligibility	From AAA Staff to HCS CM	2 business days from PE screening lock date
TSOA Financial Application	From client (with assistance from AAA) to HCS PBS	30 calendar days from PE screening lock date
Prescreen Information for service authorization	From HCS CM to AAA Staff	2 business days from PE screening finalize date
ProviderOne ID for new clients	From HCS CM to AAA Staff	2 business days from receipt of PE screening from AAA
NFLOC Functional Eligibility confirmation	From HCS CM to AAA Staff	10 business days from receipt of PE screening from AAA
TSOA only: Confirmation whether a TSOA financial application was received	From HCS PBS to AAA Staff	30 calendar days from PE start date
TSOA only: Care Receiver Financial Eligibility Determination	From HCS PBS to AAA Staff	45 calendar days from receipt of TSOA financial application

Each AAA is required to develop and maintain a MAC/TSOA WHO Protocol as part of their contract with HCLA for this Medicaid Transformation Project. For additional information or questions about your local MAC/TSOA WHO Protocol, contact your supervisor.

[AAA & HCS Warm Hand-off Protocol Standards](#)

PRESUMPTIVE ELIGIBILITY (PE)

What is PE?

PE is a process that allows us to gather preliminary information, based upon the self-attestation of the care receiver/designated representative, to decide that the care receiver appears to meet eligibility criteria. The two components reviewed for determining PE are financial and functional. The ability to authorize services under PE allows services to be delivered to dyads or individuals more quickly while the full eligibility determinations are being completed.

	MAC	TSOA
Financial	- Care Receiver's Medicaid Coverage Group = ✓ Categorically Needy (CN) or ✓ Alternative Benefit Plan (ABP) WAC 182-513-1605	- Income up to 400% of the Supplemental Security Income (SSI) Federal Benefit Rate per WAC 182-513-1635 - Countable non-excluded resources are at or below the current monthly private nursing facility rate multiplied by six months or, for a married couple, that non-excluded resources are at or below a combination of the current monthly private nursing facility rate multiplied by six months plus the current state spousal resource standard for the spousal impoverishment protections community (SIPC) spouse, based on the individual's verified household resources per WAC 182-513-1640. Rates can be found here.
Functional	Nursing Facility Level of Care (NFLOC) WAC 388-106-0355	Nursing Facility Level of Care (NFLOC) WAC 388-106-0355

PE Time Period

Services are available under PE for a limited time. The PE time period begins on the date the PE screening is completed and ends with the earlier date of:

- The day the decision was made by the HCS public benefits specialist on the TSOA financial application;
- The date it was confirmed by HCS case worker that care receiver did not meet functional eligibility criteria; OR
- The last day of the month following the month that the PE screening was completed (when no TSOA application was submitted).



Any Care Receivers who have already been determined financially eligible (for example, most MAC Care Receivers), will be fully eligible once HCS confirms functional eligibility, therefore may never enter the program under presumptively eligibility.

Example 1: Susy Que's PE assessment was completed in GetCare on August 19, 2024 and the NFLOC confirmation was made by the HCS case worker on 8/21/24. Susy submitted her TSOA application on September 12th and continued to receive services under PE until October 5, 2024, when the HCS financial worker was able to determine full financial eligibility.

PE RAC start date = the date PE was completed and locked (8/19/24)

Initial PE RAC end date = 9/30/24

PE RAC end date extended to allow financial worker time to process application = 10/31/24

Financial worker's eligibility decision = 10/4/24

Full Eligibility RAC start date = 11/1/24

Full Eligibility RAC end date = 8/31/2025

TSOA program start date for 14-443 = the date PE screening was completed and locked (8/19/24)

Example 2: Susy Que was determined to meet TSOA PE criteria on August 19, 2024. Her NFLOC confirmation decision was completed on August 21, 2024 and indicated that she did not meet NFLOC criteria. Susy Que's PE period ends August 21, 2024 and she is no longer eligible to receive services under PE. Had Susy received any paid services between August 19th and 21st, the AAA staff would also need to create the NOPE RAC (start date 8/19/24 and end date 8/21/24) to mirror the closed PE RAC. This will move the service expenditures out of the TSOA funding bucket into the NOPE funding bucket. The PE RAC start and end dates should match the NOPE RAC start and end dates.

PE RAC start date = the date PE was determined (8/19/24)

PE RAC end date = 8/21/24

TSOA program start date for 14-443 = the date PE was determined (8/19/24)

TSOA program end date for 14-443 = the date NFLOC confirmation results (8/21/24)

NOPE RAC start date = 8/19/24 (only use this RAC if care receiver received TSOA services)

NOPE RAC end date = 8/21/24 (only use this RAC if care receiver received TSOA services)

Completed
means
"Locked" in
GetCare and
"Finalized" in
CARE

Example 3: Susy Que was determined to meet TSOA PE criteria on August 19th and the NFLOC confirmation was made that day. She did not submit her TSOA application before September 30, 2024, the last day of the month following the month her initial services under PE were authorized. Her PE period ends September 30th and she cannot receive TSOA services until she submits a TSOA application and a financial eligibility decision is made by the HCS financial worker. In this case, Susy may decide to receive FCSP services until her financial eligibility for TSOA is completed. However, FCSP services are limited and expenditure levels vary, therefore FCSP may have waitlists depending upon the budget at the local AAA.

PE RAC start date = the date PE was determined (8/19/24)

PE RAC end date = 9/30/24

TSOA program start date for 14-443 = the date PE was determined (8/19/24)

TSOA program end date for 14-443 = 9/30/24

Dyads and TSOA individuals may only receive services under PE once every twenty-four months. For instance, in example 2 above, Susy would not be eligible to apply for PE and receive MAC or TSOA services under PE for two years (October 2024). She would be able to request and receive MAC or TSOA services prior to October 2024, but would need to wait until her full eligibility (both financial and functional) had been determined prior to services being authorized.

Completing the PE Screening

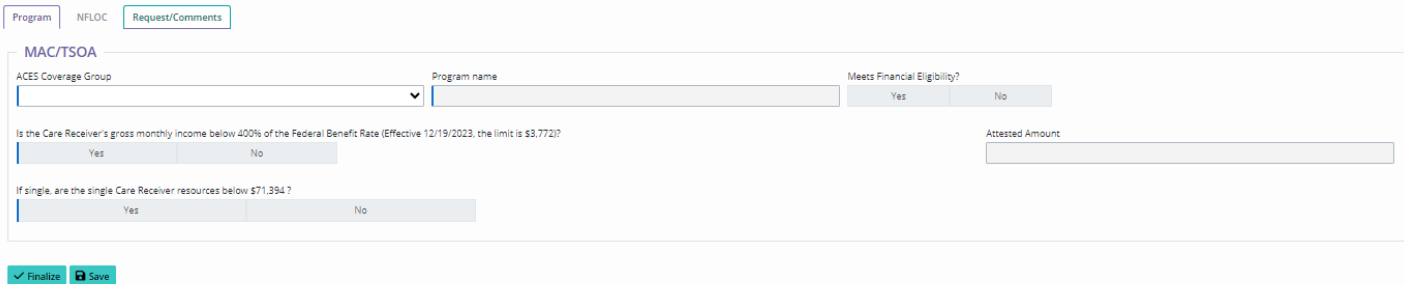
The Presumptive Eligibility screening tool has been built into CARE and GetCare to allow both HCS and AAA workers to complete the screening. This allows a MAC or TSOA applicant to enter either “door” to begin the intake process and access services in the most efficient manner.

CARE, the tool used by HCS, has a MTP node that includes the PE screening functionality. Below are screen shots of the financial and functional sections in CARE.

The financial eligibility component of the PE screening includes two main elements: income and resources. For TSOA applicants we use the care receiver’s self-attested gross monthly income. For calculating the amount of resources for a care receiver we must consider their marital status. If the care receiver is married, we must use the self-attested amount of resources for both the care receiver and their spouse.

If a married couple are both applying for services, each TSOA applicants self-attested gross monthly income would be used. Example: Married Couple Care Receiver #1 has a self-attested gross monthly income of \$2,000 a month and Married Couple Care Receiver #2 has an self-attested gross monthly income of \$6,000 a month. Married Couple Care Receiver #1 would be within the income limits and would be PE eligible but Married Couple Care Receiver #2 would show to be over income for the program and would be PE ineligible. For resource amounts, if married, we must use the self-attested amount of resources for both the care receiver and their spouse (regardless if both are applying for services or only one individual in the couple is applying).

Financial PE questions in CARE:



The screenshot shows the 'Request/Comments' tab in the CARE system. The 'MAC/TSOA' section is active. It contains the following fields and questions:

- ACES Coverage Group:** A dropdown menu.
- Program name:** A text input field.
- Meets Financial Eligibility?:** Radio buttons for 'Yes' and 'No'.
- Is the Care Receiver's gross monthly income below 400% of the Federal Benefit Rate (Effective 12/19/2023, the limit is \$3,772)?** Radio buttons for 'Yes' and 'No'.
- Attested Amount:** A text input field.
- If single, are the single Care Receiver resources below \$71,394?** Radio buttons for 'Yes' and 'No'.

At the bottom, there are two buttons: 'Finalize' (with a checkmark icon) and 'Save' (with a floppy disk icon).

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Functional eligibility questions in CARE:

Program | NFLOC | Request/Comments

Details

NFLOC Respondent

First Name MI Last Name

Does the care receiver need daily care provided or supervised by a registered nurse or a licensed practical nurse?

Yes No

In the last seven days, did the care receiver have a cognitive impairment and require supervision due to one(1) or more of the following?

+ Click + to add items.

In last seven days, what level of assistance was provided and what support was provided to the care receiver with the following activities of daily living?

ADL	Level of Assistance	Supported By
Ambulating		
Bathing		
Bed Mobility		
Eating		
Medication Management		No items available.
Toileting		
Transferring		
Turning & Repositioning		No items available.

Vaccination Discussion & Comments in CARE:

Program | NFLOC | Request/Comments

Vaccine Questions

Has the care receiver received a Pneumonia vaccine?

Yes No Unknown

Did the care receiver receive yearly dose of flu vaccine during most recent flu season?

Yes No Unknown

Has the care receiver received a COVID-19 vaccine?

Yes No Unknown

Office & Comments

Receiving AAA office

Complete the Voter Assistance form

Voter Assistance

Requested service(s) and Provider(s) Comments

Finalize Save

Training materials related to completing PE screening in CARE can be found in CARE Web - CARE Web Help – Presumptive Eligibility.

GetCare, the tool used by AAAs, includes the PE screening in the Assessments section. The screen shots of the financial and functional sections of the PE Assessment in GetCare are as follows:

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Financial eligibility questions in GetCare:

Program

WA State Resident? Name of person who answered NFLOC questions: First name MI Last name

Program:

☐ MAC ACES coverage group: ACES ID:

OR

☐ TSOA ACES coverage group: ACES ID:

If no ACES coverage group, then:

Is the Care Receiver's gross monthly income below 400% of the Federal Benefit Rate (Effective 1/1/2024, the limit is \$3,772)?

Attested Amount:

AND

Are the Single Care Receiver's resources below \$71,394?

OR

Are the Married Care Receiver's joint resources below \$71,394 + \$68,301? (Effective 1/1/2024, Joint Resources limit is \$139,695)

Functional eligibility questions in GetCare:

NFLOC Pre-screening

1. Does the care receiver need daily care provided or supervised by a registered nurse or licensed practical nurse?

2. In the last 7 days, did the care receiver have a cognitive impairment and require supervision due to one (1) or more of the following?

☐ Disorientation ☐ Memory impairment ☐ Impaired decision-making ☐ Wandering ☐ None apply

3. In the last seven days, what level of assistance was needed and what support was provided to the care receiver with the following activities of daily living?

	Level of Assistance	Support Provided
Medication management *		
Transferring		
Ambulating		
Eating		
Toileting		
Bathing		
Bed mobility		
Turning & repositioning		

*Note: Medication Management does not have a look back period. Assistance did not have to occur in the last seven days.

Vaccination Discussion & Comments in GetCare:

Has the care receiver received a pneumonia vaccine?

Did the care receiver receive yearly dose of flu vaccine during most recent flu season?

Did the care receiver receive a COVID-19 vaccine this year?

AAA Requested service(s) and provider(s)/Comments

HCS Requested service(s) and provider(s)/Comments

Training materials related to:

- Completing a PE assessment in GetCare can be found [here](#) on the MTP Community WorkSpace
- ACES coverage groups and the related financial (ACES) RACs can be found [here](#) on the MTP Community WorkSpace
- A video, [Introduction to Recipient Aid Categories](#), to help with understanding RACs can be found on the MTP Community WorkSpace.

CARE and GetCare had existing terminology before the two systems were connected for MTP. The below is a cross walk of some of the language which can be used to aid in communication between HCS and AAAs:

NFLOC – Level of Assistance Crosswalk	
CARE	GetCare
Independent	Independent
<u>Supervision</u>	<u>Minimum</u>
<u>Limited</u>	<u>Moderate</u>
<u>Extensive</u>	<u>Maximum (Both Extensive and Total in CARE =Maximum in GetCare)</u>
Total	Maximum (Both Extensive and Total in CARE =Maximum in GetCare)
Did not occur/No Provider	Did not occur/No Provider
Did not occur/Client not able	Did not occur/Client not able
Did not occur/Client declined	Did not occur/Client declined
Independent (CARE does not have the GetCare value of “Declined to State”. It is not part of the NFLOC eligibility criteria. If “Declined to State” is selected in GetCare, CARE will display “Independent”	Declined to State (This GetCare value does not count in NFLOC eligibility)

For more detailed information about RACs see the [RAC section](#) of this chapter.

NFLOC Confirmation

HCS MTP workers must confirm all initial NFLOC eligibility decisions (whether the care receiver is found eligible or ineligible). AAA workers complete all annual NFLOC reassessments. HCS does not need to confirm annual NFLOC decisions.

Confirmation of NFLOC will be completed using the following processes:

AAA Intake:

When completing the PE assessment in GetCare, in order to facilitate WHO protocols, the AAA worker will:

- describe in the comment box the type of *daily* care provided or supervised by a RN or LPN if the answer to NFLOC question #1 is “Yes”;
- describe in the comment box the cognitive impairment that caused the need for supervision, if the answer to NFLOC question #2 is something other than “None Apply”; and
- add any additional information in the comment box that may be useful for the HCS worker confirming NFLOC eligibility.

To complete the NFLOC confirmation, the HCS worker will review:

- any comments submitted with the PE screening completed by the AAA worker;
- the level of assistance and support provided coding to ensure the coding looks accurate based upon the definitions of the coding; and
- contact the AAA worker who completed the PE screening when clarification is needed on the comments submitted or the coding selected by the AAA worker.

HCS will avoid contacting the care receiver or NFLOC respondent to ask the NFLOC questions again, if at all possible.

HCS Intake:

When completing the PE screening in CARE, the HCS worker will:

- describe in the comment box the type of daily care provided or supervised by a RN or LPN if the answer to NFLOC question #1 is “Yes”;
- describe in the comment box the cognitive impairment that caused the need for supervision if the answer to NFLOC question #2 is something other than “None Apply”; and
- add any additional information (including an unpaid family caregiver if identified in the screening process) in the comment box that may be useful for the AAA worker to know.

When the PE screening completed in CARE is sent to GetCare, the NFLOC decision is considered confirmed and will be reflected as such in both CARE and GetCare.

When the PE screening is completed in CARE, the AAA worker will:

- review the comments submitted by the HCS worker who confirmed NFLOC eligibility and seek clarification as needed;
- if the care receiver does not meet NFLOC eligibility, proceed with the program denial process; and
- if the care receiver does meet NFLOC eligibility, proceed with sending the PE program approval notice, completing screening and assessments, care plans and creating the enrollment(s) and service authorization(s).

Additional information:

The AAA and HCS worker may decide to complete the PE screening via a 3-way conference call or have additional ways to communicate information related to the PE screening. Please add this to your area’s Warm Hand-Off Protocol if using this approach.

PE Notices

The following templates for the required PE notices are in GetCare and are accessible by clicking the “Write Client” button which is visible after opening the identification ribbon of the care receiver’s file section. The care receiver’s specific details can be added into the templates, printed and mailed to the care receiver and unpaid caregiver, if there is one. GetCare will also send the completed notice to Barcode to be entered into the care receiver’s Electronic Case Record (ECR). All PE notices will be generated by AAAs in GetCare even for those that begin as HCS intakes.

NOTICE TYPE	PURPOSE	# of TRANSLATED LANGUAGES
MAC PE Approval	To provide notification to care receiver that PE has been approved	8
TSOA PE Approval	To provide notification to care receiver that PE has been approved	8
MAC PE Denial	To provide notification to care receiver that PE has been denied	8
TSOA PE Denial	To provide notification to care receiver that PE has been denied	8

The top eight languages available besides English are:

- Spanish
- Korean
- Somali
- Russian
- Laotian
- Cambodian
- Chinese
- Vietnamese

The translated version of the PE approval or denial document must be stored in the care receiver’s GetCare electronic file cabinet (ECF).

FINANCIAL ELIGIBILITY

As noted previously, HCS financial workers otherwise known as Public Benefit Specialists (PBS), determine full financial eligibility for TSOA care receivers based upon information submitted on the financial application ([18-005](#)– Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Supports). The HCS PBS workers also manage MAC care receivers who are not receiving this service under a MAGI coverage group (N-track). If the MAC care receiver is receiving their CN – ABP Medical through the N-track then those cases are managed by the Health Care Authority (HCA). HCS and HCA financial workers are also responsible for completing the financial eligibility review (ER) each year.

Applications can be completed electronically through Washington Connection web portal (www.washingtonconnection.org) or by using the paper form [18-005](#). Paper applications can be submitted to:

- a local Home and Community Services (HCS) office visit dshs.wa.gov/office-locations
- faxed to 855-635-8305
- mailed to PO Box 45826, Olympia WA 98504-5826.

Intake workers at HCS or AAA offices may also assist the client with submitting their application.

Documents Needed by Financial Workers

Financial workers will need to gather information from the care receiver in order to determine their financial eligibility. The table below identifies the types of documents that may be requested:

Verification Needed	Examples of what may be used
NAME, AGE, CITIZENSHIP, ID	Birth certificate Driver's license Immigration documents Passport Adoption papers Military papers Divorce decree
SOCIAL SECURITY NUMBER	Social Security card or application receipt Tax statement Pay stubs
INCOME SOURCES	Pay stubs* Tax returns Self-employment records Letter from employer Proof of unemployment Social Security* SSI
RESOURCES & OTHER ASSETS	Bank/credit union statements (for the month the TSOA application was received)* Note: if TSOA was requested on the LTC application 18-005 then bank statements may be requested for additional months Passbooks Life and burial insurance policies Stocks, bonds, annuities, notes, trust*
VEHICLES (CARS, BOATS, RV's, ETC.)	Title Registration Sales contracts
LAND, BUILDINGS, PROPERTY	Deed Tax statements Sales contracts
OTHER IMPORTANT INFORMATION	Financial Power of Attorney Legal Guardian Include the following for both: • Phone numbers • Addresses

*most commonly used document to verify financial eligibility

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An [ACES Coverage Group Guide](#) that identifies the most common eligibility groups for MAC and TSOA can be found in the financial tile on the MTP Community Workspace. Below is a screen shot of the summary page of this document.

ELIGIBLE FOR MAC - NOT ELIGIBLE FOR TSOA			
Most common ACES coverage group	Description		Scope
N05	Adult 19-65 Medicaid Expansion coverage (ABP)		ABP
S01	A person who receives an SSI cash payment and medicaid		CN
S02	A person who does NOT get an SSI cash payment but is eligible for medicaid due to low income.		CN
Eligible for MAC - not common	Description		Scope
N01	MAGI Parent/Caretaker		CN
N02	MAGI Parent/Caretaker on 12 months transitional coverage		CN
S08	Healthcare for Workers with Disabilities (under 65 and working)		CN
S30	Breast & Cervical Cancer recipient (women only)		CN
L32	Hospice SSI-related recipient		CN
ELIGIBLE FOR TSOA - NOT ELIGIBLE FOR MAC			
TSOA coverage group	Description		Scope
T02	Tailored Supports for Older Adults		N/A
Most common ACES coverage group	Description		Scope
S95/S99	Medically needy (with spenddown)		MN
S03	QMB - Qualified Medicare Beneficiary		MSP
S04	QD/WI - Qualified Disabled Working Individual		MSP
S05	SLMB - Specified Low-Income Medicare Beneficiary		MSP
Eligible for TSOA - unlikely	Description		Scope
P05	Family planning		FPSO
P06	Take charge family planning		FPSO
NOT ELIGIBLE FOR MAC OR TSOA (ONGOING) - NON CITIZENS			
ACES coverage group	Description		Scope
A01	Blind/disabled or 65+ non-citizen		MCS
A05	Temporary incapacity - non-citizen		MCS
L24	State-funded LTSS program		SFCN
N21	AEM - MAGI parent/caretaker - Emergency Related Services		ERSO
N25	AEM - MAGI new adult - Emergency Related Services Only		ERSO
S07	AEM - Alien Emergency Medical - Emergency Related Service		ERSO
LTSS IN-HOME COVERAGE GROUPS - USE CAUTION!			
ACES coverage group	Description	Participation?	Scope
L21	HCS waiver recipient with SSI cash and Apple Health	No	CN
L31	PACE recipient with SSI cash and Apple Health	No	CN
L41	Roads to Community Living recipient with SSI cash and Apple	No	CN
L51	Community First Choice recipient on SSI cash and Apple Health	No	CN
L22	HCS waiver - low income Apple Health, without SSI cash	Yes*	CN
L32	PACE recipients, on Apple Health, without SSI cash	Yes*	CN
L42	Roads to Community Living recipient on Apple Health, without	Yes*	CN
L52	Community First Choice recipient on Apple Health, without SSI	No	CN

* These groups usually pay towards cost of care but not always. Check ACES

Changes and reporting requirements for TSOA and MAC

Reporting requirements are different for each program.

TSOA recipients only report minimal changes per WAC 182-513-1650 (2):

- (a) A change in residential or mailing address, including if the TSOA recipient moves out-of-state;
- (b) When a person admits to an institution, as defined in WAC 182-500-0050, and is likely to reside there for thirty days or longer; or
- (c) The person dies.

The only change for TSOA that must be reported within 30 days of the date of the change, is admitting into an institution (b).

Once a person is determined eligible for TSOA, they remain continuously eligible throughout the 12-month certification unless one of the following changes happens:

- The person no longer meets NFLOC;
- The person is no longer a WA state resident;
- The person moves into an institution (nursing facility);
- The person becomes eligible for CN or ABP Medicaid; or
- The person passes away.

More information can be found at: [TSOA certification periods, change of circumstances, and renewals | Washington State Health Care Authority](#)

MAC recipient must report changes within 30 days per the program they are receiving care under. MAC authorized under S-track and N-track have different reporting requirements.

If the care receiver is N-track, age 19-64 and not eligible for Medicare, they report changes to the Health Care Authority based on N-track MAGI rules:

- Income over the limit for their household size and expected to last over 30 days
- Address change
- Citizenship/Immigration Status change
- Change in Marital Status
- Moved out of state
- No asset test for N-track, no need to report resource changes if on N05, for example.

If the MAC recipient is receiving services under S-track, Example S02, they would report all changes mentioned above, including resources, within 30 days to Department of Social and Health Services - HCS.

More information can be found in the Washington Apple Health Manual at:
[Changes of circumstances reporting requirement | Washington State Health Care Authority](#)

Eligibility When in Hospital, Jail or Rehabilitation Facility

When a MAC or TSOA care receiver is in the hospital, jail or a rehabilitation facility for less than thirty (30) days, their financial eligibility is not impacted.

However, for TSOA recipients, if their stay in any of these locations is thirty (30) days or more, based on [WAC 182-513-1650](#), the care receiver would no longer be financially eligible. The PBS worker would close the TSOA T02 coverage group. T02 can be reopened when the care receiver discharges home if the care receiver is not active on CN or ABP Medicaid and the T02 is still within the original certification period. If a CN or ABP Medicaid coverage is opened by the PBS, this typically is scheduled to end at the end of the month. The T02/3199 financial RAC cannot be screened in by the PBS until after the CN or ABP Medicaid is closed. If outside the original certification period, a new application would need to be submitted. However, if they were receiving Medicaid services while in a nursing facility, they wouldn't need to complete a new application as the financial worker would be able to do a program change in ACES.

MAC care receivers in a hospital, jail, or rehabilitation facility for thirty (30) days or more, depending on the Categorically Needy (CN) or Alternative Benefit Plan (ABP) Medicaid coverage group (Apple Health) they are enrolled with, will have different actions taken by PBS staff. It is important to check the care receiver's coverage in ACES or Barcode, prior to re-establishing services when the care receiver returns to their home and community-based setting.

Eligibility When Temporarily Out of the Country or Requesting to Put Paid Services on Hold temporarily

If the care receiver is temporarily out of the country or has requested to put their paid services on hold, but their intent is to return and re-engage in services, TSOA can stay open in ACES within their annual financial eligibility period. The intent to return is key. It is important to check the care receiver's financial coverage in ACES prior to re-establishing services to ensure financial RACs remain opened and unchanged.

When is a New Application Required

As care receiver and unpaid family caregiver's situations change; transitions in both functional and financial programs may occur. The below are some scenarios on when a new LTSS 18-005 application would not be needed:

- If the care receiver has transitioned to LTSS and would like to return to TSOA they wouldn't need another application. The PBS would complete a program change.
- If the TSOA coverage group has not been closed yet by the PBS, we wouldn't need a new application. Example: it's been 30 days, but the PBS hasn't been able to go in and close the program yet, or the PBS wasn't aware of the situation which resulted in the closure (example: 30+ days in an institutional status).
- Care receiver is active on a classic Medicaid program (S02, S95, S99) PBS could complete a program change, and no application would be required.

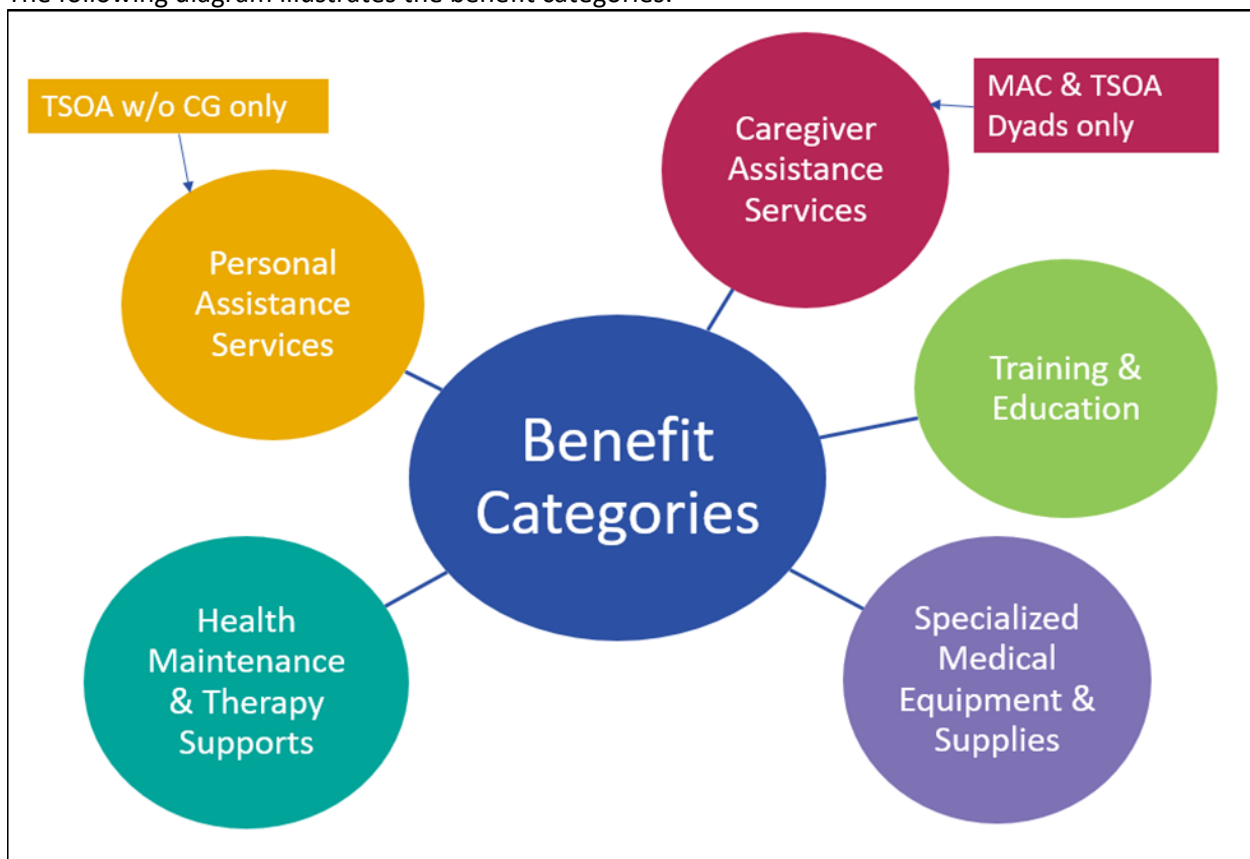
After the ACES Coverage group is closed, the PBS worker could use equal access (EA) rules to reinstate a care receiver within thirty (30) calendar days from when coverage ended, if the PBS is provided proof the care receiver is still qualified. An application or ER would only be needed if they are currently in an annual eligibility review month.

BENEFIT CATEGORIES, SERVICES AND STEPS

For MAC and TSOA programs there are five benefit categories and within each category are a selection of available services.

Benefit Categories

The following diagram illustrates the benefit categories:



- Personal Assistance Services (the orange circle) are available only for TSOA individuals who do not have an unpaid family caregiver.
- Caregiver Assistance Services (the red circle) are available for only MAC and TSOA dyads.
- Services within Training & Education, Specialized Medical Equipment & Supplies, and Health Maintenance & Therapy Supports are available for MAC and TSOA dyads and TSOA individuals.

Services

Network adequacy, mandatory for MAC and TSOA, requires that specific services be available in at least one location within each AAA planning and service area (PSA). The following contains a list of the types of services within each benefit category for MAC and TSOA. **Bolded** items in italics represent the categories used in the Centers for Medicare and Medicaid Services (CMS) Special Terms and Conditions (STCs) for MTP. Underlined subcategories and bulleted service details represent the language used in Family Caregiver Support, CLC- GetCare, and TCARE®. A purple * denotes services that may be received by a unpaid family caregiver and a care receiver. Additional services may be added to this list into the future.

Caregiver Assistance Services

Services that take the place of those typically performed by the unpaid caregiver in support of unmet needs the care receiver has for assistance with activities of daily living (ADLs) and instrumental (IADLs).

Respite

- Adult Day Care (where available)
- Adult Day Health (where available)
- Memory Care and Wellness Services
- Overnight Facility-Based Respite
- Overnight In-home Respite
- In-Home
- Nurse Delegation, in conjunction with respite care

Caregiver Assistance Services are not available to TSOA individuals without an unpaid caregiver – see Personal Assistance

Supplemental Services

- Transportation
- Home Safety Evaluation
- Housework and Errands in the Care Receivers Home*
- Yardwork
- Snow Removal
- Home Delivered Meals (HDM)*
 - Maximum limit of 2 meals per day (3rd meal can be requested via local ETR)
 - Meals may be provided for both the caregiver and the care receiver (up to 2 per day for each participant)

Note: Unlike someone receiving HDM via traditional LTC, such as COPES, a care receiver or caregiver does not have to be homebound. The cost of the meals must be deducted from the care receivers step level benefit amount (no additional hourly deductions of personal care hours are needed).

- Bath Aide
- Home Modifications and Repairs
- Specialized Deep Cleaning
- Pest Eradication

- Community Choice Guiding Service

Training & Education

Services and supports to assist caregivers with gaining skills and knowledge to implement services and supports needed by the care receiver to remain at home or skills needed by the caregiver to remain in their role. Also available for TSOA individual care receivers as applicable.

Support Groups

- Online Support Group*
- Support Group*

Training/Consultation (Group Training; Health and Wellness Consultation; Consultation on Supported Decision Making; Financial or Legal Consultation)

- Occupational Therapist Consultation*
- Physical Therapy Consultation*
- Dementia Consultation/Training*
- Long Term Care Planning*
- Legal Services*
- Caregiver Conference
- Caregiver Consultation
- Family Caregiver Training/Education
- Powerful Tools for Caregivers
- Dietician Consultation*
- Chronic Disease Self-Management Program*
- Fall Prevention Workshop*
- Medication Management*
- STAR-C
- RDAD (Reducing Disease in Alzheimer's Disease)

Each AAA must have at least one service that provides:

1. Coping/skill building, and
2. Training to meet the needs of the care receiver)

Specialized Medical Equipment & Supplies

Goods and supplies needed by the care receiver.

Supplemental Services

- Personal Emergency Response Systems (PERS)
 - PERS is a monthly service with optional add-on services such as medication reminder, falls detection, or GPS locator.
- Assistive/Adaptive Equipment
- Durable Medical Equipment (DME)
 - Requires a health care provider's order/prescription in order for DME provider to claim for payment
- Care Supplies (such as incontinence supplies)

Note: Bedrail policy in [Chapter 3](#) should be followed if a bed rail has been determined as a need in the person-centered care plan.

Health Maintenance & Therapy Supports

Clinical or therapeutic services that assist the care receiver to remain in their home or the caregiver to remain in their caregiving role and provide high quality care. Services are provided for the purpose of preventing further deterioration, improving or maintaining current level of functioning. Supports and services categorized here include those typically performed or provided by people with specialized skill, certification or licenses. Also available for TSOA individual care receivers as applicable.

Counseling*

- Must be short-term and solution oriented

Supplemental Services

- Adult Day Health (where available)
- Health promotion wellness service. This health promotion wellness service may be offered under Training/Consultation for example, Powerful Tools for Caregivers or Chronic Disease Self-Management Education (CDSME)
- Wellness Programs and Activities*
- Health promotion and wellness services such as Acupuncture* and Massage*
- RDAD (Reducing Disability in Alzheimer's Disease)
- Evidence-Based Exercise Programs*

Personal Assistance Services

Supports involving the labor of another person to help TSOA individual participants carry out everyday activities they are unable to perform independently. Services may be provided in the person's home or to access community resources.

- Personal Care
- Nurse Delegation, in conjunction with personal care
- Housework and Errands
- Yardwork
- Snow Removal
- Pest Eradication
- Specialized Deep Cleaning
- Community Choice Guide Services
- Adult Day Care
- Transportation
- Home Delivered Meals
 - Maximum limit of 2 meals per day (3rd meal can be requested via local ETR)

Note: Unlike someone receiving HDM via traditional LTC, such as COPES, a care receiver does not have to be homebound. The cost of the meals are to

be deducted from the care receivers step level benefit amount (no additional hourly deductions of personal care services should occur).

- Home Safety Evaluation
- Home Modifications and Repairs

Some of the services available through the MAC and TSOA programs are defined in WAC:

Adult Day Care: WAC [388-106-0800 through WAC 388-106-0805](#)

Adult Day Health: [WAC 388-106-1810 through WAC 388-106-1815](#)

Nurse Delegation: [WAC 246-840-910 to 960](#)

Personal Care Services: [WAC 388-106-0010](#)

CMS requires in federal policy that Medicaid is the payer of last resort. Below is the general funding hierarchy used for HCLA programs and services beginning with first payer:

- Private insurance
- Personal resources
- Medicare
- Medicaid
- Waiver funded programs (such as CFC, COPES, MAC, TSOA)
- State funded programs (such as Washington Roads)

Steps

Once a care receiver has been determined to be eligible, either presumptively or fully confirmed, services are provided at one of three different steps. The chart below lays out the steps and criteria for accessing services at each step. AAAs are responsible for tracking care receiver expenditures to prevent over-expenditures at any step.

Program	Step 1 Based on demographics & program eligibility; may receive under PE	Step 2 Based on demographics, program eligibility, & results of a TCARE® or GetCare Screening; may receive under PE	Step 3 Based on demographics, program eligibility, & results of a TCARE® or GetCare Assessment; may receive under PE
MAC/TSOA Dyads	\$250 one-time only	\$500 annually minus any expenditures at Step 1	Avg. \$844 monthly not to exceed \$5,064 in a six- month period*
TSOA Individual w/o CG	\$250 one-time only	\$500 annually minus any expenditures at Step 1	Avg. \$844 monthly not to exceed \$5,064 in a six- month period*

*as of 7/1/2024. The Step 3 benefit level formula uses the home care agency hourly rate in its calculation. Therefore, the Step 3 benefit level will change according to the rate determined by the rate setting board. Please see the “MAC-TSOA” tab on the [HCS Rates website](#) for the most current step 3 benefit level.

As is the policy for Family Caregiver Support Program, if someone had an initial risk score qualifying them for Step 3 benefit level and the next screening showed a lower risk score, we would not move

them "down" to Step 2 benefit level. The lower risk score may be an indication that the Step 3 services are benefiting the participant.

A caregiver may provide services to multiple care receivers (such as an adult daughter caring for both her mother and her father). Each care receiver has a benefit level that can be used to support their caregiver. However, the case worker needs to ensure that the funds for each care receiver is not duplicating services for their shared caregiver.

A care receiver may have more than one caregiver (such as a father that has two adult children sharing the caregiving tasks). However, the care receiver has only one benefit level that must be shared in order to provide the supports to both caregivers.

SCREENINGS AND ASSESSMENTS

Screenings and assessments for MAC and TSOA are completed in the CLC/ GetCare or the TCARE® system. Screenings must be completed at least every six months or more frequently if there is a change in the caregiver's or care receiver's condition.

- Example: Screening is completed January 15th. Next screening is due by July 31st.

If the six-month rescreen does not result in a change in the risk scores, then a six-month assessment is not required. However, both GetCare and TCARE® assessments must be completed at least annually or more frequently if there is a change in the caregiver's or care receiver's condition.

- Example: Assessment is completed January 15th. Annual assessment is due by January 31st the following year.

Assessments and Screenings may be completed outside of the care receiver's residence. For example, the assessment for the TSOA individual can be completed in the hospital or rehabilitation facility in preparation for discharge home. A benefit of doing so is facility staff may be present during the assessment to provide their feedback about the current support needs for the care receiver. Another benefit of doing the assessment and screening in an alternative setting is getting care planning started prior to discharging to expediate service delivery.

The TSOA individual care plan can be created with the services that are intended for the care receivers' home and community-based setting. Consent can be given by the care receiver and the care plan can be created while the care receiver is still in the facility. The start date of the care plan should be the discharge date or later (e.g., should not be a date when the care receiver is still in the facility). The important item to remember (CMS rule) is that the service enrollment/authorization must have a "from" date that is equal to or later than the discharge date. A face-to-face visit should occur after the care receivers discharge to view the living environment of the care receiver. The face-to-face visit does not need to occur prior to care plan creation and authorization of services but must be completed during the annual care plan period, best practice being within 30 days of discharge.

For dyads, the TCARE® assessment with the unpaid family caregiver may be completed when the care receiver is in the facility and preparing for discharge. In this situation, it may also be useful to have a

facility staff provide feedback about the current support needs for the care receivers ADLs. For dyads, the care plan can also be completed with the unpaid family caregiver while the care receiver is still in the facility. The unpaid family caregiver would need to respond and select services based upon what supports the unpaid family caregiver will need once the care receiver returns home. Consent can be given by the caregiver and care receiver and the care plan can be started while the care receiver is still in the facility. One face-to-face visit during the TCARE® assessment or consultation process is required before services can be authorized during the initial assessment/consultation process as well as during subsequent annual TCARE® reassessments/consultations. If the caregiver and care receiver live together, at least one home visit must occur in the home with both caregiver and care receiver present. This home visit allows the assessor to evaluate the living situation and must be completed before the care plan is created. When caregiver and care receiver don't live together, a home visit in the care receiver's home is strongly encouraged, though not required. Again, we still need to follow the CMS rule ensuring that the service enrollment/authorization must have a "from" date that is equal to or later than the discharge date.

GetCare

GetCare is the primary case management information system for MAC and TSOA. This system contains many elements necessary for implementing the MAC and TSOA programs including but not limited to:

- Demographic information for caregivers and care receivers
- Screening tool and assessment for TSOA individual without a caregiver
- Presumptive Eligibility assessment
- Annual NFLOC assessment

The GetCare Screening (TSOA without a CG Screening) is a process that gathers information about the individual without a caregiver in order to determine risk scores. The information gathered includes functional needs, fall risk, availability of informal support, memory and decision-making issues, and emotional well-being. The risk scores from the screening are used to determine if the individual will be referred for a TSOA without a CG Assessment.

The TSOA without a CG Assessment is a process that gathers information about an individual without a caregiver in the following areas: functional needs (All ADL's should utilize a 7-day look back period. All IADL's – essential shopping, housework, meal preparation, and medical transformation should use a 30 - day look back period. Medication management would be selecting the highest level of need (no 7 days look back period), diagnoses and conditions, behavioral health supports, oral health, and nutritional health needs. The assessment will assist the individual with choosing the Step 3 services that will address their assessed needs.

For TSOA without a caregiver care receivers, the TSOA Individual without a Caregiver Assessment may be completed remotely although best practice is to complete a face-to-face assessment. Assessments must be completed at least annually in a location convenient to the care receiver. One face-to-face visit must occur at least annually to view the living environment of the care receiver. The face-to-face visit does not need to occur prior to care plan creation but must be completed during the annual plan period.

TCARE®

The TCARE® process is based on the premise that providing the right service at the right time supports those unpaid family caregivers who are burdened by their caregiving responsibilities. TCARE® includes screening, assessment, consultation, and service planning elements that are designed to be utilized with the Family Caregiver Support Program (FSCP), Medicaid Alternative Care (MAC), and Tailored Supports for Older Adults (TSOA) programs which are administered through the Area Agencies on Aging (AAA).

The TCARE® process:

- Validates the family caregivers' feelings and experiences along their caregiving journey,
- Stimulates caregivers to reflect on their caregiving responsibilities through relevant and insightful questions,
- Provides structure to the interview between the assessor and the caregiver, and
- Identifies a broad range of support services available through public and private funding that address the specific stressors and burdens of the caregiver

There are several parts to the TCARE® process, two of which are the TCARE® Screening and the TCARE® Assessment. The TCARE® Screening can be conducted in a variety of settings: in person, by telephone, or through a self-screen form called the Personal Caregiver Survey. The scores from the screening determine whether the caregiver should be referred for the third part of the TCARE® protocol which is the TCARE® Assessment. The assessment includes all of the screening questions, as well as additional questions focused on both the caregiver's experience and the care receiver's situation. Some of the major areas covered in the assessment are care receiver behaviors, memory issues, ADLs, IADLs, Cognitive Performance questions and diagnoses/conditions. When the need for an assessment is indicated by the screening, the assessment and care plan must be completed within 30 calendar days of the screening.

For MAC and TSOA dyads, one face-to-face visit during the TCARE® assessment or consultation process is required before services can be authorized during the initial assessment/consultation process as well as during subsequent annual TCARE® reassessments/consultations. If the caregiver and care receiver live together, at least one home visit must occur in the home with both caregiver and care receiver present. This home visit allows the assessor to evaluate the living situation and must be completed before the care plan is created. When caregiver and care receiver don't live together, a home visit in the care receiver's home is strongly encouraged, though not required.

For complete details on the TCARE® process, see [Chapter 17a](#) of the LTC manual.

CARE PLANS AND SERVICE NOTICES

The Centers for Medicare and Medicaid Services (CMS) require that a care plan must be completed prior to authorizing services. Additionally, MAC and TSOA enrollees must receive a formal written notice of the services being authorized.

Step 1, 2, and 3 care plans

Care plans are created in GetCare for MAC & TSOA dyads and TSOA individuals who are receiving Step 1 or Step 2 services. TSOA individuals receiving Step 3 services will also have a GetCare care plan. MAC & TSOA dyads receiving Step 3 services will have a care plan developed in TCARE®.

PROGRAM	STEP 1:	STEP 2:	STEP 3:
MAC or TSOA dyad	Care plan in GetCare	Care plan in GetCare	Care plan in TCARE®
TSOA w/o a caregiver	Care plan in GetCare	Care plan in GetCare	Care plan in GetCare

The care plan includes paid and unpaid services addressing the identified needs of the caregiver and the care receiver. The care receiver must provide consent of the plan before services can be authorized. Verbal consent can be provided initially (and documented in the care plan) with written consent provided within 60 days of completing the plan. For MAC and TSOA dyads, the TCARE® care plan requires both the care receiver and caregiver verbal consent. The caregiver signature is best practice per FCSP policy. Written consent may be provided by secure email or other electronic means for Step 1 and Step 2 services per WAC 388-106-1980(3).

The care plan must be reviewed and updated at least annually. If there are no changes in the services/supports identified in the care plan during the 6-month rescreening process then a new care plan does not need to be created, if the 'Next Expected Care Plan Date' is in the future. The care plan should represent the services each dyad or individual has chosen to address the areas identified in their assessment and discussed during the person-centered conversation.

It is important that the care plan is locked, and verbal consent has been received from the care receiver before any service authorizations are created. There is an option to link service enrollments (linking is optional) in the GetCare care plan as a simple way to identify requested services into the plan or you can create an enrollment directly in the care plan. All paid services must be included in the care plan. Once the care plan is locked it cannot be edited.

For dyads who are receiving Step 3 services, workers will complete the Care Plan using the TCARE® process. If a caregiver has had a significant change or a change in their service needs at 6-month TCARE® screen, and/or requests to have a new assessment, a new assessment must be conducted, and a new care plan must be created that reflects the changing needs of the caregiver.

Unpaid services (services or referrals that do not require payment authorization through ProviderOne) still need to be captured on the care plan. If the care receiver is enrolled in MAC or TSOA and only receiving unpaid services such as a support group, they still need to have a locked care plan.

NOTE: If a service such as respite or personal care will be part of the care plan but you are waiting to find a home care agency with an available provider in order to complete the enrollment, you can add the service and select status of "pending" or you can identify the service in the care plan (i.e. Respite Paid Provider or Personal Care Paid Provider) and then document in the progress notes the search for a

qualified provider is underway. There should be updates on the search, ongoingly documented in progress notes until the provider is found.

There are 4 different types of Care Plans in GetCare:

- Initial – select this for the first care plan created in GetCare
- 6 month – used only if you intend to create a new care plan based upon the 6-month rescreening process and outcome
- Annual – used for on-going care plans that are completed at least every 12 months
- Change in condition – use this option if changes to care plan (such as adding new services) are identified due to change in the care receiver or caregiver's condition outside of the annual care plan process

There are 4 different types of Care Plans in TCARE® as well:

- 6 month – used only if you intend to create a new care plan based upon the 6-month rescreening process and outcome.
- Annual – used for on-going care plans that are completed at least every 12 months.
- Review – rarely used in the care planning process as the other 3 types of care plans typically are used
- Other – use this option if changes to care plan (such as adding new services) are identified due to change in the care receiver or caregiver's condition outside of the annual care plan process.

The auto-populated due date for care plans falls on the last day of the month (6 or 12 months) from the date the care plan 'Type' indicates. For example, on 6/15/24 the care annual plan is created and the 'Expected Next Care Plan Date' is populated with date of 6/30/25. This date can be edited.

For the initial care plan, when moving from Presumptive Eligibility to Full RAC, you do not need to create a new care plan if the 'Expected Next Care Plan Date' is in the future unless there is a change in condition or if you are adding/deleting services in the care plan.

If there are no changes to the care plan during the 6-month re-screening process then a new care plan does not need to be created, if the 'Expected Next Care Plan Date' is in the future. If there is a change in condition of the caregiver or the care receiver resulting in a change to the care plan such as a new service being put in place or a service being removed, then a new assessment must be completed along with a new signed care plan.

Service Notices

The purpose of the MTP Service Notice ([DSHS 15-492](#)) is to provide the care receiver with information about the amount of funding available for accessing goods and services under their specific benefit level (Step 1, 2 or 3). The notice also includes information about their administrative hearing rights if they disagree with the amount of funding approved or denied. Service notices are not required under presumptive eligibility (PE) but must be completed and sent to care

Reminder: Ensure enough time is allowed for translations, when needed. The MTP English and Translated versions should be mailed to the Care Receiver together.

receivers once they move out of PE into full eligibility. The service notice should be sent to the care receiver along with the care plan that needs to be signed.

Service notices must be sent to the care receiver at least (ten) 10 calendar days before the effective date of an adverse action such as denial, reduction, or termination. The service notice needs to describe what action is being taken and under what authority that action is being taken (the specific WAC reference).

A MTP Service Notice (DSHS 15-492) also needs to be sent when the care receiver changes from one step/benefit level to another.

Approved (includes annuals/renewals and changes)	- Initial eligibility decision for full services - Continued eligibility/services when there is no change - A change in services from one step level to another Example: - Client was receiving Step 2 benefits and at the annual is now eligible for Step 3 benefit level.
Withdrawn	- Requests for services that are withdrawn by the client after the assessment was initiated and before services were initiated or authorized. Example: - Client went from PE to Full but never received any authorized services. If client, indicates they would like to withdraw then the action 'withdrawn' can be utilized.
Denied	- Not eligible for requested service/program and services were never initiated or authorized. Example: - Client was found to be eligible for Step 2 but is requesting services only offered under the Step 3 benefit package.
Terminated	- Services/program terminated Example: - Client was found to no longer be eligible for services at the annual NFLOC - Client started services but later requested to withdraw. As services had been provided, terminated would need to be used as the action.

Create a Letter

User Admin

Template
MTP Service Notice

MTP Service Notice

The Following action(s) will go into effect on [] to []

Step	Program	Action	Unit	Amount
[]	[]	[]	[]	[]
[]	[]	[]	[]	[]
[]	[]	[]	[]	[]
[]	[]	[]	[]	[]

WAC: 388-106-19 []

Other: []

Example: Care receiver was found to no longer be financially eligible. TSOA AAA Staff was notified via Barcode that the last day of financial eligibility will be 8/31/2024. MTP Service Notice should be sent out no later than 8/20/2024 (allowing at least 10 days' notice due to an adverse action). The following action date would be 8/31/2024. All RACs and Authorizations would need to be ended and not extend beyond 8/31/2024.

There is an instruction form providing guidance on how to correctly fill out the MTP Service Notice. It can be found on the DSHS forms page at <https://forms.dshs.wa.lcl/formDetails.aspx?ID=38862>.

Translated versions of the Medicaid Transformation Project Service Notice DSHS 15-492 are available on the DSHS forms [page](#). If needing a language, not available on the DSHS forms page, please contact Adrienne Cotton and Resa Lee-Bell. Any translated version of the MTP Service Notice (15-492) document must be stored in the client's GetCare electronic file cabinet.

RACS

Recipient Aid Categories (RACs) identify to the ProviderOne system under which program (MAC, TSOA, or other) the dyad or individual without an unpaid family caregiver is going to receive services either through presumptive eligibility or fully confirmed eligibility. Additionally, ProviderOne has been configured to know which services can be authorized under which RAC. Selecting the correct functional RAC is important so that data extracted from ProviderOne accurately reflects service provision and providers are correctly paid. The functional RAC must match the financial RAC that is sent from ACES to ProviderOne or an error will occur.

The functional RACs, also known as HCLA RACs, indicate what program and related services the dyad or individual is eligible to receive. They are as follows:

**CHAPTER 30b: Long-Term Services & Supports –
Medicaid Alternative Care (MAC) & Tailored Supports
for Older Adults (TSOA)**
Long-Term Care Manual



RAC Title	RAC	RAC Description
Medicaid Alternative Care (MAC)	3170	Care receivers are Medicaid eligible
Medicaid Alternative Care : Presumptive Eligibility (Pre-MAC)	3171	Care receivers have time limited presumptive eligibility both financially and functionally
Tailored Supports for Older Adults (TSOA)	3175	Care receivers meet TSOA financial eligibility which allows for a higher income and resources than Medicaid
Tailored Supports for Older Adults: Presumptive Eligibility (Pre-TSOA)	3176	Care receivers have time limited presumptive eligibility both financially and functionally.
Tailored Supports for Older Adults No Unpaid Caregiver (TSOA-No-CGR)	3177	Care receiver does not have an unpaid caregiver, meets TSOA financial eligibility which allows for a higher income and resources than Medicaid.
Tailored Supports for Older Adults No Unpaid Caregiver: Presumptive Eligibility (Pre-TSOA-NO-CGR)	3178	Care receivers without an unpaid caregiver have time limited presumptive eligibility both financially and functionally.
Not Presumptively Eligible for MAC and TSOA (NOPE)	3190	Used when care receiver was: ○ initially enrolled as presumptively eligible for either MAC or TSOA; ○ received paid services; and ○ was later found to be ineligible. ● Once found ineligible for MAC or TSOA this RAC must be added to mirror the PE RAC dates to reprocess claims into the correct funding bucket in order to comply with federal reporting requirements.
State Only Adjustment of Payment (SOAP)	3490	This RAC should be used minimally and requires HQ pre-approval. This RAC is used only when a payment for services was made in error (the care receiver was not eligible to receive the services) and the payment

		must be made using state-only funds. The claim must be reprocessed by ProviderOne.
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AAA staff must open the MAC/TSOA Service Enrollments section in GetCare and change the care receiver's RACs when they change from presumptive eligibility to fully confirmed eligibility or when adding the NOPE.

Typical RAC Timeframes

TSOA enrollees may or may not have financial eligibility at the time of their Presumptive Eligibility screening. Presumptive Eligibility TSOA RACs will begin on the date of the locked functional PE screening and end on the last day of the following month with one exception – if the care receiver submits a TSOA financial application within the PE period, the care receiver remains presumptively eligible until the HCS financial worker determines full financial eligibility.

MAC and TSOA Presumptive Eligibility (PE) and a locked care plan must be completed prior to any services being authorized.

If the TSOA care receiver did not previously have financial eligibility, the worker must wait to hear from HCS financial worker about their financial eligibility determination before moving the individual from PE to full eligibility. In this case, the full functional eligibility date spans one year from the date that the PE assessment was confirmed by HCS worker and may extend to the end of the month. For example:

- PE assessment NFLOC confirmed 10/29/24.
- Full financial eligibility confirmed 11/17/24.
- Full eligibility RAC start date = 12/01/2024; end date = 10/31/25.
- NFLOC reassessment must be completed WITHIN one year of initial PE or in this case, before 10/31/25.

MAC enrollees must have financial eligibility at the time of their Presumptive Eligibility screening. This means that functional eligibility confirmation is the last step in determining full eligibility for MAC care receivers. Due to this, MAC care receivers often do not have a PE RACs or the MAC PE RACs coverage dates are minimal. Full MAC eligibility will begin on the date functional eligibility is confirmed by HCS and end on the last day of the month one year later. Financial eligibility will be determined on a different cycle therefore Barcode and ACES should be monitored to ensure continued financial eligibility.

Managing RACs, Enrollments and Service Authorizations When Care Receiver is in Hospital, Rehabilitation Facility or Jail

If the care receiver is in the hospital, rehabilitation facility or jail for 30 days or less, you must do the following:

- Leave the functional RAC in place and do not change start or end dates
- Leave the enrollment in place and do not change start or end dates

- Change the end date of the P1 service authorization service line to match the date of admission into the hospital/facility. Notify paid providers and have services put on hold.
- If less than 30 days, The AAA staff should evaluate if there are any changes in the care receiver service needs and if so, complete a change in condition assessment and care plan.
- If the stay becomes longer than 30 days but the intent is still to return home with MAC or TSOA services, The AAA staff would need to complete the NFLOC, updated screening and assessment as well as a change in condition care plan prior to services being re-instated.
- AAA staff must lock the change of condition care plan prior to authorizing additional services.
- Verify care receiver remains active in ACES and Barcode
- Once the care plan is locked, the AAA Staff can create a new P1 service authorization line (no earlier than the date of discharge).

No services can be authorized (including services and supports being provided to the unpaid family caregiver, while the client is hospitalized, in a rehabilitation facility or in jail).

If the care receiver is in the hospital/facility for 30 days or more. The AAA staff would need to check the MAC or TSOA care receivers' financial eligibility coverage and communicate with financial as needed to ensure the appropriate financial RAC is opened prior to re-establishing paid services. The AAA Staff would then need to complete the NFLOC, updated screening and assessment as well as a new care plan prior to services being re-instated.

Managing RACs, Enrollments and Service Authorizations when there will be a temporary pause in services

If the MAC or TSOA care receiver is requesting to temporarily pause services, for 90 days or less (example: will be out of the country but the care receiver's intent is to return and re-engage in services), you must do the following:

- Ensure the duration of the pause will not span over a functional or financial eligibility review due date. If so, proceed with a voluntary disenrollment. Leave the functional RAC in place and do not change start or end dates
- Leave the enrollment in place and do not change start or end dates
- Notify paid providers and then change the end date of the P1 service authorization lines to match the date client is departing or is requesting to pause services
- The AAA staff would need to do the annual NFLOC upon client's return to determine that the care receiver still meets NFLOC. An updated screening, assessment and care plan would also need to be completed.
- Verify care receiver remains active in ACES and Barcode
- Once the care plan is locked. The AAA Staff can create a new P1 service authorization.

If the MAC or TSOA care receiver is requesting to temporarily pause services for 90 days or more, you must do the following:

- Notify care receiver that AAA Staff will be completing a voluntary disenrollment.
- Provide instructions/contact #'s for client to call when wanting/needing services in the future

- Complete closure steps ([See Checklist](#))

If the client would like to re-engage services after being disenrolled, The AAA Staff should start the re-enrollment process similar to a new enrollee. The AAA Staff and HCS MTP staff would need to complete the Presumptive Eligibility (PE) screening. If care receiver is determined NFLOC on the PE. AAA Staff should verify client still is open on the appropriate financial coverage group. If so, CM can proceed with completion of the screening, assessment and care plan. Upon completion of the necessary items per step level ([see Step Chart](#)), services can be re-instated. If the client's financial coverage group was closed, AAA CM should notify PBS and may need to assist with a new application depending on the circumstances (please use [link](#) to determine if a new LTSS app is needed). If the client has received PE services in the last 24 months; no services can be authorized until the full financial determination is made. If the client has not received PE services in the last 24 months; the AAA Staff may enter the appropriate PE RAC and establish services as outlined in the care plan under PE until the full financial determination is made.

AUTHORIZATIONS

Authorizations for MAC and TSOA services will be completed by AAA staff through the GetCare system which interfaces with P1. Authorizations may be completed only after a P1 identification number has been obtained for the MAC or TSOA care receiver and the care plan has been completed and locked.

Prior to authorizing MAC or TSOA services, due to CMS rules, AAA staff must check for service coverage under Medicaid Apple Health, long-term care insurance, or other third parties such as private insurance. If the care receiver has LTC insurance, private insurance, Medicaid, Medicare or other federal/state programs that will cover the services requested under MAC or TSOA, then MAC or TSOA funds should not be authorized for those specific services. MAC or TSOA may be authorized for services that are not duplicative of services available under the other insurance benefit.

Note: Aid and attendant benefits through the Veterans Administration (this does not include Veterans Directed Care services) do not have an impact on the eligibility for MAC and TSOA services. The MAC or TSOA veteran can purchase additional in-home care services with their VA aid and attendant benefits, and it does not change the amount or type of services that can be purchased with MAC or TSOA funding. MTP should be the payor of last resort, by following that policy it prevents duplication and potential "stacking" or supplanting in services covered under private insurance, Medicare, state plan Medicaid, VAMC, or through other federal or state programs. Care receiver's cannot be enrolled in Veterans Directed Care while simultaneously enrolled in the MAC or TSOA programs.

Each authorization in GetCare has several elements: General, Enrollment, and the Authorization section. The General Section is where the Region, Provider, Authorization Number, Program, and details on the services are entered. The Enrollment section outlines the enrolled and disenrolled status of the care receiver. The Authorization section is where services are entered with corresponding service codes rates, business status, and dates.

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A screenshot of the 'Add New Enrollment' form in the GetCare system. The form is divided into three main sections: General, Enrollment, and Authorization. The General section includes fields for Region/Contractor, Provider, Authorization Number, and Scope of Work (TSOA). The Enrollment section shows a table of enrollment history with columns for Status, From, Thru, Reason, Needed Qty, and Unmet Need. The Authorization section includes a table of services with columns for Subservices, Code, Mod, Qty, Entered Unit, Per Period, Rate, Amount, Business Status, Start Date, End Date, and P1 #. The form also has buttons for 'Print', 'Send Service Lines', 'Save', and 'Close'.

Providers being authorized in ProviderOne to deliver MAC and TSOA services must meet certain qualifications and be contracted through the HCLA HQ or the local AAA prior to services being authorized. Each local AAA maintains a list of contracted, eligible providers for HCS and AAA.

As service lines are created in the authorization section, they are assigned a ProviderOne service line number and the ProviderOne systems confirms this is a service which can be covered under the services benefit package of the opened RAC. If a service is entered which is not configured with the appropriate RAC and error will occur.

Service authorizations created in GetCare for environmental modifications, Durable Medical Equipment (DME) and non-medical equipment and supplies should be entered in Reviewing status. Reviewing status allows the service line for these services to be submitted to ProviderOne, but not to be claimed or paid. After confirmation that the service is completed appropriately, the AAA staff can change the status of the authorization to “Approved” which will allow payment to be issued to the provider. A receipt in the GetCare Electronic File Cabinet (EFC) is also necessary.

More information on authorizations can be found in the GetCare MAC/TSOA Desk Manual in the Help Library.

Common Errors

Common errors refers to the process that occurs when ProviderOne does not recognize submitted information and stops the process of creating/modifying an authorization or allowing a claim to be made against an authorization. For MAC and TSOA, these stoppages will most commonly happen when an authorization header or a service line is submitted with information that conflicts with data that ProviderOne has already accepted. When such a stoppage occurs, ProviderOne will automatically

generate an error message letting the user know there is a problem. Each message is assigned a code by ProviderOne based upon the type of error that occurred. Below is a sample of common errors which occur in MAC and TSOA. For a more comprehensive list, please see the Get Care Help Library Common Issues and Error Codes, [MTP Community Workspace](#), or the ProviderOne Social Services Appendix [Common Errors Table](#).

MTP Related Error Codes in GetCare

GetCare users may see ProviderOne errors while working with authorizations for MAC & TSOA services. Here's a list of what the errors mean, what should be done, and by whom to resolve it.

Error	Error Description	Action Needed	By Whom
Address Errors Invalid	The care receiver's address is invalid	Review, correct, and complete steps to update ProviderOne	AAA Staff
AREP (authorized representative) Warnings	The collateral contact or caregiver with the role of "P1 Client Letters" has an invalid address	Review, correct, and complete steps to update ProviderOne	AAA Staff
02255	Client not eligible for date of service	No action needed; will resolve when full eligibility RAC is added	AAA Staff
30988	Financial Eligibility Requirement	Determine if error should be "forced" and if so, refer to HCLA HQ for action*	AAA Staff and HCLA HQ staff
40061	Unexpected error occurred, please contact system administrator (fatal error)	Review service lines to see if unresolved errors exist. If unable to determine source of the error, post error into Issue Manager entitled as "MTP authorization error" for review by AAA supervisor and escalation by local System Admin*	AAA Staff and System Admins / CARE Help Desk
40065	Proc/Svc Code service duration exceeds the maximum allowed duration limit (fatal error)	Review service limits on Service Code Data Sheet (SCDS) and modify, if necessary	AAA Staff

*The local system administrator will review the error with respective AAA staff and, if it is determined there is a valid issue, it will be posted to Issue Manager in GetCare. Escalated errors will be pulled by State System Administrator for review. Issues will be updated as to resolution, or the next steps needed for resolution. Issue Manager tickets once resolved should be closed by either the AAA staff or the system administrator.

More information related to ProviderOne common errors is available on the [DSHS/ProviderOne website](#).

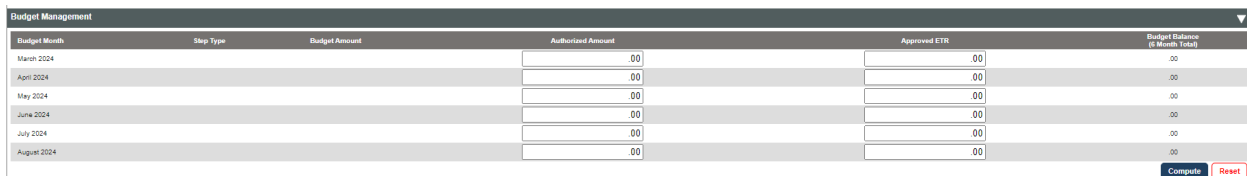
Tracking Benefit Expenditures

AAAs are responsible for tracking client expenditures to prevent over-expenditures based upon the step benefit levels identified in the table below:

Program	Step 1 Based on demographics & program eligibility; services may be received under PE	Step 2 Based on demographics, program eligibility, & results of a TCARE® or GetCare Screening; services may be received under PE	Step 3 Based on demographics, program eligibility, & results of a TCARE® or GetCare Assessment; services may be received under PE
MAC/TSOA Dyads	\$250 one-time only	\$500 annually minus any expenditures at Step 1	Avg. \$844 monthly not to exceed \$5064 in a six-month period*
TSOA Individual w/o CG	\$250 one-time only	\$500 annually minus any expenditures at Step 1	Avg. \$844 monthly not to exceed \$5064 in a six-month period*

*as of 7/1/2024. The Step 3 benefit level formula currently uses the home care agency hourly rate in it's calculation. Therefore, the Step 3 benefit level will change according to the rate determined by the rate setting board. Please see the "MAC-TSOA" tab on the [HCS Rates website](#) for the most current step 3 benefit level.

In the GetCare system, a budget management tool (calculator) is available to AAA staff to assist with managing the 6-month budget. It is located within the MAC/TSOA Service Enrollment section.



Budget Month	Step Type	Budget Amount	Authorized Amount	Approved ETR	Budget Balance (\$ Monthly Total)
March 2024			00	00	00
April 2024			00	00	00
May 2024			00	00	00
June 2024			00	00	00
July 2024			00	00	00
August 2024			00	00	00

The 6-month budget period begins the month the PE assessment or annual NFLOC assessment is locked. Once the Initial or Annual care plan is locked, the 'Step Type', the related 'Budget Amounts' and 'Budget

Balance’ will be automatically populate into the tool. Then as MTP services are authorized those will populate in the ‘Authorized Amount’ and will be subtracted from the ‘Budget Balance’.

Authorizations for the Medicaid Unit Incentive (MUI), Pest Eradication, Specialized Deep Cleaning, and Nurse Delegation are funded by MTP’s statewide aggregate funding and are not reflected in the ‘Authorized Amount’ or ‘Budget Balance’.

Approved ETR amounts will populate into the ‘Approved ETR’ column and will calculate into the ‘Budget Balance’.

PROVIDERS

In order to claim and be paid for services provided under MAC and TSOA programs, all providers, with the exception of Durable Medical Equipment (DME) providers, must have a DSHS signed contract, be registered or contracted in ACD (Agency Contracts Database), and be enrolled as a provider in ProviderOne. DME providers must have a core provider agreement with Health Care Authority (HCA) and be enrolled as a DME provider in ProviderOne.

All MAC and TSOA providers will be paid through the Health Care Authority’s ProviderOne application, the Medicaid payment system.

When a service authorization is created and/or modified and sent to ProviderOne via GetCare, the provider will receive an Authorization Notice generated by ProviderOne. ProviderOne correspondence letters are sent when the following occur:

- A new authorization is created for a client/provider pair.
- An existing authorization service line is changed.
- A service line with a new service code is added.
- Adding or removing dates of service on a service line with an existing service code.
- Change in the amount of authorized units.
- Change in associated tasks.
- Change in the amount of client responsibility applied to the authorization service line.

Mailed ProviderOne correspondence will include the following:

- Names and ID’s of provider and client
- Service Code, Modifier, Reason Code, Correspondence description
- Date ranges
- Number of units
- Dollar amount
- Client responsibility (Not applicable in the MAC and TSOA programs)
- Case worker name and phone number

A copy of the P1 Authorization Notice is also sent to the care receiver and for dyads to the unpaid family caregiver (ensure to select ‘P1 Client letters’ in the caregiver relationship role in GetCare). More information about ProviderOne correspondence can be found in the [Social Services Authorization Manual](#).

Providers need to be added into GetCare with the appropriate ProviderOne number, Location Code and Service Sets. GetCare System Administrators should use Issue Manager in GetCare to request that new providers be entered once the provider has a signed contract in the ACD and been assigned a ProviderOne number.

In an effort in sustaining home care agency providers for MAC and TSOA programs, Community Partners in collaboration with HCLA created the Medicaid Utilization Incentive (MUI) rate (originally referred to as the “MTP Capital Add-On Rate”). The MUI service line should accompany a personal care or respite care service line and can be claimed by a home care agency who has provided at least 15 minutes of personal care or respite care services in that month of service. If two home care agencies are being utilized, both would be eligible for the MUI as long as at least 15 minutes of personal care or respite care was provided, in that month of service, by each home care agency. If only housework and errands is authorized, the provider is not eligible for the MUI.

Documents Sent to Providers

Below is a table illustrating the specific documents that should be sent by the AAA staff to the provider:

Program	Service	Document
MAC and TSOA dyad - Step 1 and 2 - Step 3	Respite	- For step 1 and 2 - NFLOC assessment and care plan - For step 3 - TCARE® Respite Services Provider Assessment. If temporarily receiving out of home respite in an adult family home or assisted living facility you must also send the Respite Care Provider Addendum (DSHS 13-915).
TSOA Individual w/o CG Step 3	Personal Care	GetCare TSOA w/o CG assessment
MAC and TSOA dyad; TSOA individual w/o CG - Step 1 and 2 - Step 3	Adult Day Care Adult Day Health	- For step 1 and 2 – NFLOC assessment and care plan - For step 3 –GetCare TSOA w/o CG assessment or TCARE® Respite Services Provider Assessment
MAC and TSOA dyad - Step 2 and 3 TSOA individual - Step 2 only	Bath aide	- Dyads – send the TCARE® Respite Services Provider Assessment. - TSOA individuals – send the TSOA Individual w/o CG assessment.
MAC and TSOA dyad Step 1, 2 and 3 TSOA Individual w/o CG	Nurse delegation	- Dyads – send the TCARE® Respite Services Provider Assessment. - TSOA individuals - GetCare TSOA w/o CG assessment

		• Copy of consent form (14-012) • ND Referral and Communication form (DSHS 01-212)
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CONTRACTS

The Area Agencies on Aging (AAAs) will maintain a provider network to support the services available to MAC and TSOA enrollees. The AAAs also maintain the provider network for Family Caregiver Support Program (FCSP), traditional Medicaid programs such as CFC, MPC and COPES, and other supportive programs for older adults. MAC & TSOA programs for some services have specific MAC & TSOA contracts (example: Caregiver and Client Support or Behavior Support Services – MTP: Counseling) while other services are provided under already executed contracts held at the AAA (examples may include Personal Emergency Response Systems, Home Delivered Meals, Home Care Agencies, and Community Transition or Sustainability Services contracts). Most of the Medicaid and MAC/TSOA providers will have DSHS contracts executed and monitored by the AAAs. *(Please see the Benefit Categories/Services section for additional information about network adequacy).* When unpaid/no cost services are included in the care plan, a provider contract is usually not required.

Contracts in support of MAC and TSOA programs may be available via one of the following methods:

- Statewide contract through HCLA HQ Contract unit
- Core Provider Agreement (CPA) with Health Care Authority (DME providers)
- AAA or DSHS existing contracts
- FCSP services contracts that have the necessary Medicaid language included and the contract has been registered in the Agency Contracts Database maintained by HCLA.

The contracts that are executed and maintained by the contracts unit in HCLA Headquarters are:

- Specialized Equipment and Supplies (SES)
- Nurse Delegation (ND)
- Assistive Technology (AT)
- Adult Family Home (AFH - Respite)
- Assisted Living Facilities (ALF - Respite)
- Nursing Facilities (Respite)

For more information about contracting and network adequacy requirements see [MB H17-043](#). Refer providers who want more information about contracting to be a service provider to [HCLA internet website](#).

CHECKLIST FOR CLOSING A MAC OR TSOA CASE

When a care receiver no longer wants or needs to be enrolled in the MAC or TSOA program it is important to complete several tasks in order to officially close the case. Completion of the tasks is especially important if the care receiver is transitioning to another ALSTA program like CFC or

CFC+COPEs as it may impact the ability of the receiving case manager to add the new program RAC and create service authorizations for the new program.

The tasks to be completed include the following:

- Send a 14-443 to financial informing the Public Benefits Specialist (PBS) of the program end date and reason for closing case (such as withdrawing from services, moving to another program, passed away, etc.),
- Send MTP Service Notice (DSHS 15-492) to care receiver to provide formal notice of program/service termination (allow at least 10 days' notice for adverse actions, MTP Service Notice is not needed if the client passed away, as financial sends the condolence notification),
- Notify providers and change the end date of all service authorizations to match effective date of the MTP Service Notice or last date of service, if earlier
- Change the end date of the enrollment to match effective date of the MTP Service Notice (or date of death, when applicable)
- Change the end date of the functional RAC to reflect the last day of enrollment on the program
- Enter a progress note in CLC/ GetCare indicating reason for case closing

EXCEPTIONS TO RULE/POLICY

Before authorizing any exceptions to rule (ETR) or exceptions to policy (ETP), you must receive local or headquarters (HQ) approval, depending on the type of request. An ETR request means you are asking to make an exception to a rule (WAC). An ETP request means you are asking to make an exception to policy published in the LTC Manual or a management bulletin (MB).

CMS approved
1115 Waiver
Policy and
Procedures
cannot be
overridden with
an ETP.

ETRs that require local approval include:

- Exceeding Step 2 benefit level of \$500/annually up to \$1,000
- A caregiver or TSOA individual who is in crisis and needs to be served with step 2 or 3 services without first completing a screening or assessment. A care plan must be completed prior to receiving services. The screening and/or assessment must be completed within 30 days if ongoing services are needed.
- Request for respite services in the rare instance when a dyad asks for respite services and the TCARE® assessment does not result in a recommendation for this service.
- When excess of 2 home delivered meals per day for the caregiver or care receiver is being requested (Excess of 62 meals per month for the caregiver or 62 meals per month for the care receiver is being requested).
- Exceeding Step 3 benefit level allowed in a six-month period for MAC and TSOA dyads
- For TSOA without a caregiver, when the six-month benefit level will be exceeded due to home delivered meals, PERS service (PERS service (install, monthly fee, and add-on features such as fall

detector, medication reminders, etc.), and requests to purchase Durable Medical Equipment (DME) and care supplies when the ETR request is \$500 or less.

- Allowing Step 3 services when the assessment is only showing eligibility for Step 2 services.
- Annually, if a TSOA individual care receiver is also identified as an unpaid family caregiver for another MAC/TSOA care receiver.
- Exceeding \$2,500 for Pest Eradication and Specialized Deep Cleaning.

NOTE:

ETRs may not be used to exceed the Step 1 benefit level of \$250.

ETRs that require HCS HQ approval are:

- Exceeding Step 2 benefit level greater than \$1,000
- For TSOA without a caregiver, exceeding Step 3 benefit level allowed in a six-month period for any items not outlined in the local ETR process.
- DME/Bathroom equipment for care receivers who have Medicaid Apple Health or Medicare benefits that may also cover the requested piece of bathroom equipment. See MB [H24-067](#) for more details, tools and instructions.
- Home modifications and repairs exceeding \$500 or when the modification or repairs will cause the MAC/TSOA dyad or TSOA individual to exceed their 6-month benefit level.
- Exception to Policy requests, if not specified under local approval.
- Community Choice Guiding Services – If costs will exceed Step 3 benefit level OR if initial 160 units/40 hours for first 3 months was not sufficient and additional 160 units/40 hours for additional 3 months is needed.

ETR Process

All ETR requests and approvals/denials for MAC and TSOA should be completed in the ETR/ETP section of GetCare.

Both local and ATLSA HQ ETR and ETP requests must include the following details:

1. Request description
 - a. What item/service is being requested
 - b. Justification for request
 - c. Alternatives explored before considering ETR request
 - d. Cost of the request (e.g., hours, dollars, quantity, etc.)
2. Start and end date of request
3. WAC # or policy to which the exception applies

Complete the Medicaid Transformation Project Notice of Action Exception to Rule [DSHS form #05-255](#) in GetCare and save letter (the 'Save Letter' option will automatically save the document to the care

receivers GetCare Electronic File Cabinet). Then send to the care receiver informing them of the decision.

Detailed instructions for using the ETR/ETP functionality in GetCare can be found in the GetCare Desk Manual located in the GetCare Help Library.

Complaint Procedure for denial of initial ETRs

Initial ETRs do not have administrative hearing rights. However, care receivers do have the right to make a complaint to the Department. For complaints related to initial ETR decisions made by AAA at the field level, follow your AAA Grievance Policy.

Complaints related to initial ETR decisions made by HCS Headquarters will be reviewed as follows:

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

When responding to a complaint it is important to address, at a minimum, the specific concern perceived by the client and explain how all of the pieces of information were reviewed (e.g. screening, assessment, any additional information provided in the complaint, or information from other relevant sources) in order to make a decision. The AAA staff may want to discuss the care plan with the care receiver in order to identify service gaps that may be addressed using other available resources.

COLLABORATION WITH ADULT PROTECTIVE SERVICES (APS)

AAA/MTP staff are considered Mandated Reporters of abuse, abandonment, neglect, and financial exploitation of vulnerable adults.

If information is reported to the AAA staff about a care receiver or other vulnerable adult and the person providing the information to the AAA staff indicates they have already made a report to APS, the AAA staff may consider the following to determine if they too, should make a report to APS:

- An additional report by the AAA staff is not required if verified that the report was made. This must be done by asking the reporter for a reporting confirmation or intake number or contacting APS to verify a report was made. These steps must be documented in the GetCare progress notes.
- A mandatory reporter takes a personal risk and a risk to the agency they work for if they choose not to make a report to APS and there is a negative outcome for the vulnerable adult that was not reported to APS.
- See Adult Protective Services [policy and procedure](#) and [Chapter 74.34 RCW](#) for detailed information about mandated reporting, including consequences of failure to report.

All APS and RCS information is subject to confidentiality laws:

- Do not disclose the existence of an APS or RCS report or investigation to anyone,
- APS documents should not be placed in the ECR,
- Contact your public disclosure coordinator when:
 - You receive a request for records or information about an APS or RCS report or investigation. Do not acknowledge the existence of an investigation.
 - Your client requests to review his/her services record that contains documented APS or RCS activity. All APS and RCS related information must be redacted.

After receiving the intake notice, AAA staff should go to the APS/RCS ribbon in GetCare and do the following:

- Review the intake details,
- Do not divulge this information to anyone,
- Collaborate with the APS or RCS investigator, if contacted,
- Allow the investigator to complete his/her work before contacting the client, unpaid caregiver or anyone else unless directed to do so by the investigator,
- Document all communications and coordination activities in a progress note.
 - Use the following criteria when documenting:
 - ✓ Keep all progress notes pertinent and succinct.
 - ✓ Do not cut and paste emails or documents involving APS or RCS information (e.g., an APS outcome notice) into the progress note.
 - ✓ Summarize activities and communications in a progress note and document if you placed a printed email or document in the electronic file cabinet (e.g., “Received email from [name of person] on this date. See electronic file cabinet.”).

The APS or RCS investigator will contact the AAA staff if more information is needed during the investigation or if action is needed by the AAA staff during the investigation.

Refer to APS section on the [HCLA intranet site](#) for more information.

DSHS FORMS AND NOTICES

The forms and notices below will be used for dyads and individuals enrolled in the MAC and TSOA programs.

All of these forms will be utilized by the AAA MTP staff. These forms can be accessed on the [DSHS Internet forms site](#). Forms must be sent to care receivers in their primary language.

AAA staff will be able to complete the rest of the details in the form and save it in the care receiver’s Electronic File Cabinet in GetCare. The case worker will then print the form/notice and provide it to the care receiver and obtain their signature (note that not all of the forms/notices require a signature).

**CHAPTER 30b: Long-Term Services & Supports –
Medicaid Alternative Care (MAC) & Tailored Supports
for Older Adults (TSOA)**
Long-Term Care Manual



As forms are submitted into the Electronic Filing Cabinet, the newest (most recent) submitted form supersedes any previously submitted versions. Therefore, it is important to ensure that all documents submitted to the Electronic Filing Cabinet are completed appropriately.

TYPE	DSHS form #	PROGRAM	PURPOSE
Acknowledgement of Services	14-225	MAC	To document care receiver's choice to receive MAC services in the community rather than in a nursing facility. A signed copy must be scanned into the care receiver's electronic file cabinet in GetCare upon initial enrollment, when disenrolled and then returning to the MAC program, or at the next annual NFLOC assessment following a form revision
DSHS Notice of Privacy Practices for Client Medical Information	03-387	MAC & TSOA	To notify clients of their Health Insurance Portability and Accountability Act (HIPAA) privacy rights. Form must be distributed to both care receivers and the unpaid family caregiver, if part of a dyad, upon initially enrolling in the MAC and TSOA programs. Upon providing the form to the care receiver and the unpaid family caregiver (if applicable), a Progress Note should be entered stating the form was provided. There is no signature requirement so the form does not need to be placed in the Electronic Filing Cabinet (EFC).
Medicaid Transformation Project Notice of Action Exception to Rule (ETR)	05-255	MAC & TSOA	To provide notification to the care receiver of an ETR approval/denial or notice that request for ETR was not initiated. This form should be used for initial ETR requests or when the request does not <u>immediately precede</u> a current ETR.

			A completed copy of form must be scanned into the care receiver's electronic file cabinet in GetCare.
Consent	14-012	MAC & TSOA	To obtain consent from care receiver and caregiver to gather & share information for care planning purposes (Note: a separate consent form must be signed by the caregiver and by the care receiver.) A copy signed by the CR must be scanned into the care receiver's electronic file cabinet in GetCare. This form is valid for a maximum of one year and should be completed annually. A copy signed by the CG must be scanned into the caregiver's electronic file cabinet in GetCare.
Your Rights & Responsibilities when You Receive MAC or TSOA Services Offered by AL TSA	16-247	MAC & TSOA	To inform care receiver of their rights and responsibilities when receiving services from HCLA/AAA. A signed copy must be scanned into the care receiver's electronic file cabinet in GetCare. This form should be completed upon initial enrollment, when disenrolled and then returning to the MAC program, or at the next annual NFLOC assessment following a form revision.
Medicaid Transformation Project Service Notice	15-492	MAC & TSOA	To inform care receiver of: - actions (approval, denial, reduction, and termination) taken regarding their services; which includes decisions made on ETR extension requests that <u>immediately precedes</u> the current ETR and - Administrative Hearing rights

			A copy must be scanned into the care receiver's electronic file cabinet in GetCare. NOTE: You do not need to send a 15-492 when a client passes away. ACES/PBS sends out a condolence letter that includes termination of service language. AAA staff should send a 14-443 to financial when they become aware of a MAC or TSOA care receiver's death.
MTP TCARE® Information for Respite Care Service Providers	N/A	MAC & TSOA dyads	To provide necessary information about the care receiver's needs while receiving respite services.
Information for Respite Care Services Providers: Addendum to TCARE® Assessment (ALTSA)	13-915	MAC & TSOA dyads	To provide additional information, required by the facility's license, about the care receiver's needs during their respite stay in an adult family home or assisted living facility A completed copy of form must be scanned into the care receiver's electronic file cabinet in GetCare.
Housing Modification Property Release Agreement	27-147	MAC & TSOA	Must be completed for modifications to the residence of individuals enrolled in an Home and Community Living Administration (HCLA) program, including the installation of necessary equipment, that directly affects the interior or exterior of the dwelling.
Notice and Consent of Communication via Text or Unencrypted Email	27-156	MAC & TSOA	Have the care receiver and/or caregiver, when applicable, sign when they indicate they would like to receive communication by text messaging or via unencrypted email. Place signed copy in the care receiver's electronic file cabinet in GetCare.
Voter Registration (ABVR) forms	ABVR	MAC & TSOA	At least annually, during in-person visits, or when a change in address occurs. Continue to ask the care receiver if they would like to register to vote and if they need assistance

			with filling out the form. Use Agency Based Voter Registration (ABVR) forms and complete the voter registration section in GetCare.
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The top eight languages available besides English are:

- Spanish
- Korean
- Somali
- Russian
- Laotian
- Cambodian
- Chinese
- Vietnamese

Instructions: Saving Documents and Forms to the GetCare Electronic File Cabinet.

To scan and send a document or form to the electronic file cabinet in GetCare:

- Scan signed document
- Email scanned document to AAA staff or other worker's email address
- Save email as title of document, name of client – follow internal security policy for PHI
- Open client record in GetCare
- Open electronic file cabinet in client's file
- Select "Browse"
- Select "Add attachment"
- Find the location of the file you saved
- Select appropriate file
- Select "Open"
- In GetCare, see the add attachment pop up and select "Save".

If care receivers do not return documents such as the Consent and Rights & Responsibilities form, this is not cause for terminating the client from the program. The AAA staff should use person-centered strategies to encourage the return of the signature and document their efforts in a Progress Notes. Documenting these efforts is an important component related to the Quality Assurance and CMS signature requirement if the signed document is never returned.

When the care receiver doesn't return the signed Consent form, services should continue but there may be certain entities to whom we cannot share information. However, the "covered entities" that are most important are typically covered under HIPAA and a signature is not required.

ADMINISTRATIVE HEARING (AKA FAIR HEARINGS)

Care receivers have the right to an administrative hearing when the department (HCS/AAA):

- a. Sends a notice that approves, denies, reduces, or terminates a service or eligibility (at least 10 calendar days before the effective date of the action);
- b. Determines a client received more benefit than they were eligible for and an overpayment was issued;

- c. Reduces or terminates an ongoing service such as respite or in-home personal care that was initially approved through an ETR; and
- d. Denies or terminates financial eligibility (Note: these hearings are facilitated by HCS financial staff).

Requesting an Administrative Hearing

Hearing requests must be made within a specific timeframe. The care receiver must request a hearing (aka as an appeal) to Office of Administrative Hearings (OAH) within 90 days of the date the service notice was received.

A care receiver or their representative may request a hearing in any of the following ways:

- a. Verbal request. Department staff or their designee must notify OAH of any verbal request from the client, preferably in writing.
- b. Written request (of any kind). Department staff or their designee must notify OAH of any written request that doesn't go directly to OAH.
- c. The Request for Hearing form that accompanies every Service Notice (15-492). This form can be completed by the care receiver and mailed or faxed to OAH. The care receiver may also ask department staff or their designee to help them complete and submit the hearing request to OAH.

Administrative hearings related to financial eligibility decisions (full eligibility not PE) are handled by the financial staff.

Hearings related to decisions for services and functional eligibility (full eligibility not PE) are handled by AAA staff. Each AAA will designate who completes this work.

For more details about administrative hearings (AH), the AH process, and roles of the AAA staff/case manager and AH coordinator see [Ch. 26 of the LTC Manual](#).

WAIT LIST

The state has client numbers and expenditure limits for each year of the 1115 demonstration waiver. It is possible that a wait list will be required if it appears that the limit will be reached. The renewal waiver, also deemed as MTP 2.0, has been approved from July 1, 2023 to June 30, 2028.

In the event that a wait list is implemented, the MAC and TSOA programs will stop conducting presumptive eligibility (PE) determinations. Dyads or individuals receiving services under presumptive eligibility established prior to implementation of the wait list will be able to continue receiving services until their PE period ends or their final eligibility determination is completed whichever comes first.

If additional funds become available, dyads or individuals may be removed from the wait list on a first come, first served basis.

During the time a wait list is in place, dyads or individuals should be referred to other options such as FCSP, local community resources, or other Medicaid long-term care services (CFC, MPC, New Freedom, Residential Support Waiver, COPES, etc.).

CONFLICT FREE CASE MANAGEMENT

Background

Federal requirements for the Community First Choice program, COPES, New Freedom, Residential Supports Waiver, and the Medicaid Transformation Project require Home and Community Living Administration (HCLA) to ensure that conflict of interest safeguards are in place for all Medicaid participants. These safeguards outline provider qualifications, require a strategy for solving conflict and outline clear conflict-of-interest guidelines per Washington State MTP, Special Terms and Condition (STC) #52. Conflict of Interest, § 42 CFR 441.301(c)(1)(v)(vi), § 42 CFR 441.730, and § 441.555 (c).

In some areas of the state, it is challenging for HCLA and Area Agencies on Aging (AAA) to recruit and enroll providers of evidence-based services or other services with a low demand such as support groups. This can be especially true when looking for culturally or linguistically appropriate providers or when serving a minute population spread across a vast frontier area or tribal reservation. Yet often these are the exact services that a participant needs and desires at the time they are assessed.

HCLA and the AAAs are committed to providing needed services at the time and location that is right for the participant. Both entities acknowledge there may be occasions when safeguards are needed to protect participants from conflict of interest. This policy details the safeguards that must be in place when an AAA provides assessment and/or service planning and is the only qualified and willing entity available to be authorized to provide a home and community-based service.

Area Agency on Aging Requirements

AAA's must attest (see attached sample attestation form below) that they will adhere to the following conflict of interest policies:

1. The AAA will ensure that participants:
 - a. As part of the assessment and authorization process, receive information about the full range of services available to the participant and not just the service furnished by the AAA; and
 - b. Are supported in exercising their right to free choice of providers; and
 - c. Are informed of their opportunity to identify other qualified and willing providers available in the participant's geographic area to provide the service.

2. The AAA's grievance resolution process must refer the participant to DSHS if they wish to dispute the assertion that there is not another qualified and willing entity available in the participant's geographic area to provide the service.
3. Where the AAA attests it is the only willing and qualified provider, the AAA must request HCLA approval prior to authorizing service provision by an AAA employee. The approval shall be in effect as long as these policies are followed and until an alternative provider is identified. HCLA will verify AAA is the only willing and qualified provider by:
 - a. Reviewing the AAA provider recruitment efforts and results annually; and
 - b. Confirming there is no available contracted provider in the State's contract database, ACD.
4. The development of the service plan is administratively separated, from the provision of authorized services. With the functions ideally accomplished by separate units.
5. Where service provision and/or assessment and service planning functions are provided by the same AAA employee because the only available qualified provider of the service is also the AAA staff/case manager who assists the client with service planning, supervision must be provided separately from the assessment and/or service planning functions. For this purpose, supervision means verifying that the requirements of this Conflict-of-Interest policy are being met as services are being delivered and that authorization levels are consistent with what is typical for the service.
6. That the AAA staff will remain unbiased and impartial during the development of the person-centered service plan.
7. That the AAA will include the service in its process for continuous recruitment and open enrollment of qualified providers required by [Chapter 6](#) of the AAA policy and procedures manual.
8. That the AAA staff training includes these policies prior to providing services along with training on confidentiality, ethics and grievance procedures.

Home and Community Living Administration Requirements

HCLA will provide oversight and monitoring of the conflict-of-interest safeguards for Medicaid participants when service provision and service planning are provided by the same AAA employee. The results of the activities will be reported to the State Medicaid Agency at the quarterly waiver management committee meeting. Monitoring and oversight activities will include an annual review of:

1. AAA compliance with these policies and adherence to the AAA attestation.
2. AAA efforts to enroll service providers.
3. A comparison of service utilization patterns where the AAA is the direct provider with utilization that is typical for comparable services provided by contracted providers.

4. A comparison of rates paid to the AAA with rates paid to contracted vendors for comparable services.



Conflict of interest
attestation form.docx

QUALITY ASSURANCE

As part of the special terms and conditions with the 1115 demonstration waiver, the state developed a Quality Improvement System (QIS) which includes:

- a. Performance measurement and reporting in accordance with the quality reporting and review standards outlined in Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers guidance issued March 12, 2014, and reporting timelines outlined in Revised Interim Procedural Guidance issued February 6, 2007.

Performance measures should address the following areas:

- i. Identification of needs and goals, and access to services (Level of Care/Functional assessment and Person-Centered Plan of Care at least annually);
 - ii. Services are delivered in accordance with the Person-Centered Plan of Care
 - iii. Providers meet required qualifications;
 - iv. Settings meet the home and community-based setting requirements for those services that could be authorized under 1915(c) and 1915(i);
 - v. Number of substantiated incidents of neglect, exploitation or abuse and average time to resolution;
 - vi. The State Medicaid Agency (SMA) retains authority and responsibility for program operations and oversight; and
 - vii. Washington State Medicaid Transformation Project 2.0 Section 1115(a) Demonstration Approval Period: July 1, 2023 through June 30, 2028 Page 45 of 154 vii. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1115 participants by qualified providers.
- b. Ongoing quarterly/annual reporting that includes:
 - i. Number of LTSS beneficiaries broken out by program (MAC and TSOA);
 - ii. Number of new MAC and TSOA person-centered service plans;
 - iii. Percent of MAC and TSOA level of care re-assessments annually; and
 - iv. Number of people self-directing services under employer authority.

All MAC and TSOA AAA staff are eligible for a Quality Assurance review, regardless of length of employment. The HCLASocial Service Quality Assurance unit will complete statewide monitoring using a statistically valid sample size when pulling cases for review.

During the annual Quality Assurance review, PSA's should complete the following:

- i. Review any completed Initial Process Review and make corrections indicated for specific questions and their associated “no” responses.
- ii. Correct the items identified in the Initial Process Review within 30-calendar days.
Note: AAA/HCS social service staff must lock any care plans and/or return any scanned copies of corrected documents required by the deadline to the HCLA QA Lead. Original documents should still be sent to the Electronic File Cabinet.
- iii. Correct items identified in the 30-day review by the 60-day due date.
- iv. Any questions that did not meet or exceed the proficiency standard at the Initial Process Review and are not already being addressed in the HQ Proficiency Improvement Plan (PIP), will need to be included in each area’s PIP.
- v. E-mail PIPs, based on Initial Process Review findings, to headquarters within 30 calendar days of receiving the area Final Report.

RESOURCES

Related LTC Chapters

Chapter 3	Assessment and Care Planning
Chapter 4	Social Service Intake
Chapter 5	Case Management Chapter - Challenging Cases Protocol
Chapter 11	Consumer Directed Employer
Chapter 12	Adult Day Services
Chapter 13	Nurse Delegation
Chapter 15A	Communicating with Individuals with LEP & SD, Guidance for AAA Staff
Chapter 15B	Communicating with Individuals with LEP & SD Guidance for HCLA and DDA Staff
Chapter 20	Transportation
Chapter 23	Quality Assurance and Improvement
Chapter 26	Administrative Hearings
Chapter 28	Medicaid Fraud
Chapter 30A	Intro to Medicaid Transformation Project

Related WACs

[Functional WAC 388-106- 1900 thru 1990](#)

[Financial WAC – MAC 182-513-1600 and 1605, and 182-513-1660](#)

[Financial WAC – TSOA 182-513-1610 thru 1655, and 182-513-1660](#)

Acronyms

AAA	Area Agency on Aging
ABP	Alternative Benefit Plan
ACD	Agency Contracts Database
ACES	Automated Client Eligibility System
ADLs	Activities of Daily Living
AFH	Adult Family Home
AH	Administrative Hearing
ALF	Assisted Living Facilities
ALTSA	Aging and Long-Term Support Administration (Being replaced by HCLA)
APS	Adult Protective Services
AREP	Authorized Representative
AT	Assistive Technology
CARE	Comprehensive Assessment Reporting and Evaluation
CDSME	Chronic Disease Self-Management Education
CFC	Community First Choice
CG	Caregiver
CLC	Community Living Connections
CM	Case Manager
CMS	Centers for Medicare and Medicaid Services
CN	Categorically Needy
COPES	Community Options Program Entry System
CPA	Core Provider Agreement
CR	Care Receiver
CS	Community Spouse
DME	Durable Medical Equipment
ECR	Electronic Case Record
EFC	Electronic Filing Cabinet
ER	Eligibility Review
ETP	Exception to the Policy
ETR	Exception to the Rule
FBR	Federal Benefit Rate
FCSP	Family Caregiver Support Program
GPS	Global Positioning System

**CHAPTER 30b: Long-Term Services & Supports –
Medicaid Alternative Care (MAC) & Tailored Supports
for Older Adults (TSOA)**

Long-Term Care Manual



HCA	Health Care Authority
HCLA	Home and Community Living (Replacing ALTSA)
HCS	Home and Community Services
HDM	Home Delivered Meals
HQ	Headquarters
IADLs	Instrumental Activities of Daily Living
ID	Identification
IP	Individual Provider
LTC	Long Term Care
LTSS	Long Term Services and Supports
MAC	Medicaid Alternative Care
MMIS	Medicaid Management Information System
MN	Medically Needy
MPC	Medicaid Personal Care
MSP	Medicare Savings Program
MTP	Medicaid Transformation Project
MUI	Medicaid Unit Incentive
ND	Nurse Delegation
NFLOC	Nursing Facility Level of CARE
NOPE	Not Presumptively Eligible for MAC and TSOA
OAH	Office of Administrative Hearings
P1	ProviderOne
PBS	Public Benefits Specialist
PE	Presumptive Eligibility
PERS	Personal Emergency Response Systems
PSA	Planning Service Area
RAC	Recipient Aid Category
RCS	Residential Care Services
RCW	Revised Code of Washington
RDAD	Reducing Disability in Alzheimer's Disease
RU	Reporting Unit
SCDS	Service Code Data Sheet
SES	Specialized Equipment and Supplies
SIPC	Spousal Impoverishment Protections Community
SOAP	State Only Adjustment of Payment
SSI	Supplemental Security Income
SSN	Social Security Number
STCs	Special Terms and Conditions
SUA	State Unit on Aging
TIVA2	Tracking Incidents of Vulnerable Adults
TSOA	Tailored Supports for Older Adults
WAC	Washington Administrative Code

WHO Warm Hand Off

Outreach & Marketing Materials

[MAC & TSOA Brochure](#)

Publications, rack cards, poster

Other

For AAA Staff/MTP Case managers

HCLA Intranet – HCS Medicaid Transformation Project
[ProviderOne Social Services Authorization Manual for case managers](#)
[Service Code Data Sheets \(SCDS\) for ProviderOne authorizations](#)
[Health Care Authority – MTP Website](#)
[TCARE® – Caregiver Assessment and Planning](#)

For Care receivers and Caregivers

HCLA Internet – Caregiver Resources

For Potential Providers/Contractors

[HCLA internet – Potential Service Providers](#)

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
12/2019	Debbie Johnson	1. Moved to new template 2. Incorporated QA section 3. Updated content 4. Added policy decisions from 2017 & 2018 MBs 5. Added policy info from Community WorkSpace 6. Modified policy related to sending DSHS 15-492 to	H19-0xx

		GetCare electronic file cabinet rather than DMS	
4/2025	Resa Lee-Bell	1. Added policy decision from 2019-2024 MBs 2. Added policy info from Community WorkSpace 3. Added policy info from GetCare Help Library 4. Incorporated language from June 2023 CMS Approval/STC's 5. Added Acronyms 6. Style Formatting Update	H24-009 H23-093 H23-091 H23-057 H23-029 H21-079 H21-012 H20-033 H19-053 H19-049 H19-020
4/2026	Resa Lee-Bell	1. Replaced references to ALTSA with HCLA. 2. Added updated form and policy clarification. 3. Added more related chapters. 4. Added general policy clarifications.	H25-056



Foundational Community Supports– Supported Employment

Chapter 30c describes the Supported Employment program offered through the Foundational Community Supports (FCS) of the Medicaid Transformation and the related rules, policy and procedures.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Supported Employment Team mailbox: SupportedEmployment@dshs.wa.gov

Michael Corcoran	Employment Unit Manager 360.725.2614	Michael.Corcoran@dshs.wa.gov
Jim Bischoff	HCS Region 1 Employment Specialist 360.870.4511	James.Bischoff@dshs.wa.gov
Sammy Bernardy	HCS Region 1 Employment Specialist 360.890.2910	samantha.bernardy@dshs.wa.gov
Ruby Pham	HCS Region 2 Employment Specialist 564.200.2264	Ruby.Pham@dshs.wa.gov
Muriel McAuliff	HCS Region 2 Employment Specialist 360.706.3047	muriel.mcauliff@dshs.wa.gov
Laura DeVol	HCS Region 3 Employment Specialist 360.870.4918	Laura.DeVol1@dshs.wa.gov
Katie Stettler	HCS Region 3 Employment Specialist 564.200.4238	katie.stettler1@dshs.wa.gov



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BACKGROUND

The Medicaid Transformation is an agreement between the State and the Centers for Medicare and Medicaid Services (CMS) that contains multiple initiatives. The intent of Foundational Community Supports (FCS) – Supported Employment (SE), is to support individuals in obtaining and retaining employment in support of their broader health goals. Evidence strongly suggests that individuals with disabilities who are employed experience increased health status, such as:

- Psychological benefits which lead to decreases in mental health symptoms, smoking, and other health factors
- Increased success in recovery and rehabilitation processes including mental health, substance use disorders, and even smoking cessation
- Reduced health care costs

Supported Employment services are designed to be person-centered and individualized one-to-one supports to individuals interested in employment in the community. FCS creates a system of services which will provide pre-employment and post-employment services to an individual at any point in their pathway to employment. The services are not time-limited but are intended to support the individual for as long as there is an identified need.

ADMINISTRATION OF FOUNDATIONAL COMMUNITY SUPPORTS

The FCS services are part of the Medicaid Transformation (MT). For more information on MT see [Chapter 30a](#) of the LTC Manual. The larger Demonstration, and FCS in particular, involves multiple state agencies including the Home and Community Services Division (HCS) of Home and Community Living Administration (HCLA). Due to the multiple agencies involved, the state has set up a single, statewide Third-Party Administrator (TPA) for the FCS services, which includes Supported Employment services.

The TPA is a contracted, non-state entity that provides administrative oversight of the benefit programs and services. The TPA is responsible for:

- Provider network development and maintenance
- Client eligibility determination
- Service Authorizations for services to providers
- Distribution of reimbursement payments
- Encounter data tracking



Wellpoint has been contracted with the state through the Health Care Authority and will be functioning as the TPA for the duration of MT.

PROGRAM DESCRIPTION

Supported Employment services assist those individuals who want to work and meet FCS criteria to become employed in integrated community employment. Activities are intended to ensure successful employment outcomes through the utilization of collateral contacts, skills training, cueing, modeling and supervision as identified by the person-centered employment plan.

Individualized Supported Employment services include identifying career and occupational targets, developing ongoing relationships with prospective employers, assisting with the interviewing and hiring process, and once employed, support with maintaining employment. Coaching and skill-building of interpersonal relationships in the work setting as well as education for self-advocacy and support with the American with Disabilities Act are also included.

The focus is on obtaining competitive employment that reflects the interests and desires of the individual through:

- **Pre-employment services** — activities that assist an individual with obtaining employment.
- **Employment-sustaining services** — activities that support the individual in retaining and maintaining employment.

Pre-employment services support an individual's ability to prepare for and transition to competitive employment, including direct face-to-face contact with the client as well as collateral service.

Pre-employment services include the following:

- Prevocational/job-related discovery or assessment
- Person-centered employment planning
- Individualized job development and placement
- Job carving — defined as working with the client and employer to modify an existing job description so it contains one or more, but not all, of the tasks from the original job description when a potential applicant for a job is unable to perform all the duties identified in the job description
- Benefits education and planning — defined as counseling to assist the client in fully understanding the range of state and federal benefits he or she might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the client's options for returning to work
- Transportation (only in conjunction with the delivery of an authorized service)



Employment-sustaining services include the following:

- Career advancement services — defined as services that expand opportunities for professional growth, assist with enrollment in higher education or credentialing and certificate programs to expand job skills or enhance career development, and assist the individual in monitoring his/her satisfaction with employment and determining the level of interest and opportunities for advancement with the current employer, and/or changing employers for career advancement
- Negotiation with employers — defined as services where a provider identifies and addresses job accommodations or assistive technology needs with the employer on behalf of the individual
- Job accommodations can include the following:
 - Adjusting work schedule to reduce exposure to triggering events (i.e., heavy traffic triggering symptoms of agoraphobia)
 - Providing a private area for individuals to take breaks if they experience an increase in symptoms
 - Access to a telephone to contact a support person if needed while at work
 - Adjusting job schedule to accommodate scheduled appointments
 - Small, frequent breaks as opposed to one long one
- Assistive technology can include the following:
 - Bedside alarms
 - Electronic medication reminders while at work or at home
 - Use of headset/iPod to block out internal or external distractions
- Job analysis — defined as gathering, evaluating and recording accurate, objective data about the characteristics of a particular job to ensure the specific matching of skills and amelioration of maladaptive behaviors.
- Job coaching
- Benefits education and planning — defined as counseling to assist the client in fully understanding the range of state and federal benefits he or she might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the client's options for returning to work
- Transportation (only in conjunction with the delivery of an authorized service)
- Asset development — defined as services supporting clients' accrual of assets that have the potential to help clients improve their economic status, expand opportunities for community participation and positively impact their quality-of-life experience
 - Assets are defined as something with value owned by an individual, such as money in the bank, property and retirement accounts
- Follow along supports — defined as the ongoing supports necessary to assist an eligible client to sustain competitive work in an integrated setting of his or her choice.



- This service is provided for, or on behalf of, a client and can include communicating with the client's supervisor or manager, whether in the presence of the client or not (if authorized and appropriate). There is regular contact and follow-up with the client and employer to reinforce and stabilize job placement. Follow-along support and/or accommodations are negotiated with an employer prior to the client starting work or as circumstances arise.

Service providers will be engaged in individualized job development services that support individuals in searching for and securing a job in the community such as:

- Identifying and negotiating jobs.
- Building relationships with employers.
- Customized employment development, job analysis and job carving.
- Linking with community resources to support job search.

ELIGIBILITY, INTAKE, REFERRAL AND SERVICE DELIVERY FLOW

Eligibility determination is completed by the TPA, Wellpoint, based on criteria established by the state in agreement with the Centers for Medicare & Medicaid Services (CMS), the federal funding agency for MT. There are multiple sets of criteria for eligible clients, including an HCS/HCLA specific set.

To be determined eligible for FCS Supported Employment services by the TPA, a client must meet the following criteria:

- Be aged 16 or older
- Eligible for Apple Health (Medicaid)
- Desire to obtain employment

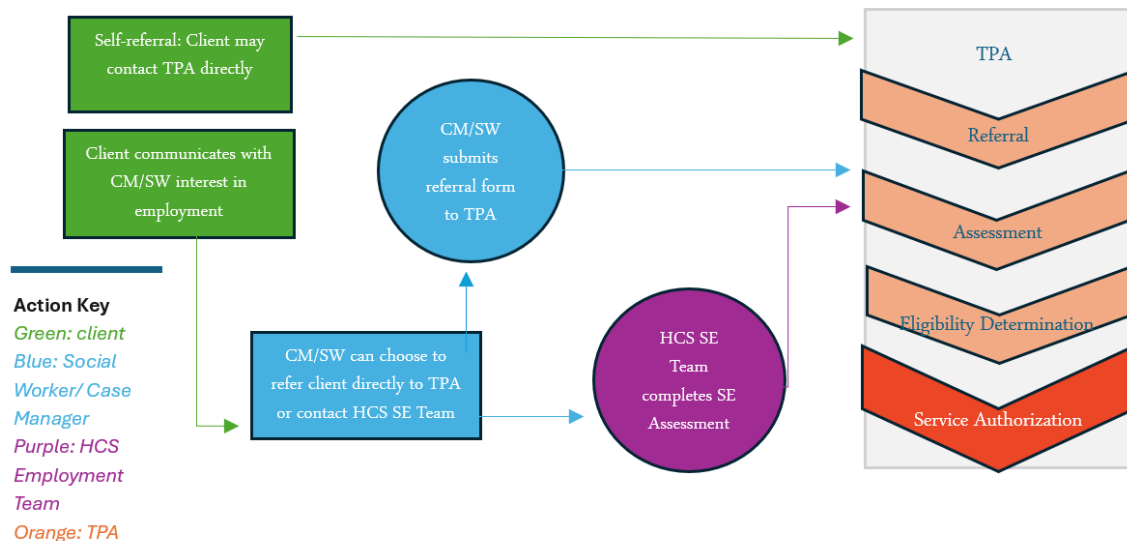
The client must also meet both the needs-based health and risk factor indicated below:

- **Health Factor:** An HCS/HCLA client meets the necessary health needs criteria by being financially and functionally eligible with a current CARE assessment identifying the need for assistance with 3 Activities of Daily Living (ADLs) and/or hands-on assistance with at least one ADL, which may include body care
- **Risk Factor:** Meets the necessary risk factor criteria by having an inability to obtain or maintain employment resulting from age, physical disability, or traumatic brain injury (TBI).

A more detailed description of needs-based criteria for FCS may be found in the [FCS Quick Reference Guide](#). Intake and service delivery flow consists of identifying an individual interested in employment, assessing them for eligibility, referring them to the TPA for eligibility determination and assignment to a local employment provider to begin services. The intake and referral process for an individual can take a

number of paths including self-directed referral or assistance from HCS/AAA field staff and/or the HCS Employment team (see image below).

How does an LTSS client access FCS-SE services?



The most effective and quickest referral process for the client is to communicate the client’s interest to the HCS Employment team. This process assures that the client will have a complete eligibility determination packet assembled and submitted to the TPA and facilitate a more rapid eligibility determination and assignment to a provider.

Ways to communicate a referral to the HCS Employment team:

- Contact the HCS Employment team through the SupportedEmployment@dshs.wa.gov email or 1-844-427-8256
- Contact one of the HCS Employment team directly through the contact information in the “Ask an Expert” section of this Chapter.

To indicate a client’s interest in Supported Employment services in CARE:

- Select Client Details and go to their Profile Screen.
- Enter "Yes" to the Supported Employment question under General Information. A box will pop up with instructions on how to contact the HCS Employment team.



- Click on the link to SupportedEmployment@dshs.wa.gov and provide the client's name and one-piece identifying information, such as, ProviderOne number, ACES ID, or date of birth.

General information

Interested in Supported Employment? ⓘ

☒ Yes ☐ No ☐ Already receiving

For ALISA: CM/SWs please contact
ALISA Employment team at
SupportedEmployment@dshs.wa.gov
for support/questions.

For DDA: CRMs should connect with
their Regional Employment Specialist
for support/questions.

Clients may also be referred directly to TPA. Clients, their family or any support person, including HCS/AAA field staff, may contact the TPA directly through either phone or email to inquire about services and begin the assessment and eligibility determination process. Points of contact to begin the process are: phone – 1-800-451-2828; email – fcstpa@wellpoint.com.

More information for clients about the FCS services and how to apply can be found on Wellpoint's [FCS website](#).

If a client is referred directly to TPA, the TPA will evaluate the individual for the eligibility criteria indicated above. For the needs-based health and risk factor criteria, the TPA will refer the client to an employment provider directly for supporting documentation and resubmission for a final eligibility determination.

Once a client is determined to be eligible for FCS services by the TPA, the TPA will assign the client to a local employment service provider and set up a Service Authorization in Provider One directly. Billing for services by providers will be through the TPA. The TPA will process billing and reimburse providers directly, then enter encounter data and billing information into Provider One directly.

HCS/AAA field staff and/or HCS Employment team will document each stage of the process from initial communication regarding FCS Supported Employment services with the client through the establishment of a Service Authorization with a provider in ProviderOne for FCS Supported Employment services through Service Episode Records (SERS).

HOUSING & EMPLOYMENT STABILIZATION SERVICES FOR AN HCS/HCLA CLIENT

Housing and Employment Stabilization Services should be used when an HCS/HCLA client is enrolled in Foundational Community Supports (FCS) Supported Employment or has their employment support needs coordinated through HCS and requires additional assistance to obtain/maintain their job and the needed support is not able to be met through federal funding.. These services are designed to promote self-sufficiency and recovery by helping participants find and maintain stable housing and employment.



How To Authorize Housing and Employment Stabilization Services

- Note in the Service Episode Record (SER) that the client is eligible for Housing & Employment Stabilization services and that you have Supervisory approval to authorize state only funds.
- Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan.
- The HCS/AAA CM will need to authorize a Contracted Provider (i.e. Community Choice Guide) to make payments or/and purchases on behalf of the client.
 - 1) Complete Sustainability Goals to be shared with Provider. For Goal Short Description, enter "Employment". For Goal Description write a brief description of what services/items will be completed.
 - 2) The HCS/AAA CM will open RAC 3131- LTSS Housing Stabilization
 - 3) Use Service Code SA294,U4 (Housing Subsidy-Purchasing) to authorize the necessary goods and services.
 - For "Start" enter the date you authorized the Contracted Provider to make payment on a client's behalf.
 - For "End", enter the date that falls two weeks after the start date. For example, start date is March 3, 2025, and the end date would be March 17, 2025
 - For "# of Units" enter 1.
 - Unit type will be set to "Each".
 - For "Rate", enter the amount the Contractor was authorized to pay on behalf of the client.
 - Select reason code "Employment Stabilization"
 - For "Business status" select "Reviewing" status. Please do not put an authorization in "approved" status until you have received an invoice/receipt and the amount matches.
 - Once the invoice is received, update the start and end date, and verify the rate amount. If the rate doesn't match, please update the rate to match the invoice/receipt amount. Change "Business status" to "Approved".
 - When submitting an ETR, select "other" for both ETR/ETP category & type. Please note: an ETR will be required if the goods and services exceeds \$5000
 - Note: If the amount Exceeds \$500, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Supported Employment Specialist to force the error.
 - 4) Submit the ETR to "Committee, Housing ETR" and email housingcommitteetr@dshs.wa.gov to inform us about the ETR request.



- 5) Receipts for all purchases must be included in the participant’s electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615)

How to Document Employment Stabilization Services in CARE:

Once the client is authorized for Employment Stabilization Services the HCS/AAA CM must:

- Add “Other” for Community Supports under Treatments
 - On the Medical Screen in CARE, choose the Program “Other”
 - Check “No” for Received in Last 14 days?
 - Check “Yes” for Need
 - Choose “Agency” for Provider
 - Choose “PRN” for Frequency
- For Comments, type: *“Employment Stabilization item(s) as identified to assist with the client’s [return to/stabilization in] independent living.”*
 - Add the Contracted Provider as a Paid Provider in the Care Planning section under the Supports Screen and assign the provider the task of “Other” (for Community Transition Services)

SHORT-TERM RENTAL ASSISTANCE FOR SUPPORTED EMPLOYMENT CLIENTS (STRA)

Short-Term Rental Assistance (STRA) supports are available for HCS clients receiving LTSS services and enrolled in FCS Supported Employment services that meet the program requirements. STRA are funded through the Health Related Social Needs (HRSN) program of the 1115 waiver funded Medicaid Transformation.

STRA can provide up to 6 months of rental and utilities assistance during the 1115 demonstration period for eligible clients. Demonstration period runs until June 2028. Utilities support can only be provided in months in which rental support is also provided.

Eligibility for STRA:



- Clients receiving Home and Community Long-Term Services Supports through CARE
- Has Federal Medicaid coverage (Apple Health)
- Enrolled in Foundational Community Supports Supported Employment services
- Experiencing chronic homelessness OR at risk of homelessness including
 - Exiting a publicly funded institution or system of care
 - Living in housing with characteristics associated with instability and an increased risk of homelessness

STRA covered services:

- Rent payments up to 150% of the Fair Market Rate (FMR) for their area
- Past due and/or future payments for a total of 6 months
- Renter's insurance (if required by the lease)
- Utilities can be paid only in months that rental assistance is received and include:
 - Landlord-paid utilities included in rent (non-duplicative of other HRSN utilities)
 - Recurring utilities owed directly to utility providers: garbage, water, sewer, recycling, internet, phone
 - Non-refundable utility set-up and restart costs

How to refer a client to STRA:

HCS and AAA case managers can submit an STRA referral through the [Office of Housing & Employment SharePoint](#)

- Select "Submit A Referral"
- Select "Supported Employment Short-Term Rent & Utility Payment"
- Complete the online form

The Management Bulletin (MB) H26-006 **Guidance on Planned Action Notices (PANs) Procedure for Health-Related Social Needs (HRSN) Funded Supportive Housing Programs** became effective March 4, 2026. In alignment with those rules a Planned Action Notice (PAN) is required whenever HRSN funds are used. Please see MB H26-006 for more information.

Resources for creating PANs for the STRA HRSN services are available. Please contact the Employment Unit for any guidance, support and questions.

RESOURCES

Additional resources about the Foundational Community Supports (FCS) and Supported Employment program are available below and by contacting the Employment Unit at SupportedEmployment@dshs.wa.gov:



Office of Housing and Employment website:

[Office of Housing and Employment website](#)

[Supported Employment SharePoint](#)

[Supported Employment One-Pager_Digital](#)

[Supported Employment_Brochure_print](#)

[Benefit Brochure_PPTOffice of Housing and Employment SharePointMTP Community Workspace - Home](#)

[Medicaid Transformation Project \(MTP\) | Washington State Health Care Authority](#)

[HCS MTD intranet site for staff](#)

[Wellpoint TPA Provider Website with Resources](#)

[Wellpoint TPA Website for Clients](#)

[FCS Referral Form for Direct Referral to TPA](#)

[Supported Employment Assessment](#)

[FCS Quick Reference Guide](#)

[FCS Marketing Flyer - English](#)

[FCS Marketing Flyer - Spanish](#)

Housing & Employment Stabilization Services Chart:

Housing Subsidy - Purchasing SA294u4

Housing & Employment Stabilization Services (H&ES) These state funded services are intended to fill specific gaps to provide transitional or stabilizing supports for clients, who have received a housing or Supported Employment resource or had their housing/employment coordinated through HCS to sustain community living.

Who is eligible for state H&ES?

When an HCS client meets these qualifications:

1. Received a housing resource or had their housing coordinated through HCS; **or**
2. Enrolled with Supported Employment or had their employment coordinated through HCS; **and**
3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; **and**



	- Do not have other programs, services, or resources to assist you with these costs; and - The needed support is not able to be met through federal funding
What employment supports are covered under state H&ES?– This is some examples but not a fully inclusive list.	- Bus pass - Cellphone - Chromebook /laptop computer or other device to connect to internet to support job development or when required for a job - Food Handlers card - Identification card - Clothes (interview clothes, first set of uniforms to begin work) - Other employment supporting licenses, credentials, certifications, services or items as needed - Etc.
What is not covered under state H&ES?	- Recreational or diversional items such as television, cable or DVD players. - Assistive Technology
When do I need a provider contract?	A contracted provider (i.e. Community Choice Guide) will need to be authorized to complete purchases or/and payments on behalf of the client.
How do I authorize state H&ES?	- Note in the Service Episode Record (SER) that the client is eligible for Housing & Employment Stabilization services and that you have Supervisory approval to authorize state only funds. - Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan. - Complete Sustainability Goals to be shared with Provider. For Goal Short Description, enter "Employment". For Goal Description write a brief description of what services/items will be completed. - The HCS/AAA CM will open RAC 3131- LTSS Housing Stabilization - Use Service Code SA294,U4 (Housing Subsidy-Purchasing) to authorize the necessary goods and services. - For "Start" enter the date you authorized the Contracted Provider to make payment on a client's behalf.



	7. For “End”, enter the date that falls two weeks after the start date. For example, start date is March 3, 2025, and the end date would be March 17, 2025 8. For “# of Units” enter 1. 9. Unit type will be set to “Each”. 10. For “Rate”, enter the amount the Contractor was authorized to pay on behalf of the client. 11. Select reason code “Employment Stabilization” 12. For “Business status” select “Reviewing” status. Please do not put an authorization in “approved” status until you have received an invoice/receipt and the amount matches. 13. Once the invoice is received, update the start and end date, and verify the rate amount. If the rate doesn’t match, please update the rate to match the invoice/receipt amount. Change “Business status” to “Approved”. 14. When submitting an ETR, select “other” for both ETR/ETP category & type. Please note: an ETR will be required if the goods and services exceeds \$5000 15. Submit the ETR to “Committee, Housing ETR” and email housingcommitteetr@dshs.wa.gov to inform us about the ETR request. 16. Receipts for all purchases must be included in the participant’s electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615)
When do I authorize this service?	When an HCS client meets these qualifications: 1. Received a housing resource or had their housing coordinated through HCS; or 2. Enrolled with FCS Supported Employment or had their employment support needs coordinated through HCS; and 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; and 4. Do not have other programs, services, or resources to assist you with these costs; and 5. The needed support is not able to be met through federal funding
Are ETRs allowed for state H&ES?	Yes. 1. An ETR will be required if the total amount of goods & services exceeds \$5000. 2. Select “other” for both ETR/ETP category & type.



	3. Submit the ETR to “Committee, Housing ETR” and email housingcommitteeetr@dshs.wa.gov to inform us about the ETR requested. Note: If the amount Exceeds \$500, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Supported Employment Specialist to force the error.
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Short-Term Rental Assistance (STRA) supports are available for HCS clients receiving LTSS services and enrolled in FCS Supported Employment services that meet the program requirements. STRA are funded through the Health Related Social Needs (HRSN) program of the 1115 waiver funded Medicaid Transformation.

STRA can provide up to 6 months of rental and utilities assistance during the 1115 demonstration period for eligible clients. Utilities support can only be provided in months in which rental support is also provided.

Who is eligible for STRA?	When an HCS client meets these qualifications: - Clients receiving Home and Community Long-Term Services Supports through CARE - Has Federal Medicaid coverage (Apple Health) - Enrolled in Foundational Community Supports Supported Employment services - Experiencing chronic homelessness OR at risk of homelessness including - Exiting a publicly funded institution or system of care - Living in housing with characteristics associated with instability and an increased risk of homelessness
What does STRA cover?	<u>Rent payments up to 150% of the Fair Market Rate (FMR) for their area</u> <u>Past due and/or future payments for a total of 6 months</u> <u>Renter’s insurance (if required by the lease)</u> <u>Utilities can be paid only in months that rental assistance is received and include:</u> <u>Landlord-paid utilities included in rent (non-duplicative of other HRSN utilities)</u> <u>Recurring utilities owed directly to utility providers: garbage, water, sewer, recycling, internet, phone</u> <u>Non-refundable utility set-up and restart costs</u>



How to make a referral to STRA?	Submit an STRA referral through the Office of Housing & Employment SharePoint • Select “Submit A Referral” • Select “Supported Employment Short-Term Rent & Utility Payment” • Complete the online form
What happens after client is found eligible for STRA?	Employment Unit will communicate eligibility determination to Spokane Housing Authority (SHA) and referring staff. • SHA will coordinate with HCS/AAA Case Manager to compile all necessary documents to pay rent and landlord-paid utilities for period authorized • Employment Unit will provide guidance to HCS/AAA Case Manager on completing any needed authorizations. • HCS/AAA Case Manager will issue PANs following MB H26-006

Forms:

[FCS Referral Form for Direct Referral to TPA](#)

Related WACs:

[FCS WACs](#)

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
10/2018	Michael Corcoran	Initial publication	
6/2022	Michael Corcoran	Updated information	
5/2023	Michael Corcoran	Updated information	
6/2024	Michael Corcoran	Updated Information	
4/2025	Michael Corcoran	Updated chapter format. Added information about SA294, U4- Housing and Employment Stabilization Services. Added information on How to document	



		Employment stabilization services in CARE. Added a chart demonstrating SA294, U4.	
8/2025	Michael Corcoran	Changed Chapter title and updated information	
4/2026	Michael Corcoran	Updated information. Added information regarding HRSN Short-Term Rental Assistance program.	

Foundational Community Supports- Supportive Housing

Chapter 30d describes Supportive Housing, a collaborative wraparound service for individuals with complex needs. These services are available in one of two ways for HCS recipients: Foundational Community Supports (FCS), or the Governor’s Opportunity for Supportive Housing (GOSH). This chapter describes program eligibility, service areas, referral process and case coordination for Foundational Community Supports – Supportive Housing services. For more information on GOSH, please see Long-Term Care Manual Chapter 6E: GOSH Services.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Samantha Thurston Housing Integration Unit Manager
564.200.2296 or Samantha.thurston1@dshs.wa.gov

For additional information please visit our website: [Office of Housing and Employment](#)

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BACKGROUND

Supportive Housing (SH) is a philosophy and a program that is rooted in the belief that no one should have to prove “housing readiness” to be housed. The service is an evidence-based practice with decades of research, as well as personal and professional stories that highlight the success of community living paired with intensive, personalized supports. A person is supported in the process of securing community-based, affordable housing of their choice along with individualized support to assist them with stabilization and self-identified goals. SH adheres to the principles of Housing First, Harm Reduction, Trauma Informed Care, Motivational Interviewing, Person Centered Planning, and Strengths-Based Approach. Program participation, medication adherence, and abstinence are not required to keep one’s housing.

SH services are available in two ways for HCS recipients:

- Individuals who are currently residing in the community may be eligible for Supportive Housing services under [Healthier Washington Medicaid Transformation](#): Foundational Community Supports (FCS) - Supportive Housing services.
 - Individuals with challenging or complex needs who are currently residing at Eastern or Western State Hospital or can be diverted from these institutions may access Supportive Housing Services through the Governor’s Opportunity for Supportive Housing (GOSH). For more information about GOSH, see chapter 6E.

SH provides dedicated housing support to people with complex needs wishing to live independently. The service provides wraparound support, which means facilitating cross-sector coordination of all services the person needs, including Long-Term Services and Supports (LTSS), mental health, substance use disorder, physical disabilities, developmental disabilities, and legal and/or financial issues. Supportive Housing services may be an option for individuals who want to live independently and have a history of unsuccessful housing episodes without coordinated focused support services. HCS seeks to provide person-centered, responsive, low barrier services for these individuals.

Contracted Supportive Housing Providers (SHP), service capacity and service areas are continuously expanding across the state. The HCS Supportive Housing Program Managers maintain the list of contracted SHPs. To find your Region’s Supportive Housing Program Manager, please see the [HCLA Housing Regional Map](#).

Supportive Housing Services: Pre-Tenancy

These specialty services provide assistance and support to aid an eligible individual’s successful transition to independent housing. Supportive Housing Pre-Tenancy services may include, but are not limited to the following:

- Facilitating a cross-sector system of care.
- Locating and arranging independent, accessible housing, including working with local housing authorities and other community resource providers when applicable.

- When relevant, liaising with and among the individual, institutional facility staff, case managers, housing providers, medical personnel, legal representatives, formal caregivers, family members, informal supports and any other involved parties.
- Educating individual on tenant rights, expectations and responsibilities.
- Assisting individual with filling out forms and obtaining needed documentation to aid in maintaining successful community living (forms may include initial and renewal voucher forms, lease agreements, etc.).
- Assisting individual in developing a basic household budget.
- Creating individualized Crisis Plan that is shared with cross sector team.

Supportive Housing Services: Tenancy

Once a Supportive Housing client has secured independent housing, signed a lease and moved into independent housing, they are considered a Supportive Housing tenant for the purposes of [WAC 388-106-1710](#). These specialty services provide assistance and support to ensure the eligible individual's maintenance of independent housing. Supportive Housing Tenancy services may include, but are not limited to the following:

- Necessary assistance to support the individual's community living, including assistance in settling disputes with landlords and/or neighbors.
- Working with an individual to identify a broad range of life goals and providing support to meet the goals documented on the goal and service plan. This housing support plan is created with the client and the Supportive Housing Provider.
- Assisting individuals with locating and arranging transportation resources to effectively connect with community resources.
- Facilitating connections to engage and enhance community integration activities.
- Educating individuals on accessing community settings or health services.
- Personal skill development for individuals and/or caregivers related to the individual's care plan.
- Connecting with emergency resources to avoid utility shut off and/or eviction.

FOUNDATIONAL COMMUNITY SUPPORTS: SUPPORTIVE HOUSING

In 2017, Washington State and the Centers for Medicare and Medicaid Services (CMS) finalized an agreement for a five-year Medicaid Transformation Project (MTP) to improve the state's health care systems, provide better health care, and control costs. In 2021, CMS approved a one-year extension. On June 30, 2023, [CMS renewed MTP for an additional five years, beginning on July 1, 2023, and running through June 30, 2028](#). By renewing MTP, our state can continue to develop innovative projects, activities, and services that improve Apple Health (Medicaid). To learn more about MTP 2.0, please see [HCA's MTP renewal website](#). You can also read the full [waiver renewal application](#).

The research is clear—unemployment and job insecurity, homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders. Similarly, evidence links unemployment to poor physical and mental health outcomes, even in the absence of pre-existing conditions. Foundational



Community Supports (FCS), part of Washington’s federally authorized Medicaid Transformation project addresses these factors with targeted benefits for Supportive Housing and Supported Employment.

In 2018, FCS began providing targeted Supportive Housing and Supported Employment services for eligible Medicaid beneficiaries in Washington State.

For more information regarding HCS FCS Supported Employment benefits, please see [LTC Manual Chapter 30c](#).

Eligibility

To receive Foundational Community Supports – Supportive Housing services, an individual must:

- 1) Be 16 or older Medicaid-eligible
- 2) Must meet at least **one** assessed health needs-based criteria:
 - a) Mental health need where there is need for improvement, stabilization or prevention of deterioration of functioning resulting from the presence of a mental illness (receiving services through a Managed Care Organization under the Behavioral Health Services Only (BHSO) plans or the Fully Integrated Managed Care (FIMC) plans).
 - b) Need for outpatient substance use disorder (SUD) treatment (receiving services through the Behavioral Health Services Only (BHSO) plans or the Fully Integrated Managed Care (FIMC) plans).
 - c) Need for assistance with three or more activities of daily living (ADL) (receiving long-term care [LTC] services).
 - d) Need for hands-on assistance with one or more ADL (receiving LTC services).
 - e) Complex physical health need, which is a long continuing or indefinite physical condition requiring improvement, stabilization or prevention of deterioration of functioning. For HCS clients to receive Supportive Housing services through FCS, an individual must meet HCS Functional and Financial Eligibility.
- 3) Must meet at least **one** of the following Risk Factors:
 - More than one institutional contact in the past 12 months or one 90+ day stay in an institutional setting in the past 12 months.
 - More than one adult residential care* stay in the past 12 months.
 - Three or more in-home caregivers, or agencies, in the past 12 months.
 - HUD definition Chronic Homeless as verified through the homeless service system.
 - PRISM score of 1.5 or higher.**

For HCS clients to receive Supportive Housing services through FCS, an individual must meet HCS Functional and Financial Eligibility. Case Managers can assist in submitting referrals for HCS clients meeting the above eligibility criteria, or prior to a client being terminated from services. Referrals can be emailed to SupportiveHousing@dshs.wa.gov or audrey.morford@dshs.wa.gov. If someone is not found functionally and financially eligible for HCS services, and no longer assigned to a case manager, they can still self-refer to FCS through this [online form](#).

*Adult residential care settings may include:

- Long-Term Services and Supports settings such as Adult Family Home, Assisted Living, Enhanced Adult Residential Center, Enhanced Service Facility, and
- Behavioral Health Settings such as Evaluation and Treatment Centers, Detoxification Centers, Inpatient Substance Use Treatment Facility.

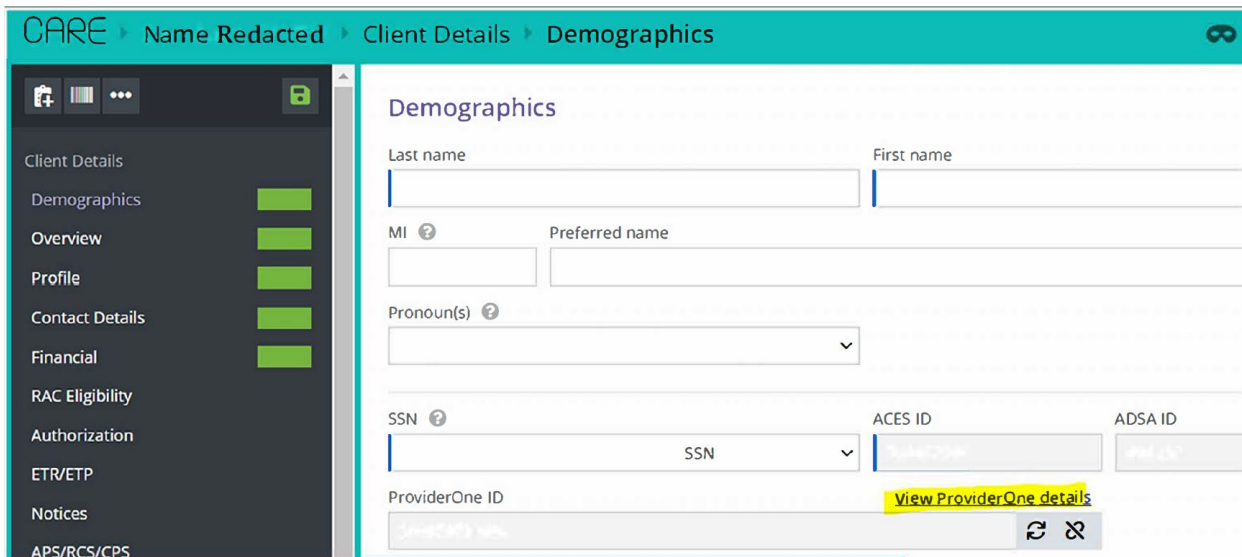
**HCS Supportive Housing Program Managers can verify PRISM scores for LTSS clients.

Note:

- A CARE assessment determines HCS functional eligibility. Functional eligibility is defined in WAC [388-106-0210](#), [388-106-0277](#), [388-106-0310](#), [388-106-0338](#), or [388-106-1410](#)
- Healthcare Authority WACs pertaining to FCS: [182-559-100 to 182-559-600](#)
- Long Term Care WAC: [388-106-1700 to 388-106-1765](#)

How can I tell if my client is enrolled in FCS-SH?

- Open the client's file in CARE Web
- Go to Client Details
- Go to the Demographics screen
- Click the "View ProviderOne Details" link
- From the "ProviderOne Demographics" screen, click on "Managed Care"
- Look for Program to contain "Foundational Community Supports-Housing" with Wellpoint Washington Inc listed as the plan



The screenshot shows the CARE web application interface. The top navigation bar is teal with the text 'CARE > Name Redacted > Client Details > Demographics'. On the left is a dark sidebar with a menu: Client Details, Demographics (highlighted with a green bar), Overview, Profile, Contact Details, Financial, RAC Eligibility, Authorization, ETR/ETP, Notices, and APS/RCS/CPS. The main content area is titled 'Demographics' and contains several input fields: Last name, First name, MI (with a help icon), Preferred name, Pronoun(s) (with a dropdown arrow and help icon), SSN (with a help icon and a dropdown menu showing 'SSN'), ACES ID, ADSA ID, and ProviderOne ID. A yellow highlight is under the 'View ProviderOne details' link next to the ProviderOne ID field. At the bottom right of the form are two icons: a refresh icon and a close icon.

▶ Client Details ▶ ProviderOne Demographics

ProviderOne Demographics
Addresses
Responsibility
Budgets
Home & Community Based
Nursing Home Record
AREP
Indicators
RAC
Source System Identifiers
Managed Care

ProviderOne details

ProviderOne Demographics

ProviderOne ID
Demograph

First name
Last name

Gender

Mortality date

ProviderOne Demographics
Addresses
Responsibility
Budgets
Home & Community Based
Nursing Home Record
AREP
Indicators
RAC
Source System Identifiers
Managed Care

ProviderOne details

Managed Care

Start date	End date	Program	Plan
11/01/2023	12/31/2999	Behavioral Health Services Only	Community Health Plan of Washington
03/01/2024	12/31/2999	Foundational Community Supports-Housing	Wellpoint Washington Inc

The above client is currently enrolled in Supportive Housing through Foundational Community Supports beginning 03/21/2024. Service authorization periods are 6 months but can be reauthorized by the provider if the client still wants/needs the service and is active on Medicaid.

FCS-SH Referral Process

1. When case managers identify a client who could benefit from these services, speak with them about Supportive Housing services and get verbal confirmation that they would like to be referred to these services.
2. Potential client, AAA/HCS Case Manager or HCS contracted provider contacts HCS Supportive Housing Program Manager, who will facilitate eligibility determination and, with client's verbal consent, make referral to Wellpoint.
 - a. Referrals can be made directly to Wellpoint by a potential client, AAA/HCS Case Manager or Wellpoint FCS contracted provider.
 - b. For direct referrals please see [Wellpoint's FCS Provider website](#).

3. All referrals go through Wellpoint to determine eligibility, for service authorization and assignment to a SHP.
4. If eligible for FCS, Wellpoint refers client to SHP.
5. SHP accepts or declines referral
 - a. If SHP declines a referral, Wellpoint will find another SHP to accept the referral.

Regardless of whether the individual is an HCS recipient, anybody can make a referral for FCS.

- Contact Wellpoint directly: call 1-844-451-2828 or email FCSTPA@wellpoint.com.
- Contact an HCS Supportive Housing Program Manager, call 1-844-704-6786 or email SupportiveHousing@dshs.wa.gov.
- To file an appeal or grievance with Wellpoint, call 1-844-451-2828 or email FCSTPA@wellpoint.com.

Note: Individuals on the Residential Support Waiver setting who wish to transition to an independent living setting with supports **may** be referred to Supportive Housing services.

FCS-SH Client Accepted

1. HCS Supportive Housing Program Manager will email/connect the LTSS case manager with the SHP to coordinate continuity of care.
2. LTSS case manager should schedule time with the SHP to discuss client needs, CM role, SHP role and assist SHP connect with client.
 - As referenced in [Chapter 3](#), page 3.17, LTSS case manager should share the plan of care with the SHP.
 - HCS Supportive Housing Program Manager is available to participate in meeting. Best practice would be to coordinate regular check-ins between LTSS and SHP.
3. Once client is authorized for Supportive Housing the case manager must:
 - a. Add the Supportive Housing Provider's contact information to the collateral contacts
 - b. Open an interim assessment
 - c. Add supportive housing to the treatment screen
 - d. Select "Other" as the provider
 - e. Select "Weekly" as the frequency
 - f. Add a comment explaining that the FCS Provider is the "Other" provider listed and how this provider is helping the client (tenancy sustaining support or housing search)
 - g. In the support screen, add FCS Provider and assign "Other" to them
 - h. Move interim assessment to current
 - i. Use the Purpose Code "Housing" for any SERs related to FCS-SH.
4. SHP works with clients to pursue independent housing and support clients in maintaining independent housing.
 - LTSS case managers should work with client and SHP to identify any LTSS goods, services and/or supports client might need to be authorized to transition into or sustain independent housing.

Reimbursements

[Community Transition and Sustainability Services](#) are available to provide transitional or stabilizing supports for HCS clients to sustain community living. With prior approval from the AAA/HCS CM or HCS Supportive Housing Program Manager, an HCS contracted provider, such as a Community Choice Guide (CCG) or Governor's Opportunity for Supportive Housing (GOSH) provider, is reimbursed for the authorized purchases after it is verified the individual received the goods or service. Based on an individual's eligibility, the following services could be reimbursed: Shopping for necessary household goods/items or paying for rental deposit, tenant background screening to aid housing search, utility hookup fees, or rent/emergency rental assistance service.

Additionally, starting in May 2022, Wellpoint launched the Transition Assistance Program (TAP) for FCS-SH enrollees. TAP is a time-limited, flexible funding assistance that covers housing-related fees, including move-in costs, first and last month's rent, deposits, and non-refundable fees. For more information on TAP please see the Transition Assistance Program section on [Wellpoint's FCS Provider webpage](#).

Community Choice Guides and FCS-SH Providers

Community Choice Guides (CCG) and FCS-SH Providers have similar pre-tenancy duties, such as housing search, identifying housing resources, independent skills development, and landlord relations. State Supportive Housing services do not include transition funds to pay for items such as background checks, application fees, security deposits or furniture. Therefore, when there are no individual or other community resources available, LTSS case managers should authorize Community Transition or Housing & Employment Stabilization Services to supplement the services provided by CCGs and/or FCS-SH Providers. Please see the [reference tools document](#) for assistance in determining the appropriate funding source.

Who authorizes CCG and FCS-SH Providers?

CCGs are authorized in CARE by HCS and/or AAA staff per HCS policy.

FCS-SH Providers are contracted and authorized by Third Party Administrator Wellpoint. These authorizations are not in CARE.

When is it OK to have both a CCG and FCS-SH authorized?

CCGs and FCS-SH Providers can work simultaneously with a client as long as there are clearly defined and separate tasks. For example, an FCS-SH Provider could assist with independent housing search and paperwork/applications, while the CCG could assist with purchasing and residential facility search.

When is it *not* OK to have both a CCG and FCS-SH authorized?

When both CCG and FCS-SH Providers are assisting a client with the same tasks, such as housing search, it is a duplication of service. It is important to note that not all FCS-SH referrals come from HCS Supportive Housing Program Managers. Referrals can come from many sources, including providers, community partners, and clients themselves. Clients may already be enrolled in FCS Supportive Housing at the time of LTSS intake/assessment.

Can FCS-SH Providers be reimbursed directly without authorizing a CCG?



Supportive Housing Providers that are contracted directly with DSHS through [HCS's Governor's Opportunity for Supportive Housing \(GOSH\) service](#) or through CCG contracts may complete purchasing for items pre-approved by the case manager and be reimbursed through ProviderOne. However, if a Supportive Housing Provider through Foundational Community Supports is not dually contracted with DSHS through a GOSH or CCG contract, they will not be able to purchase items directly and be reimbursed. In these cases, a case manager will need to authorize a CCG to make a purchase on behalf of a client. Foundational Community Supports SHPs are authorized via Wellpoint to provide services. The FCS-SHP will bill Wellpoint for the services and submit the invoice/receipt for reimbursement to the HCS/AAA case manager. The FCS-SHP would not be authorized through HCS to provide a service, as they are already authorized via FCS to provide services and this would be a duplication of service to be doubly authorized.

Please consult your [Regional Supportive Housing Program Manager](#) if you are not sure if a FCS-SH Provider is contracted directly with DSHS.

How is this funded?

Foundational Community Supports is part of the Healthier Washington Medicaid Transformation (MT). MT is a six-year demonstration waiver funded 100% by the federal Centers for Medicare and Medicaid Services through 2022. On July 15, 2022, the State submitted a waiver renewal application for MTP to CMS. If CMS approves the application, MTP will continue for an additional five years – from 2023 – 2027+.

Note: There is no participation required for clients receiving FCS - Supportive Housing services.

Can a DDA services recipient receive FCS-SH Services?

An individual receiving DDA services may be eligible for FCS Supportive Housing services. Such individuals must be found to meet an eligible health need and a risk factor. Individuals dually eligible for DDA and HCS services are eligible for FCS through the long-term care eligibility pathway if they also meet a risk factor. Individuals only receiving DDA services could also be found eligible with a mental health diagnosis/substance abuse disorder or experiencing homelessness with a disability determined by a coordinated entry assessment and an accompanying risk factor. Please refer to Wellpoint for specific eligibility questions. They can be reached directly by phone: 1-844-451-2828 or email FCSTPA@wellpoint.com.

What about Contracting?

Wellpoint Washington Inc. was awarded the contract providing the Third-Party Administrator services for FCS. Providers interested in contracting for FCS should contact Wellpoint directly by phone: 1-844-451-2828 or email FCSTPA@wellpoint.com.

SUPPORTIVE HOUSING AND CASE COORDINATION

How do SH services and Long-Term Services and Supports (personal care, client training, community transition services, etc.) complement each other?

SHPs will need to coordinate closely with case managers to ensure all necessary LTSS services are authorized. Clients who are eligible for LTSS may receive MPC, CFC, CFC + COPES, RCL and RSW services while receiving Supportive Housing services.

- I. Based on the LTSS program the client is eligible for, Community Supports: Goods and Services may be considered.
 - a. [LTC Manual Chapter 7b](#) discusses the Community First Choice (CFC) Community Transition Services (CTS) and its eligibility parameters
 - b. As for Community Transition and Sustainability Services (CTSS), dependent on client's eligibility and the situation, see:
 - i. LTC Manual Chapter 6D for coverage under Housing & Employment Stabilization Services
 - ii. [LTC Manual Chapter 7d](#) for COPES eligibility
 - iii. [LTC Manual Chapter 29](#) for coverage under RCL
 - c. HCS Supportive Housing Program Managers are available to answer questions regarding accessing these resources.
- II. The SHP should be in contact with the case manager as well as the HCS Supportive Housing Program Manager to provide updates. The case manager should document communication as a service episode record (SER).
- III. In partnership with the SHP, any purchases made on behalf of the individual to assist with community transition and sustainability as well as any subsequent reimbursement processing will be completed per regional policy. Any ETRs necessary for these goods and services will be completed per regional policy.
- IV. If the individual is eligible for long term services based primarily on a psychiatric condition and the criteria indicated in [Chapter 7h](#), the case manager will follow the process as outlined in LTC Manual [Chapter 7h](#) for requesting funding from the MCO to cover the client's personal care.

If someone receiving Supportive Housing services "refuses" or declines personal care, do I need to close the case for all services?

Yes, but before closing out a case, consider the following:

- Certain community settings, client choice, or other situations may create a care plan where Personal Care is not feasible. Has the possibility of setting up personal care in a non-traditional setting (e.g., shelter or hygiene station) been explored?
- Other HCS services may be authorized in order to move an assessment to current and provide an official start date for services. Some examples of these services could be: GOSH, Wellness Newsletter, PERS, Behavioral Supports, DME, Skilled Nursing, Client Training, etc. As a reminder, per Management Bulletin [H18-056](#), AAA's are paid to case manage clients with *any* open authorization for LTSS.

- What supports do the collateral contacts (including formal and informal supports) report the client is utilizing? These supports should be captured in CARE.
- Medication Management is a “look forward” screen. Will the client benefit from ongoing medication management assistance?
- What support services, outside of caregiving, will the client benefit from in order to stabilize community living?
- Has the case been staffed with an HCS Supportive Housing Program Manager?

Note: If you believe you must close a case, please see requirements to do so in the [Challenging Cases Protocol](#).

RESOURCES

[Housing Team Contacts](#)

Office of Housing and Employment SharePoint site: [Office of Housing and Employment](#)

Office of Housing and Employment website: [Office of Housing and Employment Webpage](#)

Brochures and Videos

- [Wellpoint FCS Quick Reference Guide](#)
- [HCS Foundational Community Supports - Supportive Housing \(FCS-SH\)](#)
- [Wellpoint Transition Assistance Program Quick Reference Guide](#)
- [Transition Services Resource Guide](#)

Related RCWS and WACs:

The following rules and policy support case management functions:

RCW 74.38.010	Legislative Recognition – Public Policy
RCW 74.38.040(1)	Scope and Extent of Community-Based Services Program
RCW 74.39.005(7)	Long-term Care Service Options - Purpose
RCW 74.39A.040(3)(c)	Department Assessment of and Assistance to Hospital Patients in Need of Long-term Care
RCW 74.42.057	Notification Regarding Resident likely to Become Medicaid Eligible
RCW 74.42.058	Department Case Management Services
RCW 74.39A.090	Discharge Planning-Contracts for Case Management Services and Reassessment and Reauthorization – Assessment of Case Management Roles and Quality of In-Home Care Services – Plan of Care Model Language
RCW 74.39A.095	Case Management Services – Agency on Aging Oversight Plan of Care – Termination Contract – Rejection of Individual Provider Contract

[RCW 70.41.310](#) Long-term care -- Program information to be provided to hospitals --
Information on options to be provided to patients.
[WAC 388-106-1700](#) to [WAC 388-106-1765](#)

Forms:

[Behavioral Health Personal Care Request for MCO Funding DSHS form 13-712](#)

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
10/2018		Established	
01/2019		Edits to section on when a client declines personal care that that the case may remain open to receive supportive housing services or subsidy.	
08/2019		Edits for clarity on program services.	
06/2020		Edits to update FCS and GOSH sections for clarity on program services and for formatting.	
8/2020		Hyperlinks added for LTC Manual Chapters 5b and 9b; updated FCS-SH and GOSH procedural steps.	
10/2020		Updated GOSH Pre-Tenancy Service Code, provided clarification around SHPM vs CM responsibility in "GOSH Client Accepted" section and updated link for DSHS form 13-712	
02/2021		Rearranged chapter sections; Moved section on Governor's Opportunity for Supportive Housing (GOSH) from Chapter 30d to Chapter 5b: Housing Resources for HCSHCS Clients ; Clarified FCS-SH Eligibility criteria; Added clarification that there is no participation for Supportive Housing services; Added section on verifying if client is already enrolled in FCS-SH; Added clarification around Community Choice Guides and FCS-SH Providers.	



05/2021		Updated hyperlink in Chapter Section for Supportive Housing and Case Coordination	
02/2022		Updated hyperlinks, Updated Medicaid Transformation Project end date to December 31, 2022 to include the approved extension year, clarified some language throughout the Chapter	
08/2022		Updated "Foundational Community Supports: History" section to include information on the five-year waiver renewal application the State submitted to CMS; updated "How can I tell if my client is enrolled in FCS-SH?" section to CAREWeb version.	
08/2023		Updated with information on MTP 2.0 renewal and new end date. Reference to FCS-SH Transition Assistance Program added under Reimbursements section.	
08/2024		Updated page numbers, table of contents, and replaced Amerigroup with Wellpoint. Added additional info regarding FCS-SH with DSHS (CCG/GOSH) contracts. Added Office of Housing Website link	
04/2026		Replaced ALTSA with HCS. Removed language around client not having to be closed out if refusing or declining personal Care.	
07/2026		Updated instructions on how to document FCS Supportive Housing Service Authorizations in CARE.	



Long-Term Services and Supports Presumptive Eligibility (LTSS PE)

Chapter 30e describes LTSS PE as part of the 1115 Medicaid Transformation Project waiver. LTSS PE will establish presumptive eligibility for individuals in need of long-term services and supports under Medicaid state plan and 1915(c) waiver authorities and Medicaid medical coverage and will be implemented in three phases.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Collin Young LTSS PE Policy Program Manager
collin.young1@dshs.wa.gov

Rebecca Schwartz Financial Policy Analyst for LTSS PE
rebecca.schwartz1@dshs.wa.gov

If you have questions or need clarification about the 1115 Waiver:

Resa Lee-Bell 1115/MTP Waiver Program Manager
resa.lee-bell@dshs.wa.gov

Annie Moua Medicaid Unit Manager
anne.moua@dshs.wa.gov

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BACKGROUND

Long-Term Services and Supports Presumptive Eligibility, or LTSS PE, was approved by the Centers for Medicare and Medicaid Services in July 2023 with the 1115 Medicaid Transformation Project (MTP) waiver. Under the 1115 MTP waiver, specific Medicaid requirements are waived. LTSS PE is a package of services based on self-attested functional and financial eligibility determination. LTSS PE provides individuals an opportunity for expedited access to both home and community-based services in their own home and Medicaid (Apple Health) medical coverage benefits while full functional and financial eligibility are being determined.

Recipients of PE must be residing in their own home and plan on enrolling in one of the following Washington State programs:

- Medicaid Personal Care (MPC)
- Community First Choice (CFC)
- CFC + Community Options Program Entry System (COPES)

They must then complete a PE Assessment which uses preliminary information based on self-attestation to determine eligibility for the program. If found to be eligible for PE, they will be offered a limited benefit package during the PE period. Services included in the limited benefit package are described in subsequent sections. Rules governing LTSS PE can be found in [WAC 388-106-1800](#) thru [388-106-1855](#). LTSS PE was developed to be implemented in three phases:

Phase 1 was implemented statewide on December 4, 2023, offered to applicants who will be or have transitioned from an acute care hospital or diverted from a community psychiatric hospital to their own home, in the last 30 days.

Phase 2 statewide implementation occurred on July 1, 2026. Phase 2 expands LTSS PE services to applicants who choose to receive services in their own home. Phase 2 no longer requires applicants to be transitioning from an acute care hospital or diverting from a community psychiatric hospital to their own home as an eligibility criteria.

Phase 3 will be reviewed by Centers for Medicare & Medicaid Services (CMS) at a later date. If approved, LTSS PE will be expanded to include individuals who are interested in receiving LTSS in a residential setting.

WHY LTSS PE?

The goal of LTSS PE is to provide individuals with expedited access to home and community-based services. By doing so, LTSS PE will provide services to assist clients to live as independently as possible in their home.

LTSS PE allows individuals access to Medicaid Apple Health medical coverage and a limited package of services while full functional and financial eligibility is being determined. Individuals already determined financially eligible for Medicaid state plan medical benefits will only require a functional LTSS PE determination.



WHO IS ELIGIBLE FOR LTSS PE?

To be eligible for the LTSS PE program, and before services can be authorized, the client must meet the criteria below.

LTSS MPC PE Eligibility

1. Meet functional eligibility requirements as defined in [WAC 388-106-0210](#).
2. Meet financial eligibility requirements as defined in [WAC 182-513-1225](#)
3. Live in their own home, as defined in [WAC 388-106-0010](#).
4. Are not receiving any other Medicaid funded long-term services and supports.
5. Have not received LTSS PE services in the last 24 months.
 - a) This will be calculated from the time the previous LTSS PE ended. Applicants who are approved for LTSS PE during Phase 1 but did not receive services during the LTSS PE period could reapply for an LTSS PE Assessment.

LTSS NFLOC PE Eligibility

1. Meet functional eligibility requirements as defined in [WAC 388-106-0355](#)(1)(a), (b), (c), or (d).
2. Meet financial eligibility requirements as defined in [WAC 182-513-1315](#).
3. Live in their own home, as defined in [WAC 388-106-0010](#).
4. Are not receiving any other Medicaid funded long-term services and supports.
5. Have not received LTSS PE services in the last 24 months.
 - a) This will be calculated from the time the previous LTSS PE ended. Applicants who are approved for LTSS PE during Phase 1 but did not receive services during the LTSS PE period could reapply for an LTSS PE Assessment

Eligibility during LTSS PE Phase 1 was limited to clients who were discharging or diverting from an acute care hospital or a community psychiatric hospital or had discharged or diverted from an acute care hospital or community psychiatric hospital in the last 30 days, as well as the other criteria above.

Note: If a client was discharged from the hospital to a skilled nursing facility (SNF) for less than 30 days before discharging to an in-home setting and did not have contact with the NFCM, they could still be considered for LTSS PE.

WHERE CAN INDIVIDUALS RECEIVE LTSS PE SERVICES?

LTSS PE services will be provided in home and community-based settings. To be eligible to receive LTSS PE services, the client must live in their own home as defined in [WAC 388-106-0010](#). Examples of own home include:

- In an apartment that the client rents.
- In an established home that the client owns.
- In a relative's established home.

- In the home of another where rent is not charged.
- In a motel, where the client pays an established weekly/monthly rate of pay to reside (i.e., rent).

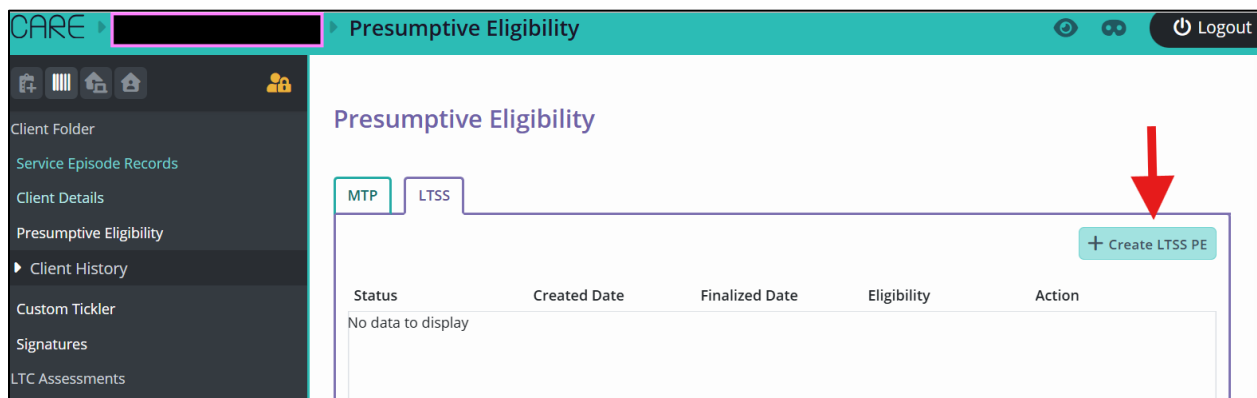
ASSESSING FOR LTSS PE ELIGIBILITY

HCS Social Service Specialist (SSS) or Area Agencies on Aging (AAA) staff will use the LTSS PE Assessment in CARE Web to gather preliminary information that will determine financial and functional eligibility for LTSS PE. The LTSS PE assessment is conducted telephonically.

Full LTSS functional and financial eligibility will be determined while the client is accessing LTSS PE services. The full functional determination will be completed via the CARE Web Assessment which will be conducted via an in-person process, as outlined in Long Term Care Manual [Chapter 3: Assessment and Care Planning](#).

Creating an LTSS PE Assessment in CARE Web

The LTSS PE Assessment can be accessed via the *Client Folder > Presumptive Eligibility > LTSS tab > + Create LTSS PE*:



The LTSS PE Assessment has three (3) sections: Financial, Functional, and Care Plan. Each section of the Assessment is dynamic, meaning once all required fields in the Financial section have been completed, the PE Assessment will display the Financial indicator as “Eligible” or “Ineligible”. When displayed as “Eligible”, then the LTSS PE Functional section will enable. When the Functional section is displayed as “Eligible”, the LTSS PE Care Plan will be enabled to complete the Assessment process.

LTSS PE Financial Eligibility Overview

LTSS PE applicants who plan to enroll in CFC, CFC+COPEs, or MPC programs are either already financially eligible for Medicaid state plan medical benefits or will self-attest to financial eligibility. Eligibility factors for LTSS PE are based on the eligibility criteria for LTSS, and do not necessarily reflect the eligibility criteria for a medical program a client may currently be receiving. The financial criteria for a client's current medical program should not be used in determining LTSS PE. The financial eligibility factors listed below are based on the criteria for the final LTSS application eligibility.

Financial Eligibility for LTSS NFLOC or MPC PE is met when:

1. The applicant is a current recipient of:
 - a) Categorically Needy (CN); **or**
 - b) Alternative Benefit Plan (ABP) Medicaid coverage; **or**
 - c) Individual is not a current recipient of CN or ABP but meets the criteria in a.-f. below and submits a completed HCA form 19-0054 if under age 65.
 - i. An S32 will be opened during the period of PE approval.
2. The applicant is financially eligible for LTSS NFLOC PE when a.– d. **and** either e. **or** f. apply:
 - a) Has Washington State residency; **and**
 - b) Is a U.S. citizen, U.S. national, or eligible immigrant; **and**
 - c) Social Security Number (SSN); **and**
 - i. If there is no SSN or it is unknown, it will not preclude the applicant from applying for LTSS PE. Provide the individual with assistance applying for an SSN or getting the person's SSN, unless the individual meets the exception under WAC 182-503-0515 subsection (2).
 - d) Is Aged, Blind, or Self-Attests to Disability; **and**
 - e) If *single*: the single individual's non-excluded monthly income is equal to or less than the Categorically Needy Income Level (CNIL), and the individual's separate non-excluded resources are at or below \$2,000; **or**
 - f) If *married*: for a married couple with a non-institutional spouse, the individual's non-excluded income is equal to or less than the CNIL with spousal impoverishment protections, and that non-excluded resources (calculated as of the first point at which the individual is deemed to have the status of an "institutionalized spouse") are at or below a combination of \$2,000, plus the current state Community Spouse Resource Allowance, based on the individual's self-attested statement of their household resources.

If the applicant attests to resources over the allowable limits as a single person or married person, they do not meet the criteria for LTSS PE services. They can still pursue LTSS services through the traditional eligibility determination process.

Defining "Resources"

A "resource" is any cash, other personal property, or real property that an applicant, recipient or other financially responsible person owns, can convert to cash (if not already cash), and has the legal right to use for support and maintenance (see [WAC 182-512-0200](#)). Any asset that does not meet this criterion is not a resource. Resources examples: checking accounts, stocks, bonds, annuities, pensions, vacation property, multiple cars, and cash in a safe.

A "countable resource" is something that meets the definition of a resource, is not excluded as a resource, and is available to convert into cash (if not already cash). A resource that ordinarily cannot be converted to cash within 20 working days is considered unavailable as long as a reasonable effort is being made to convert the resource to cash ([WAC 182-512-0250](#)). A person may provide evidence

showing that a resource is unavailable. A resource is not counted if the person shows sufficient evidence that the resource is unavailable.

An “excludable resource” can be:

- The home, household goods, certain other property ([WAC 182-512-0350](#)).
- One vehicle used for transportation ([WAC 182-512-0400](#)).
- Life insurance up to \$1,500, but the rule can get complex ([WAC 182-512-0450](#)).
- Burial fund up to \$1,500, but the rule can get complex ([WAC 182-512-0500](#)).
- Other resources excluded by federal law ([WAC 182-512-0550](#)).
- Certain American Indian or Alaska Native resources ([WAC 182-512-0770](#)).

HCA Form #19-0054 Certification of Potentially Disabling Condition

To be eligible for LTSS PE, client’s must be aged, blind, or self-attest to a disability. If the client is not determined Aged, Blind, or Disabled, and S02, S95, or S99 ACES codes are not open for a first-time client, then the HCA [#19-0054](#) form is required for LTSS PE financial eligibility. The [#19-0054 form](#) will be needed before the LTSS PE period is over and full financial and functional eligibility is determined. HCS/AAA staff will support the client to have this form completed by a licensed medical professional (as described in [WAC 388-449-0010](#)) to confirm a disabling condition for the client on long-term services and supports.

The [#19-0054 form](#) would not be required for clients 65 years and older or already active on a DSHS Classic Medical program (S01, S02, S95, and S99 ACES codes) because they would have already been determined Aged, Blind or Disabled in order to be active on a DSHS Classic Medical.

Scenario 1

Q: Do I need to get a [19-0054](#) presumptive disability form when the client is already receiving Medicaid coverage at the time LTSS PE is requested?

A: No, for clients who are already Medicaid eligible (on MAGI or classic Medicaid coverage) and functionally eligible for LTSS PE services, no [19-0054 form](#) is required. Proceed with authorizing LTSS PE services.

Scenario 2

Q: If the client is already Medicaid eligible under MAGI and receiving LTSS PE services and is found to need waiver services when the full Assessment is completed, do I still need to get the [19-0054](#)?

A: No, you don’t need to have the [19-0054 form](#) completed. You will need to communicate with financial and let them know waiver services are required so they can request an application and start the NGMA process (see [Chapter 7h](#)) to get disability approved following existing processes. If found eligible after the full Assessment, the client can be approved for CFC only. You can end LTSS PE services and authorize CFC services while waiting for the disability determination (NGMA) for waiver services to be completed. Once the disability determination is completed and approved, the client may move to CFC + COPES, if needed.

Scenario 3

Q: If the client is not already Medicaid eligible (under any program) and is determined financially and functionally eligible for LTSS PE services, do I need to get the [19-0054 form](#)?

A: Yes. Under the terms of the 1115 waiver, a person applying for COPES or CFC may self-attest to disability status. If the client self-attests to having a disability, we must get the [19-0054 form](#) completed by their health care professional to confirm presumptive disability status.

LTSS PE Client Responsibility/Participation/Cost of Care

LTSS PE applicants financially eligible for a CN or ABP Medicaid coverage program does not pay toward the cost of care in an in-home setting.

LTSS PE applicants receiving LTSS MPC PE services **do not** pay toward the cost of care for those services.

LTSS PE applicants receiving LTSS NFLOC PE services **may** need to pay toward the cost of care as outlined (see [WAC 182-515-1509](#)).

To calculate Client Responsibility, HCS/AAA staff will use the LTSS PE Participation Calculator to enter/complete:

1. Client's gross earned income (income a client receives when being employed).
2. Client's gross unearned income (such as a pension, SSA income, VA income, etc.).
3. Client Has a Payee? (Check box Yes or No)
4. Does client pay a guardianship fee? (Check box Yes or No)
5. Medical Deductions (such as old medical bills, premiums, out-of-pocket expenses, etc.).

Post-Eligibility Treatment of Income (PETI)

LTSS PE applicants are subject to Post-Eligibility Treatment of Income (PETI) based on self-attested available income and allowable deductions, including a Personal Needs Allowance (PNA) during the LTSS PE period. The cost of care applied during the LTSS PE period will not be adjusted when full eligibility is determined. If applicable, an updated PETI will be applied the first of the month following determination, based on completion of the client's full financial and functional eligibility determinations.

Estate Recovery

LTSS PE applicants are subject to Medicaid estate recovery rules. Estate recovery is the department's process of recouping the cost of Medicaid and LTSS benefit payments from the estate of the deceased client. Information on estate recovery will be provided to an LTSS PE-eligible client via the LTSS PE Approval Notice.

LTSS PE Functional Eligibility Overview

Once financial eligibility is determined as "Eligible", the LTSS PE Functional section will be enabled and the LTSS PE Assessor will complete the LTSS PE Assessment.



LTSS PE AND FAST TRACK

Most often, full financial and full functional eligibility determinations for LTSS will be done concurrently.

If the client received a full functional CARE Web Assessment and financial eligibility is not yet determined, the LTSS PE functional Assessment cannot be retroactively accessed during the interim. Consider Fast Track, a process that allows the authorization of HCS services prior to a financial eligibility determination, when staff can reasonably conclude that the applicant will be financially eligible. See [Chapter 7a, Financial Eligibility for Core Programs](#) for an overview on Fast Track.

Note: A client cannot access Fast Track when accessing LTSS PE.

If the client meets full financial eligibility for Medicaid state plan medical benefits but has not yet received a CARE Web Assessment to determine full functional eligibility, then the LTSS PE functional Assessment can be accessed (given the circumstances that the client has an established home setting).

IDENTIFYING LTSS PE SERVICE OPTIONS

Clients may receive a combination of LTSS PE services once the LTSS PE Assessment indicates LTSS MPC PE or LTSS NFLOC PE functional and financial eligibility, the client provides verbal consent and approval for their LTSS PE Plan of Care, and the client's choice of care provider meets DSHS qualifications (see [WAC 388-71-0510](#)).

Clients may receive LTSS PE services in their own home (see [WAC 388-106-0010](#)). Clients may also receive LTSS PE services while they are out of their home accessing the community or working while:

1. Within Washington State; **or**
2. In a recognized out-of-state bordering city (see [WAC 182-501-0175](#)).

The client's choice of services under LTSS PE cannot duplicate services covered under private insurance, Medicare, state plan Medicaid, or through other federal or state programs.

LTSS PE services may not supplement the reimbursement rate from other resources.

SERVICES AVAILABLE THROUGH LTSS MPC PE

LTSS MPC PE services include up to 34 hours of authorized Personal Care Services per month.

SERVICES AVAILABLE THROUGH LTSS NFLOC PE

LTSS NFLOC PE services are available in two steps. Step 1 services should be offered to LTSS NFLOC PE individuals first if they meet the eligibility criteria for each service. These services could meet people's assessed needs while being more cost effective and while waiting to get services available through Step 2 in place. See [Chapter 7b](#) for Assistive/Adaptive Technology & Equipment and PERS and [Chapter 7d](#) for Home Delivered Meals eligibility criteria.



Note: Service limits match other program limits. For example, AT would follow the CFC limits of \$550 per SFY.

Step 1 Services

1. Home Delivered Meals
 - a) When authorizing Home Delivered Meals (HDM), there is no deduction of personal care hours for each meal.
2. Assistive/Adaptive Technology & Equipment
3. Personal Emergency Response Systems (PERS)

Step 2 Services

1. Personal Care Services
 - a) Tier 1 Classification = 34 hours per month
 - b) Tier 2 Classification = 47 hours per month
 - c) Tier 3 Classification = 59 hours per month
 - d) Tier 4 Classification = 69 hours per month
 - e) Tier 5 Classification = 103 hours per month
2. Nurse Delegation
3. Specialized Medical Equipment and Supplies
4. Community Transition or Sustainability Services (CTSS): Goods and services which are nonrecurring set-up items and services to assist with expenses to move from an acute care hospital or diversion from a psychiatric hospital stay to an in-home setting and may include:
 - a) Security deposits that are required to lease an apartment or home;
 - b) Activities to assess need, arrange for, and obtain needed resources, including essential household furnishings.
 - c) Set-up fees or deposits for utility or services access, including telephone, electricity, heating, water, and garbage.
 - d) Services necessary for your health and safety such as pest eradication, and one-time cleaning prior to occupancy.
 - e) Moving expenses.
 - f) Minor home accessibility modifications necessary for hospital discharge.
5. Community Choice Guide (CCG): Specialty services which provide assistance and support to ensure an individual's successful transition to the community and/or maintenance of independent living.
6. Supportive Housing

Is a person experiencing homelessness eligible for Presumptive Eligibility?

GOSH clients are eligible to utilize the Motel for Interim Stay Transition (MIST) program. MIST can be authorized for up to 6 months. If the HCLA client qualifies for LTSS PE, desires GOSH, and has no safe place to stay or resources to pay for a place, the HCS/AAA staff can utilize MIST. When a GOSH recipient is paired with MIST, they are not considered homeless and can then access the LTSS PE benefits.

NOTE: Clients eligible for LTSS PE could access WA Roads if they meet eligibility criteria. See [Chapter 5a](#) for WA Roads eligibility criteria. Requests for LTSS PE clients to utilize WA Roads must be sent to HQ for approval. These requests are to be sent to the [LTSS PE Program Manager](#).

ETRS AND LTSS PE

Exception to Rules (ETRs) will not be granted for LTSS NFLOC PE or LTSS MPC PE eligibility determinations or service determinations per [WAC 388-106-1855](#).

ADMINISTRATIVE HEARING RIGHTS

Applicants do not have an administrative hearing right as defined in [WAC 388-02](#) on LTSS NFLOC PE or LTSS MPC PE eligibility determinations.

LTSS PE NOTICES

LTSS PE uses four forms:

1. The “**Long-Term Services and Supports Presumptive Eligibility Approval Notice**” (LTSS PE Approval Notice) is used when the client is determined LTSS MPC PE or LTSS NFLOC PE eligible. The notice informs the client of eligibility, and that once a final determination is made, the client may be eligible for different services, more or fewer monthly personal care hours, or be determined not eligible for any services. The notice informs the client of:
 - a. Next action steps to make a full financial and functional determination,
 - b. inform the client of their rights and responsibilities, and
 - c. estate recovery.

HCS/AAA PE staff **MUST** review this approval notice with the client and obtain the client’s/authorized representative’s signature.

2. The “**Long-Term Services and Supports Presumptive Eligibility Denial Notice**” (LTSS PE Denial Notice) is used when the client is determined ineligible for LTSS MPC PE or LTSS NFLOC PE. The notice informs the client of the reason(s) for ineligibility and informs them of their rights.
3. The “**Presumptive Eligibility Care Plan**”, is used as the Plan of Care. This form **MUST** be signed by the client/representative, HCS/AAA PE staff, and the paid provider responsible for implementing the Plan of Care.



4. HCA/AAA PE staff **MUST** obtain client/authorized representative's signature on the **Consent Form** ([DSHS Form #14-012](#)).

Financial Ineligibility Notices

When the client submits their application, the Public Benefits Specialist (PBS) will determine a client to be financially eligible or ineligible. When determined financially ineligible, the PBS sends a denial letter to the client. HCS/AAA staff do not need to send additional notice following the PBS worker's financial ineligibility notice in order to close services. Best practice is that the HCS/AAA will contact the client and let them know that services will end the date the decision was made on client's application and the providers on the day the decision is made. The LTSS PE Denial Notice applies to *initial* denial of LTSS PE services before a LTSS PE period were to begin, and therefore, would not be used for this purpose.

If the client fails to cooperate with providing the requested information needed to determine financial eligibility or provides information which indicates they are not financially eligible, the application decision would be to deny LTSS, and they are no longer eligible for LTSS PE as of that date. The client does have a 30-day reconsideration period for their LTSS application, but that does not apply to LTSS PE. The HCA/AAA worker will contact the client and provider on the day the decision is made and the LTSS PE RAC and authorizations for services should be ended.

DEVELOPING THE LTSS PE PLAN OF CARE

After the LTSS PE Assessment is completed in CARE Web, a brief Plan of Care will be generated based on the level of care (LTSS MPC PE or LTSS NFLOC PE) and services chosen. Before identifying and authorizing a service indicated in the client's LTSS PE Plan of Care, the client must have verbally approved the Plan of Care. Utilizing voice signature or electronic signature would replace the need to obtain verbal approval prior to obtaining the signature. See attachment in [Appendix](#) for more information about voice signatures. Contact the client to obtain verbal approval for the LTSS PE plan of care.

- In CARE Web, use Service Episode Record (SER) Purpose code, *Plan Approval*, to document verbal approval.
- Review with the client and send the LTSS PE Approval Notice, LTSS PE Care Plan, and Consent Form ([DSHS Form 14-012](#)).

Prior to authorizing services in CARE Web, all services must be indicated in the client's LTSS PE Plan of Care, and the paid supports must be qualified:

- Ensure the Home Care Agency and other chosen service vendors of LTSS PE services are qualified and contracted through the local [Area Agency on Aging](#) (AAA). Each local AAA maintains a list of contracted, eligible providers for HCS and AAA. Contact the Contract Specialist for each AAA for the current list of contracted vendors.
- CDWA Individual Provider (IP): clients may also choose Personal Care Services be provided by one or more CDWA Individual Providers (IPs), as defined in [WAC 388-115-0503](#).



Additional Reminders:

Work with the client to identify qualified providers and authorize services consistent with the procedures for other programs like CFC ([Chapter 7b](#)), MPC ([Chapter 7c](#)), or COPES ([Chapter 7d](#)).

Send Plan of Care to the Home Care Agency or CDWA per client's choice, if they choose Personal Care Services.

If discharging from a hospital at the time of the LTSS PE Assessment, use the designation "Discharged with HCS services pending".

COMMUNICATING WITH PUBLIC BENEFITS SPECIALIST (PBS)

When HCS/AAA PE staff complete the LTSS PE Assessment in CARE Web, HCS/AAA PE staff will communicate eligibility with the PBS team. If the client is not assigned an ACES ID, the PE staff will email the Application Assistance Unit/AAU at 1115PresumptiveEligibility@dshs.wa.gov requesting an ACES ID be established. The AAU PBS team will respond to the email providing the ACES ID.

PE staff will submit a [14-443](#) communication via Barcode under the client's ACES ID, checking "LTSS Presumptive Eligibility (PE)" as a program option and indicating the LTSS MPC PE or LTSS NFLOC PE program start date.

The 1115presumptiveeligibility@dshs.wa.gov email address is specific to LTSS PE only and **should not** be used for Medicaid Alternative Care (MAC) or Tailored Supports for Older Adults (TSOA) inquiries or needs.

COLLABORATION BETWEEN AAA AND HCS INTAKE AND IN-HOME ASSESSOR

With LTSS PE, intake can occur at either the AAA or HCS front door. Due to this, a feature called "Case Sharing" is available in CARE Web. Case Sharing allows a client to be assigned in one Reporting Unit (RU) to an AAA LTSS PE Assessor while simultaneously being assigned to an HCS In-Home Assessor.

To begin Case Sharing, the AAA must email HCS Intake at hcsintakerequests@dshs.wa.gov with the request to assign an HCS In-Home Assessor. HCS In-take will then assign an HCS In-Home Assessor to the case.

The email must include the following information:

- Client first and last name
- ADSA ID

A screenshot of an email template for HCS Intake requests. The email header shows "To: hcsintakerequests@dshs.wa.gov" and "Subject: LTSS PE". The body of the email starts with "Hello," followed by "Please see the following individual being referred for in-home social worker assignment:". Below this, it says "Client Name: [Insert Client First and Last Name]" and "ADSA Number: [Insert ADSA Number]". It then says "Let me know if any additional information is needed." and ends with "Regards, [Your Name]".

Send	To: hcsintakerequests@dshs.wa.gov
	Cc:
	Subject: LTSS PE
Hello,	
Please see the following individual being referred for in-home social worker assignment:	
Client Name: [Insert Client First and Last Name]	
ADSA Number: [Insert ADSA Number]	
Let me know if any additional information is needed.	
Regards, [Your Name]	

COLLABORATION BETWEEN AAA AND HCS IN-HOME ASSESSORS

When an LTSS PE case originates at an AAA, communication between the AAA and HCS is critical. CARE Web has automatic ticklers to keep workers assigned in the CARE Web Overview screen aware of action taken on the case. CARE Web also has a custom tickler feature which will allow workers to send information to other workers in the Overview screen in other RUs.

PERIOD OF LTSS PE

LTSS PE begins the date the applicant is determined to be eligible for LTSS PE and ends with the earlier date of:

- The date the decision was made on the client's full LTSS application (see WAC [388-106-1835](#));
 - The date the client was determined by a CARE Assessment to **meet** functional eligibility.
 - The LTSS PE RAC ends that day and the LTSS program RAC starts the next day.
- The date the client was determined by a CARE Web Assessment to **not meet** functional eligibility (see [WAC 388-106-0355](#) or [388-106-0210](#)), at which time the In-Home worker will close the PE authorizations and notify the providers to stop service; **or**
- If the client does not submit an application, then the LTSS PE period and all LTSS PE services will end on the last day of the month following the month in which the client's LTSS PE services were authorized.
- The date client voluntarily withdraws or dies.
- If the HCS In-Home Assessor was not able to contact the LTSS PE client for a full Assessment. A 10- day letter must be issued.

HCS/AAA staff must discuss with the client that LTSS PE is not a final eligibility decision. LTSS PE services are temporary, unless the client takes action to apply for LTSS. The client needs to complete the functional determination (CARE Web Assessment) and complete a financial determination (telephone interview and providing necessary verifications after review of the submitted application). HCS/AAA staff will explain that once a final determination is made, the client may be eligible for different services, more or fewer monthly personal care hours, or be determined not eligible for any services.

LTSS PE is intended to end on the last day of the month following the month in which the client's LTSS PE services were authorized. For example, when a client is found eligible for LTSS PE in October, then the LTSS PE period will end on the last day of November. However, the LTSS PE RAC can be added for 90 days from when eligibility is determined.

A Medicaid application must be submitted within 10 days from the LTSS PE Assessment completion date. If the client does not submit their application, LTSS PE services will end the last day of the following month that LTSS PE was determined.

When a Medicaid application is submitted, the LTSS PE period can be extended beyond the initial end date, until the earlier date of:

- Full functional and financial eligibility has been determined.
- An ineligible decision was made on the client's Medicaid application.



- The date the client was determined by a CARE Web Assessment to not meet functional eligibility. *(When found functionally ineligible, it is the responsibility of the HCS In-Home worker to close the PE authorizations, contact the providers to stop services, and inform the AAA PE Assessor when the case originated with an AAA and case sharing is occurring).*

LTSS PE PROGRAM RACS

Before authorizing an LTSS PE service, a program RAC must be established. The RAC start date must be on or after the LTSS PE Assessment was completed/locked in CARE Web. When establishing services to implement the Plan of Care, the RAC end date must not be greater than the initial LTSS PE period. The initial LTSS PE period will end on the last day of the month following the month in which the client's LTSS PE was determined. For instance, when a client is found eligible for LTSS PE in October, then initially, the LTSS PE period should end the last day of the following month, being the last day in November, but the LTSS PE RACs can be added to CARE Web for up to 90 days.

LTSS PE has two program RACs:

- LTSS MPC PE RAC: 3209
- LTSS NFLOC PE RAC: 3208

AUTHORIZING LTSS PE SERVICES

The LTSS NFLOC PE or LTSS MPC PE service authorization(s) start date may begin when:

- Verbal approval and consent are obtained from the client/authorized representative for the LTSS PE Plan of Care,
- LTSS NFLOC PE or LTSS MPC PE Assessment is completed and locked, and
- The appropriate RAC is determined.

The service authorization end date must not exceed the LTSS PE RAC end date.

Example: The LTSS PE Assessment determined the client was eligible for LTSS PE MPC services on August 19, and the client's verbal approval and consent to services was obtained on this same date. Client submitted their Medicaid application on September 21 and continued to receive LTSS PE MPC services. The HCS In-Home Assessor conducts an *Initial* CARE Web Assessment on October 1. The PBS determined full financial eligibility on October 5. The HCS/AAA worker obtains verbal plan approval for the full LTSS Assessment on October 15. **HCS adds a SER stating LTSS PE RAC ended and LTSS program RAC opened. AAA staff will then end case sharing in CARE Web.**

- LTSS MPC PE RAC start date = 08/19
- LTSS MPC PE RAC end date = 10/15 *(authorized hours used under LTSS PE up till the 15th then end LTSS PE. There is no carryover of unused hours)*
- Full Eligibility RAC start date = 10/16 *(If the client is eligible for a core program (MPC/CFC/CFC+COPES), the client will be authorized the full benefit of that program to include*

the personal care hours for the remainder of that month and each month thereafter through the plan period).

- **If case-sharing with the AAAs, this is when case-sharing ends.**
- Full Eligibility RAC end date = 10/31 of the following year (to match the Assessment Plan Period End date).

If a client identifies additional services needed that are not already in an approved Plan of Care, a new approval from the client/representative will be required to be obtained.

AUTHORIZING SERVICES AND RACS WHEN CASE SHARING

When LTSS PE cases originate at an AAA, Case Sharing between the AAA will occur in CARE Web with the HCS In-Home Assessor. AAAs are responsible for building the client in CARE WEB, sending an email notification to the HCS Intake team (see this [Section](#) for more information on this), completing the LTSS PE Assessment, opening LTSS PE RAC and authorizing services (if eligible). The AAA PE Assessor will monitor the Plan of Care, update authorizations, and adjust RACs as determined necessary through their primary case management role. If the RAC needs to be extended beyond 90 days, the AAA PE Assessor and HCS In-Home Assessor may need to communicate. This can be done through SERs or custom ticklers.

An example of when this may occur is if the full functional or financial determinations are postponed or not completed by the end of the 90 days. HCS In-Home Assessor may need to use custom ticklers to notify the AAA PE Assessor to extend the RAC and authorizations.

However, the exception of this is when HCS makes the full functional or financial eligibility determinations. Whether there is an approval or denial for full LTSS, the HCS In-Home Assessor will be responsible for ending the LTSS PE RAC.

- If the client was denied (financially or functionally), the HCS In-Home Assessor will be responsible to notify the client of the outcome of the full eligibility determination and notify providers. HCS In-Home Assessor will then end the authorizations for services and RACs. The HCS In-Home Assessor will also complete a custom tickler to the AAA PE Assessor with notification of the end of case sharing.
- If the client was approved (financially and functionally), the HCS In-Home Assessor will be responsible for notifying the client of the outcome of the full eligibility determination, update services based on the newly created full Plan of Care, notify providers as appropriate, update service authorizations, close the LTSS PE RAC, and open new program RAC(s).

The LTSS PE RAC must be ended, whether approval or denial, on the date the determination was made on the full LTSS application (see [WAC 388-106-1835](#)).



WHAT IF THE LTSS PE CLIENT IS HOSPITALIZED OR ADMITTED TO A SKILLED NURSING FACILITY (SNF)?

Contact all service providers the day an individual is admitted to a SNF or hospital. All service authorizations should be suspended as applicable, when the service intended for the in-home setting cannot be provided in the client's own home (due to reasons such as hospitalization/SNF admit), this includes Personal Care Services provided by CDWA Individual Providers (IPs) and/or Home Care Agencies. HCS/AAA staff must contact the provider immediately.

If the client does go to the hospital or SNF on a **short-term basis**, authorizations should be suspended under LTSS PE. If the client is staying longer than 14 days, close LTSS PE services and notify PBS.

Scenario: Client on the LTSS PE S02 workaround enters a SNF during the LTSS PE period.

Once the client is in the SNF 14 days, HCS/AAA staff will end the LTSS PE service authorization(s) and notify the PBS that the client is in the SNF and the date LTSS PE services will end.

PBS will close the S02. S02 will continue through the end of the month if closure is completed prior to 10-day notice deadline. PBS will suppress the termination letter.

If the PBS closes the S02 after 10-day notice deadline, the system will still show a paid through date through the following month.

If the client discharges from the SNF prior to the 30th day, a short stay letter can be issued off the S02 LTSS PE AU for an admission under 30 days.

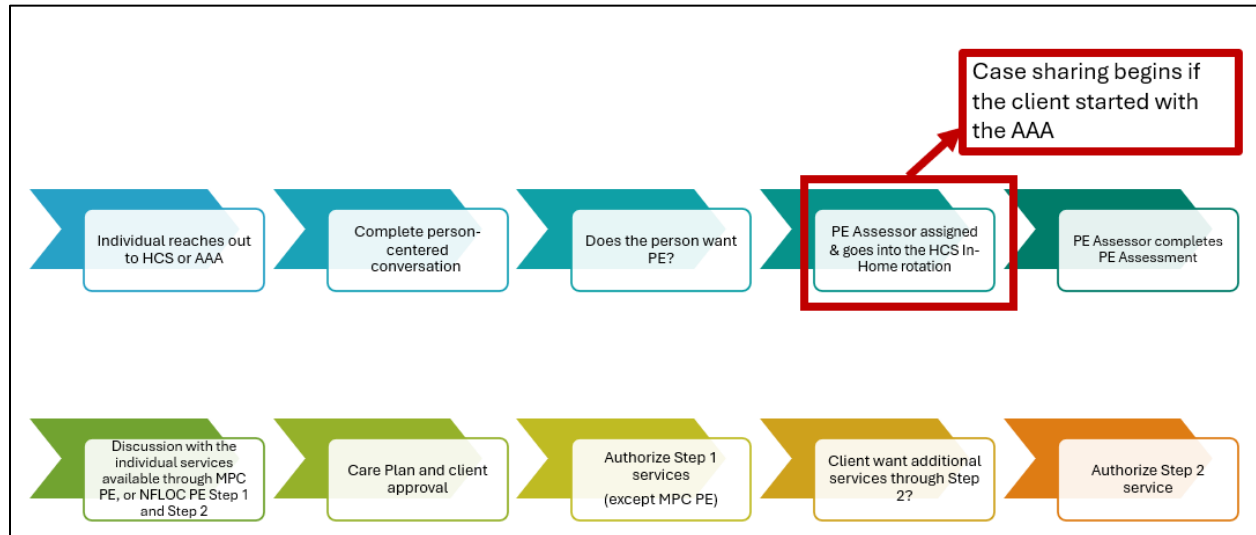
Notify HCS/AAA staff when the client has discharged from the SNF.

LTSS PE WAITLIST

Should program expenditures or enrollment exceed funding availability, a statewide waitlist will be implemented. If a waitlist for LTSS NFLOC PE or LTSS MPC PE is implemented:

1. LTSS PE Assessments will be put on hold; **and**
2. If additional funding becomes available, LTSS NFLOC PE or LTSS MPC PE applicants on the waitlist will be considered on a first come first serve basis. This will be based on the applicant's request date for LTSS NFLOC PE or LTSS MPC PE.

LTSS PE WORKFLOW



RESOURCES

Related WACs

[WAC 388-106](#)
[WAC 388-106-1800](#)
[WAC 388-106-1805](#)
[WAC 388-106-1810](#)
[WAC 388-106-1815](#)
[WAC 388-106-1820](#)
[WAC 388-106-1825](#)

[WAC 388-106-1830](#)

[WAC 388-106-1835](#)
[WAC 388-106-1840](#)
[WAC 388-106-1845](#)
[WAC 388-106-1850](#)

[WAC 388-106-1855](#)

[WAC 388-449-0010](#)

Long-Term Care Services
What definitions apply to LTSS PE?
Am I eligible for LTSS NFLOC PE services?
What services may I receive under LTSS NFLOC PE?
Am I eligible for LTSS MPC PE Services?
What services may I receive under LTSS MPC PE?
Who can provide long-term care services when I am eligible for LTSS NFLOC or LTSS MPC PE services?
When will the department authorize my LTSS NFLOC or LTSS MPC PE services?
When do LTSS NFLOC PE or LTSS MPC PE services end?
Where can I receive LTSS NFLOC PE or LTSS MPC PE services?
What do I pay for if I receive LTSS NFLOC PE or LTSS MPC PE services?
Do I have the right to an administrative hearing on LTSS NFLOC PE or LTSS MPC PE determinations?
Can an exception to rule (ETR) be granted for eligibility or service determinations?
What evidence do we consider to determine disability?

Acronyms

A complete list of Washington State DSHS acronyms can be found [here](#).

AAA	Area Agency on Aging
ABP	Alternative Benefit Plan
CARE	Comprehensive Assessment Reporting Evaluation
CCG	Community Choice Guide
CDWA	Consumer Direct of Washington
CN	Categorically Needy
COPES	Community Options Program Entry System
DSHS	Department of Social and Health Services
ETR	Exception to Rule
HCA	Health Care Authority
HCLA	Home and Community Living Administration
HCBS	Home and Community Based Services
HCS	Home and Community Services
HQ	Headquarters
LTSS	Long-Term Services and Supports
MPC	Medicaid Personal Care
PBS	Public Benefit Specialist
RCW	Revised Code of Washington
SER	Service Episode Record
SME	Specialized Medical Equipment
SNF	Skilled Nursing Facility
SSS	Social Service Specialist
WAC	Washington Administration Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
6/2026	Annie Moua	Updated throughout for clarity Eligibility criteria updated for Phase 2 implementation Stepped services Tiered Personal Care classifications	TBD
11/2025	Annie Moua	Clarification for PE and WA Roads	H25-057
8/2025	Rhonda Widhalm	Improved guidance	H25-039
5/2025	Rhonda Widhalm	Improved guidance Language clarification	H25-010
11/2024	Rhonda Widhalm	Language clarification	H24-062
7/2024	Rhonda Widhalm	Language clarification	H24-044
12/2023	Dru Aubert	Initial draft	H23-081



APPENDIX

Certification of Potentially Disabling Condition
[19-0054-hospital-certification-disabling.pdf](#)

Voice Signature Instructions
[Voice Signature Chapter 30E Attachment.docx](#)

GOSH and Supportive Housing Brochure
[GOSH and Supportive Housing.pdf](#)



Health-Related Social Needs Program

Chapter 30H outlines the policies and procedures related to the Health-Related Social Needs (HRSN) Program funded through Washington State’s 1115 Waiver Medicaid Transformation Project (MTP) 2.0.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

General HRSN Inbox	HRSN@dshs.wa.gov
Whitney Joy Howard HRSN Administrator	whitney.howard1@dshs.wa.gov
Lindsey Lozoskie HRSN Policy Development Manager	lindsey.lozoskie1@dshs.wa.gov

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BACKGROUND

In 2017, Washington State's Health Care Authority (HCA) and the Centers for Medicare and Medicaid Services (CMS) finalized an agreement for a five-year Medicaid Transformation Project (MTP) to improve the state's health care systems, provide better health care, and control costs. In 2021, CMS approved a one-year extension of MTP. On June 30, 2023, CMS renewed MTP, now MTP 2.0, for an additional five years, beginning on July 1, 2023, and running through June 30, 2028. MTP 2.0 includes the Health-Related Social Needs (HRSN) Program.

The Washington State HRSN Program services will allow qualifying Apple Health (Medicaid) enrollees to receive evidence-based, non-medical services to address unmet, adverse social conditions that contribute to poor health outcomes. This chapter specifies the set of covered HRSN Program services under Washington's 1115 MTP 2.0 waiver that the Home and Community Living Administration (HCLA) has been authorized to implement. Included is information on service type, client eligibility, how to authorize, documentation requirements, and notification requirements.

- Given the magnitude of new services authorized under the HRSN Program, HCA chose a phased-in implementation approach. HRSN Rent/Temporary Housing was among the Phase 1 benefits, which was implemented in February 2025 by Home and Community Services (HCS) Office of Housing and Employment (OHAE). HRSN Program Nutrition Supports, Home Accessibility, Remediation, and Adaptation Devices and Caregiver Respite Services are the Phase 2 benefits. Throughout this chapter, the term "Phase 2 benefits" will be used when referring to these benefits for ease of reading.

To read the approval letter from CMS, please see [here](#). To learn more about MTP 2.0, please see HCA's MTP renewal [website](#). You can also read the full waiver [renewal application](#).

PROGRAM DESCRIPTION & GENERAL ELIGIBILITY CRITERIA

Health related social needs (HRSNs) are social and economic needs that individuals experience which affect their ability to maintain their health and well-being. HRSNs put individuals at risk for worse health outcomes and increased health care use. While Social Determinants/Drivers of Health (SDOH) refer to the community-level factors that can impact health, HRSNs refers to individual-level factors such as financial instability, and lack of access to healthy food, affordable and stable housing and utilities, health care, and transportation.

The Home and Community Living Administration (HCLA) Home and Community Services (HCS) and Developmental Disabilities Administration (DDA) are implementing the HRSN Program benefits of 1. rent/temporary housing, 2. nutrition supports, 3. home accessibility, remediation, and adaptation devices, and 4. caregiver respite services. The HRSN Program holds HRSN specific nutrition support, home accessibility, remediation, and adaptation devices, and storage and mover's contracts across the state. DDA HRSN Program services are authorized by dedicated HRSN Case Resource Managers (CRM). HCS clients who wish to live in-home have HRSN services authorized by dedicated HRSN Social Service



Specialist 2s (SSS2). HCS clients in Skilled Nursing Facilities (SNF), Acute Care or State Hospitals, and Long-Term Service and Supports (LTSS) clients currently living in-home and case managed by an Area Agency on Aging (AAA) case manager (CM) are authorized for HRSN services by the Assessor/CM. More information on the process is found below.

To be eligible for HRSN program services, individuals must:

- Be **enrolled in Apple Health** (Medicaid),
- Meet **clinical risk factor(s)**, and
- Meet **social risk factor(s)**.

Non-Duplication of Services

Duplication of services means providing the same level and type of service as a client is already receiving. If a client is receiving a service that does not fully meet their needs and they screen eligible for HRSN, they may also receive HRSN services as an enhancement.

There is no hierarchy of waiver authority. When a client is eligible for more than one waiver, they should be provided with information on benefits available through both waivers and provided the opportunity to decide which waiver they would like to receive services from. For example, if a client is eligible for and in need of environmental modifications through COPEs and eligible for home accessibility through HRSN, the client should be provided with information on both and provided the opportunity to choose which waiver benefit they would prefer. For more information on specifics of HRSN services, please see the corresponding service section below.

Non-Supplantation of Services

Supplantation of services is replacing existing state or local funding with new federal funding and using the existing state or local funding to pay for something else. If a client is receiving a service that does not meet their needs, they may also receive HRSN services to supplement or expand their existing benefits.

INTAKE AND SERVICE DELIVERY FLOW

If a potential client communicates food or housing needs, intake staff should enter a Service Episode Record (SER) in CARE noting this. This will act as a point of reference for the assigned HCS case manager (CM) or DDA case resource manager (CRM) to inquire about interest in HRSN benefits when completing an Assessment with a potential client. For clients coming through Area Agency on Aging's (AAA) Intake and Assistance/Aging and Disability Resource Centers/Community Living Connections, the AAA staff should inform HCS that the client is in need of and/or interested in HRSN benefits.

If a client wanting to live in-home has been found functionally and financially eligible for Long-Term Services and Supports (LTSS) and agrees to a referral for HRSN benefits, the HCS in-home CM should go to the [HRSN SharePoint](#) and click "[Referral to SSS2](#)". A Microsoft Form will open, with some basic client information for the CM to fill out. Upon submitting the form, an email will be sent to a dedicated HRSN



SSS2 to verify client eligibility, add themselves to the client's case in CARE, and authorize HRSN benefits if the client is eligible and would like to receive the service. The HCS CM must enter a SER that they submitted a referral for HRSN. SSS2 will add SER when client has been authorized for HRSN.

HCS Nursing Facility Case Managers (NFCMs), Hospital and State Hospital Assessors, and Area Agency on Aging (AAA) case managers (CMs) can directly authorize HRSN benefits. Details on authorizing HRSN benefits directly are outlined in the corresponding service sections below.

Please note: Due to limited HRSN funding, Presumptive Eligibility clients are not eligible for HRSN benefits. HCS HRSN RAC can only be opened for clients with a current assessment.

HRSN BENEFITS

HRSN Program services are designed to support a client's health outcomes by addressing housing stability, nutrition, home safety, and care giver respite. These services aim to support client choice by allowing them to remain in their housing of choice and community of choice.

This section provides more information about the specific HRSN benefits HCLA and DDA have or will implement, including detailed eligibility and step-by-step instructions on how to authorize in CARE.

RENT/TEMPORARY HOUSING FOR HCS CLIENTS

HRSN rent/temporary housing provides the opportunity for an eligible client to receive limited time reoccurring rent, temporary housing, and/or emergency rental assistance through Medicaid. This benefit aids stability in independent living situations for individuals transitioning out of institutional care or congregate settings who are homeless or at risk of homelessness. The HCS HRSN rent/temporary housing benefit launched in February 2025.

Allowable services under HRSN rent/temporary housing include:

1. Rent payment.
 - a. A client may use rent payment for past due or forward rent or for temporary housing. This benefit is capped at six months of total rent payments per demonstration period.
 - i. Rent payment may be through Supported Employment rental assistance or related to the Nursing Home to Community (NH2C), Acute Care Hospital, or [Governor's Opportunity for Supportive Housing \(GOSH\)](#) subsidies.
 - ii. Past due rent is through the [Emergency Rental Assistance](#) program.
 - iii. Temporary housing payment is through the [Motel Interim Stay for Transitions \(MIST\)](#) service.
2. Renter's insurance, if required by the lease.



3. Recurring utilities, including expenses for garbage, water, sewage, recycling, gas, electric, internet, phone (inclusive of land line phone service and cell phone service), with a ceiling of up to six months in total retrospective/prospective payments of utilities per demonstration period.
4. Non-refundable, non-recurring utility set-up costs for utilities or restart costs if the service has been discontinued, and up to six months of arrears related to unpaid utility bills but capped at six months of total arrears/prospective utility payments per demonstration.
5. Storage fees and movers' fees. This benefit is anticipated to launch in the Summer of 2026.

Eligibility for Rent/Temporary Housing

- Enrolled in Apple Health (Medicaid); and
- Living unhoused or at risk of homelessness; and
- Meet **at least one** of the following three health needs-based criteria:
 - 1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria:
 - a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or
 - b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment.
 - 2) Individual assessed to have a need for assistance, demonstrated by the need for:
 - a) Assistance with three or more Activities of Daily Living (ADLs) defined in [WAC 388-106-0010](#), one of which may be body care, and/or
 - b) Hands-on assistance with one or more ADLs, one of which may be body care.
 - 3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration.

For more information on housing resources please see Long Term Care Manual Chapters 6 [a](#), [b](#), [c](#), and [d](#). To review eligibility for HRSN rent/temporary housing and submit a [referral](#), please go to the Office of Housing and Employment (OHAE) [SharePoint](#).

RENT/TEMPORARY HOUSING FOR DDA CLIENTS

HRSN rent/temporary housing provides the opportunity for an eligible client to receive limited time reoccurring rent, temporary housing, and/or emergency rental assistance through Medicaid. This benefit aids stability in independent living situations for individuals transitioning out of institutional care or congregate settings who are homeless or at risk of homelessness. The DDA HRSN rent/temporary housing benefit launched on July 1st, 2026.

The program provides short-term rental assistance payments for up to 6 months. The payment is made directly to a landlord on behalf of a DDA client who is facing **immediate eviction due to unpaid rent** or is struggling to pay forward rental payments. Eligible clients will have rent at or below 150% FMR for the

area they live in. We will ask the client how they will plan to pay rent going forward as HRSN rent/temporary housing is a 6-month max lifetime benefit.

The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders. Similarly, evidence links unemployment to poor physical and mental health outcomes, even in the absence of pre-existing conditions.

HCS staff, because DDA and HCS use the same HRSN funding stream, both HCS and DDA rent benefits are included under Chapter 30H as separate sections.

Client Eligibility

When individuals are facing eviction or housing insecurities, they may be eligible for the STRA program.

What are the Eligibility Criteria for clients to enroll in STRA?

- Enrolled in Apple Health (Medicaid); and
- Living unhoused or at risk of homelessness; and
- Meet **at least one** of the following three health needs-based criteria:
 - 4) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria:
 - a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or
 - b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment.
 - 5) Individual assessed to have a need for assistance, demonstrated by the need for:
 - a) Assistance with three or more Activities of Daily Living (ADLs) defined in [WAC 388-106-0010](#), one of which may be body care, and/or
 - b) Hands-on assistance with one or more ADLs, one of which may be body care.
 - 6) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration.

STRA and MIST Program Descriptions

The **DDA HRSN Short-Term Rental Assistance (STRA) program** provides short-term rental assistance payments for up to 6 months. The payment is made directly to a landlord on behalf of a DDA client who is facing immediate eviction due to unpaid rent or is struggling to pay forward rental payments. Eligible clients will have rent at or below 150% FMR for the area they live in. We will ask the client how they will plan to pay rent going forward as HRSN rent temporary housing is a six-month max lifetime benefit.



The **DDA HRSN Motel Interim Stays for Transition (MIST) program** is intended to provide a temporary solution for clients who have been displaced from their homes, are at risk of or experiencing homelessness, fleeing domestic violence, discharging from a medical or institutional setting, or have a housing resource (voucher/subsidy) and are searching for housing. The goal of MIST is to provide opportunities for stability upon discharge; reduce the number of clients discharging from institutions to street and/or experiencing episodes of homelessness and to increase the chance of clients continuing to access DDA services and end up in their own homes.

STRA Can & Cant's

What <i>can</i> STRA pay for?	What <i>can't</i> STRA pay for?
Past due rent or rent going forward, paid directly to the landlord; funds are never paid directly to a client.	Payments to a collection agency for any reason.
Utilities if included in rent, or the client is HRSN eligible and both are authorized together.	Any housing funds paid directly to client.
	Utility payments made to outside organizations.
	Security Deposits/move in fees, pet deposits or application fees.
	Attorney Fees.

What to look for when receiving a request

When receiving Short-Term Rental Assistance requests, it's important to look for a sustainable path forward for paying rent. STRA can't continually pay a client's rent for them. There needs to be a plan in place to ensure the rent is paid after STRA funding clears out their back-owed or forward rent. Sometimes that plan may be having a roommate move in to help with rent, agreeing to the use of a payee to ensure bills are paid, or rent will be more affordable going forward due to a rental assistance program. Sometimes a client may just have a temporary setback or financial difficulties that has prevented them from paying their rent like an unexpected bill or a stolen purse. At minimum, a client's income needs to be more than their monthly rent amount.

Approval Process for DDA Rent/Temporary Housing

The DDA HRSN CRMs will have a desk guide which overviews all the processes for authorizing a DDA client for HRSN STRA and MIST. Please contact the DDA Housing Program Managers if you are a CRM and need this information.

NUTRITION SUPPORTS

Nutrition plays an integral role in health outcomes. Lack of access, resources, and education can all contribute to poor health outcomes. HRSN Nutrition Supports provide eligible Apple Health (Medicaid) clients with access to nutritional supports to increase food security and support improved health outcomes for chronic conditions. Specific nutrition services allowed under this benefit are detailed in this section.

Please note that the below are important definition clarifications which define eligibility criteria associated with HRSN Nutrition Supports.

1. **USDA Definition of Food Insecurity**
 - **Low food security:** reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake.
 - **Very low food security:** reports of multiple indications of disrupted eating patterns and reduced food intake.
2. **Chronic Condition(s):** When assessing "chronic" an individual's self-attestation can be accepted and we are typically referring to any medical or behavioral health condition that persists over time, or does not quickly resolve itself, or require continuous management.
 - We are including these examples to assist with eligibility, but please note that these are just examples and if the individual has a chronic condition(s) not included here, they still meet this requirement.
 - Examples of chronic condition(s) include but are not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders, neurodevelopmental disorders and chronic behavioral health conditions, including substance use disorder.
3. **High risk of hospitalization or nursing facility placement:** HCLA and DDA consider Apple Health (Medicaid) clients who meet the USDA definition of low or very low food security and have a chronic condition at high risk of hospitalization due to living with a chronic condition without the ability to manage nutritional needs.
 - Home and Community-Based Services (HCBS) provides care for individuals in their desired setting who would otherwise require institutional care.

HRSN Nutrition Supports Providers

HRSN Nutrition Supports are accessible through [HRSN Contracted Provider Spreadsheet](#). This can also be found on the [Transition Academy SharePoint](#) for HCS CMs. You can also email HRSN@dshs.wa.gov with any questions regarding contractor availability and rates or to make the HRSN team aware of service location gaps within the HRSN provider network.

After verifying HRSN eligibility, a SSS2/HCS AAA CM/CRM or DDA HRSN CRM must use [DSHS Form 11-200](#), Health Related Social Needs (HRSN) Nutrition Services Referral, to submit to the referral email listed on the HRSN contracted provider spreadsheet to confirm ability to accept a referral prior to authorizing the service in CARE.

Nutrition Counseling

Nutrition counseling provides personalized guidance to eligible clients to help improve their dietary habits and subsequent overall health. Strategies are designed to motivate and facilitate voluntary adoption of food choices and other food and nutrition-related behaviors conducive to health and wellbeing. This benefit can be paired with other HRSN Nutrition Supports to more holistically support a client's nutritional needs.

This service may consist of the following:

1. Provision of nutrition counseling or information to an individual or group that offers evidence based or evidence informed strategies on adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being and guidance on food and nutrition resources.
2. Meal preparation education in an individual or group setting.

This service may be provided in the following locations:

- Clinical settings (inpatient and outpatient)
- Food banks
- Community centers
- Farmers markets
- Own home
- Other locations as approved by DSHS or AAA and included in the contractor's HRSN Nutrition Supports contract

Eligibility

- Enrolled in Apple Health (Medicaid); and
- Meets the USDA definition of low food security or very low food security; and
- Has a chronic condition.

HRSN Nutrition Counseling **can** be delivered to dually enrolled clients on Original Medicaid/Part A and B (OM) or Medicare Advantage/Part C (MA) without risk of duplication of services, **except** when the dually eligible client meets one of the following three conditions:

1. The client has diabetes;
2. The client has kidney disease; or
3. The client has had a kidney transplant in the last 36 months.

If the client is dually eligible and meets one of the three conditions stated above, please first refer the client to their provider and reach out to HRSN@dshs.wa.gov to discuss service options before proceeding with HRSN Nutrition Counseling.

Provider Type

A Registered Dietitian Nutritionist (RDN) or Registered Dietitian (RD) (either preferred), a qualified health care professional, and if not available, a Community Health Worker (CHW).

Community Health Worker or “CHW” means a worker, as defined in [WAC 182-562-0100](#). CHWs are required to meet minimum qualifications, such as a CHW certificate and complete training as specified in [WAC 182-562-0400](#).

Qualified Health Care Professional means the following providers who are qualified to provide nutrition counseling and education services:

- (1) Doctor of medicine (MD);
- (2) Doctor of osteopathic medicine (DO);
- (3) Medical professionals who are certified diabetes educators (CDEs);
- (4) Registered nurse (RN);
- (5) Licensed practical nurse (LPN);
- (6) Certified health education specialist (CHES);
- (7) Certified nutritionist; and
- (8) Other provider types as approved by DSHS or its designee.

Duration, Frequency, and Payment Rate

HRSN Nutrition Counseling can be authorized through the Current CARE Plan period and reauthorized as needed. Frequency of benefit will be determined by the client and contracted provider. For HCS, RAC 3132 (HCS)/RAC 3532 (DDA) and service code H2014,U4 will provide the contractual rate for each provider. There is no lifetime limit on how many Nutrition Counseling authorizations a client may receive during the MTP 2.0 waiver period.

Documenting Eligibility and Need

After authorizing the benefit, the SSS2/HCS AAA CM or DDA CRM/DDA must enter the following SER: “Client screened eligible for Health-Related Social Needs (HRSN) Nutrition Counseling. They have been authorized to receive this benefit for the full 6-month authorization allowance.”

Nutrition Education

Nutrition education is the process of teaching the principles of nutrition, providing education on the link between diet and health, and providing tools and knowledge on how to make healthier food choices. This service allows for the provision of educational strategies designed to motivate and facilitate voluntary adoption of food choices and other food and nutrition-related behaviors conducive to health and wellbeing.



This service may consist of the following:

1. Provision of nutrition education or information that offers evidence based or evidence informed strategies on adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being and guidance on food and nutrition resources.
2. Nutrition education services may be provided via handouts, take- home materials, newsletters, and other informational resources that support nutritional health and well-being.

This service may be provided in the following locations:

- Clinical settings (inpatient and outpatient)
- Food banks
- Community centers
- Farmers markets
- Own home
- Other: settings included in the contractor's HRSN Nutrition Supports contract

Eligibility

- Enrolled in Apple Health (Medicaid); and
- Meets the USDA definition of low food security or very low food security; and
- Has a chronic condition.

Provider Type

A Registered Dietitian Nutritionist (RDN) or Registered Dietitian (RD) (either preferred), a qualified health care professional, and if not available, a Community Health Worker (CHW).

Community Health Worker or "CHW" means a worker, as defined in [WAC 182-562-0100](#). CHWs are required to meet minimum qualifications, such as a CHW certificate and complete training as specified in [WAC 182-562-0400](#).



Qualified Health Care Professional means the following providers who are qualified to provide nutrition counseling and education services:

- (1) Doctor of medicine (MD);
- (2) Doctor of osteopathic medicine (DO);
- (3) Medical professionals who are certified diabetes educators (CDEs);
- (4) Registered nurse (RN);
- (5) Licensed practical nurse (LPN);
- (6) Certified health education specialist (CHES);
- (7) Certified nutritionist; and
- (8) Other provider types as approved by DSHS or its designee.

Duration, Frequency, and Payment Rate

HRSN Nutrition Education can be authorized through the Current CARE Plan period and reauthorized, as needed. A provider may be authorized to provide handouts, newsletters, take-home materials, and other informational resources that support nutritional health and well-being at a rate of \$10 per unit through RAC 3132 (HCS)/RAC 3532 (DDA) and SA080,U2. There is no lifetime limit on how many Nutrition Education authorizations a client may receive during the MTP 2.0 waiver period.

Documenting Eligibility and Need

After authorizing the benefit, the SSS2/HCS, AAA CM, or DDA HRSN CRM must enter the following SER: "Client screened eligible for Health-Related Social Needs (HRSN) Nutrition Education. They have been authorized to receive this benefit for the full 6-month authorization allowance."

Fruit and Vegetable Provisions

This service provides an individual with monthly fruits and vegetables from participating food retailers and farms for a 6-month authorization period. Fruits and vegetables may be fresh, frozen, or canned. This service cannot provide food or drinks not considered a fruit or vegetable.

Eligibility

- Enrolled in Apple Health (Medicaid); and
- Meets the USDA definition of low food security or very low food security; and
- Has a chronic condition.

Duration, Frequency, and Payment Rate



A client may be authorized for 6 months using RAC 3132 (HCS)/RAC 3532 (DDA) and SA420,U2. A HRSN SSS2/HCS, AAA CM, or DDA HRSN CRM can reauthorize additional 6-month authorizations if the need continues. There is no lifetime limit on how many fruit and vegetables provisions a client may receive during the MTP 2.0 waiver period.

Documenting Eligibility and Need

After authorizing the benefit, the HRSN SSS2/HCS, AAA CM, or DDA HRSN CRM must enter the following SER:

"Client screened eligible for Health-Related Social Needs (HRSN) Fruit and Vegetable Provisions. They have been authorized to receive this benefit for the full 6-month authorization allowance."

Authorizing Nutrition Counseling, Nutrition Education, and/or Fruit and Vegetable Provision in CARE

If a client has expressed interest in HRSN Nutrition counseling, education, and/or fruit and vegetable provisions, HRSN SSS2/HCS, AAA CM, or DDA HRSN CRM must verify eligibility. These three benefits all have the same eligibility criteria and can be confirmed by following:

- Enrolled in Apple Health: Clients with Current CARE Assessments will be open on Apple Health.
 - This can be confirmed in ACES or in CARE by clicking on "Client Details" → "Demographics" → "View ProviderOne details" → "Managed Care". This will show the client is actively enrolled with one of the five Managed Care Organizations in WA.
- Meets the USDA definition of low food security or very low food security.
 - The HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA should ask the client about their food security. The USDA definitions of low or very low food security are listed below. Client can verbally self-attest to meeting this criteria by answering yes to one of the following:
- Do you lack access to quality, variety, or desired food?
 - If yes, meets USDA definition of low food security.
- Have you skipped meals or eaten less food to try and conserve food due to lack of money or access to food?
 - If yes, meets USDA definition of very low food security.
- Has a chronic condition.
 - This can be confirmed in CARE by opening the Current Assessment, clicking on "Medical" and reviewing for diagnosis(es).
 - **Chronic Condition(s):** When assessing "chronic" an individual's self-attestation can be accepted and we are typically referring to any medical or behavioral health condition that persists over time, or does not quickly resolve itself, or require continuous management.
 - We are including these examples to assist with eligibility, but please note that these are just examples and if the individual has a chronic condition(s) not included here, they still meet this requirement.
 - Examples of chronic condition(s) include but are not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders,

neurodevelopmental disorders and chronic behavioral health conditions, including substance use disorder.

Documenting Eligibility in CARE

After confirming eligibility and verifying the client would like to be authorized for one or more HRSN Nutrition Supports:

- Open the **Sustainability Goals** screen in CARE.
- Select “Add to the Goal” List:
 - Under “Goals detail” click the drop down for Goal short description
 - select “Manage nutritional needs”
 - Select the Status “On going”
 - For HCS clients, in the Goal description type “Client meets USDA low or very low food security. Client is eligible for HRSN Nutrition Supports and has requested referral for *[enter specific HRSN Nutrition Support benefit]*.”
 - For DDA clients, in the Goal description type “Client meets USDA low or very low food security. Client is eligible for HRSN Nutrition Supports and has requested referral for *[enter specific HRSN Nutrition Support benefit and (Client) approved for (amount) from (start) to (end)]*.”

Contacting a Provider and Authorizing Services

HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM should confirm a client has signed a DSHS Consent Form 14-012 in which the client consented to share information with “Other DSHS contracted providers”. If that box is not selected, ask the client if they are willing to check that box and update the DSHS Consent Form. Once confirmation of consent is verified, HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA should review the [HRSN Contracted Provider Spreadsheet](#) and confirm which provider a client would like to be referred to. Once selected, fill out and send [DSHS Form 11-200](#) to the provider to determine capacity and ability to provide HRSN Nutrition Counseling, Education, and/or Fruit and Vegetable Provision services. Contractually a provider has two business days to respond to a referral. If a provider accepts the referral, open an authorization. If the provider declines a referral, re-review the [HRSN Contracted Provider Spreadsheet](#) with a client to look for alternative options.

Once a provider has accepted a referral, the HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM should:

- Open the RAC screen in CARE and add HRSN RAC 3132 (HCS)/RAC 3532 (DDA). For HRSN Nutrition Counseling and Education, the end date can match the end date of the Current Assessment or a 12-month period for clients without a plan. For HRSN Fruit and Vegetable Provision, the end date should be six months past the start date.
- Open Authorization screen and select “Create Client Payment” and follow the authorization steps outlined in the specific HRSN Nutrition Supports service section for which you are authorizing.
- Enter a SER. Select Contact method “Admin Task/Email/Fax/Mail”. Select Purpose “Care Plan Implementation”. Enter the date and Subject “HRSN Authorization”. Enter a SER that client requested “HRSN Nutrition Supports”, was screened eligible, and authorized.



Pantry Stocking

This service allows for the purchase of an assortment of food aimed at promoting improved nutrition for the individual. **Important note**, this HRSN service is limited to **those under 21 years of age and/or pregnant individuals** who meet the additional eligibility criteria. For those who do not meet this criteria, please see eligibility for **Short-Term Grocery Provisions**.

This service may consist of the following:

Purchase and delivery, as needed, of the following food items:

- Fruits and vegetables
- Meat, poultry, and fish
- Dairy products
- Breads and cereals
- Snack foods and non-alcoholic beverages
- Seeds and plants

Eligibility

- Enrolled in Apple Health (Medicaid) and **under 21 years old and/or a pregnant individual**; and
- Meets the USDA definition of low food security or very low food security; and
- Has a chronic condition.

Duration, Frequency, and Payment Rate

A client may receive up to \$500 in groceries within a 6-month authorization period. The client may determine the frequency of benefit within the authorization period, e.g. a client could request \$500 worth of pantry stocking at once or spread the benefit out across the 6-month authorization period. HRSN pantry stocking can be renewed for additional 6-month periods if eligibility and the need continue.

A client **cannot** receive pantry stocking benefits concurrently with medically tailored meals and/or short-term grocery provisions. A client may receive the maximum authorized amount under pantry stocking and then be authorized for medically tailored meals.

Documenting Eligibility and Need

After authorizing the benefit, the HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM must enter the following SER:

"Client screened eligible for Health-Related Social Needs (HRSN) Pantry Stocking. They have been authorized to receive this benefit for the full 6-month authorization allowance."

Authorizing Pantry Stocking in CARE



If a client has expressed interest in HRSN Nutrition Supports, a HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM should determine eligibility for Pantry Stocking.

- Under the age of 21 and/or a pregnant individual.
 - While client age is verified in CARE by Date of Birth, pregnancy status may be self-attestation and should be SER-ed when documenting referral for HRSN Pantry Stocking.
- Enrolled in Apple Health: Clients with Current CARE Assessments will be open on Apple Health.
 - This can be confirmed in ACES or in CARE by clicking on “Client Details” → “Demographics” → “View ProviderOne details” → “Managed Care”. This will show the client is actively enrolled with one of the five Managed Care Organizations in WA.
- Meets the USDA definition of low food security or very low food security.
 - The HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA should ask the client about their food security. The USDA definitions of low or very low food security are listed below. Client can verbally self-attest to meeting this criteria by answering yes to one of the following:
- Do you lack access to quality, variety, or desired food?
 - If yes, meets USDA definition of low food security.
- Have you skipped meals or eaten less food to try and conserve food due to lack of money or access to food?
 - If yes, meets USDA definition of very low food security.
- Has a chronic condition.
 - This can be confirmed in CARE by opening the Current Assessment, clicking on “Medical” and reviewing for diagnosis(es).
 - **Chronic Condition(s):** When assessing "chronic" an individual's self-attestation can be accepted and we are typically referring to any medical or behavioral health condition that persists over time, or does not quickly resolve itself, or require continuous management.
 - We are including these examples to assist with eligibility, but please note that these are just examples and if the individual has a chronic condition(s) not included here, they still meet this requirement.
 - Examples of chronic condition(s) include but are not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders, neurodevelopmental disorders and chronic behavioral health conditions, including substance use disorder.

Documenting Eligibility in CARE

After confirming eligibility and verifying the client would like to be authorized for HRSN Pantry Stocking:

- Open the Sustainability Goals screen in CARE
- Select “Add to the Goal” List:
 - Under “Goals detail” select the drop down for Goal short description
 - Select “Manage nutritional needs”
 - Select the Status “On going”



- For HCS clients, in the Goal description type “Client meets USDA low or very low food security. Client is eligibility for HRSN Nutrition Supports and has requested referral for Pantry Stocking.”
- For DDA clients, in the Goal description type “Client meets USDA low or very low food security. Client is eligible for HRSN Nutrition Supports and has requested referral for [enter specific HRSN Nutrition Support benefit and (Client) approved for (amount) from (start) to (end)].”

Contacting a Provider and Authorizing Services

HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM should confirm a client has signed a DSHS Consent Form 14-012 in which the client consented to share information with “Other DSHS contracted providers”. If that box is not selected, ask the client if they are willing to check that box and update the DSHS Consent Form. Once confirmation of consent is verified, HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM should review the [HRSN Contracted Provider Spreadsheet](#) and confirm which provider a client would like to be referred to. Once selected, fill out and send [DSHS Form 11-200](#) to the provider to determine capacity and ability to provide HRSN Pantry Stocking services. Contractually a provider has two business days to respond to a referral. If the provider declines a referral, re-review the [HRSN Contracted Provider Spreadsheet](#) with a client to look for alternative options.

Please note, the service code used to authorize HRSN Pantry Stocking is temporary unable to be place in “reviewing” status. This means, an authorization should not be entered until the HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM has received an invoice. Waiting until the invoice is received with the exact amount billed will minimize likelihood of overpayment. Once a provider has a submitted invoice for payment, the HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM should:

Open RAC Eligibility screen

- Add new RAC – “3132 – HRSN” for HCS or “3532 – HRSN” for DDA
 - Please note that an Assessment must be Current to authorize HRSN RAC 3132 (HCS)
 - For DDA HRSN RAC 3532, an assessment is not needed
- Start Date: enter date service is authorized to start
 - End Date: 30 days from start date
 - If you enter the authorization for six months, it will go into error and need to be forced. Since the provider will submit an invoice each month, the authorization should be opened for one month at a time either until the six-month authorization period has lapsed or the \$500 maximum rate has been exhausted, whichever comes first.

Open Authorization Screen

- Select “Create new service Line”
- Enter SA420,U1 (pantry stocking Federal Match) in the “search service code box” and select service code.
- An “edit Line Data” screen will appear. Enter the following information:
- Start Date: enter date the service is authorized to start



- End Date: 30 days from the start date
- # of units and Rate: confirm on [HRSN Contracted Provider Spreadsheet](#)
- Reason code: select the appropriate reason code, “child (0-20)” or “Pregnant Person”
 - Do not select “Pantry Stocking” as the reason code as that is for Roads to Community Living (RCL) clients only.
- Select submit
- Submit receipts/invoices to Barcode using DSHS form 02-615

Please note: when creating a Provider Authorization, once you select the provider make sure to select a location that lists “HRSN”. For example, when authorizing PurFoods LLC, you would want to select the location name “HRSN -Mom's Meals - 05”

Enter a SER

- Select Contact method “Admin Task/Email/Fax/Mail”.
- Select Purpose “Care Plan Implementation”.
- Enter the date and Subject “HRSN Authorization”.
- Enter a SER that client requested “HRSN Nutrition Supports”, was screened eligible, and authorized.

A client **cannot** receive short-term grocery provisions concurrently with medically tailored meals and/or pantry stocking. A client may receive the maximum authorized amount under short-term grocery provision and then be authorized for medically tailored meals.

Short-Term Grocery Provisions

This service allows for the purchase of an assortment of food aimed at promoting improved nutrition for the individual. A client may utilize this benefit at once or spread out the benefit across the 30-calendar-day authorization period.

This service may consist of the following:

Purchase and delivery, as needed, of the following food items:

- Fruits and vegetables
- Meat, poultry, and fish
- Dairy products
- Breads and cereals
- Snack foods and non-alcoholic beverages
- Seeds and plants

Eligibility

- Enrolled in Apple Health (Medicaid); and
- Meets the USDA definition of low food security or very low food security; and



- Is enrolled in LTSS; and
- Has been or is being discharged within 6 months from the hospital or skilled nursing facility; **OR**
- Is at high risk of hospitalization or nursing facility placement.
 - HCLA considers Apple Health (Medicaid) clients who meet the USDA definition of low or very low food security and have a chronic condition at high risk of hospitalization due to living with a chronic condition without the ability to manage nutritional needs.
 - Home and Community-Based Services (HCBS) provides care for individuals in their desired setting who would otherwise require institutional care.

Duration, Frequency, and Payment Rate

A client may receive up to \$584 in groceries for 30 days, once per calendar year. Short-term grocery provision may be renewed for another 30 days in a separate calendar year, if eligibility and the need continue. For example, a client could be authorized for HRSN short-term grocery provision in December and again in January. In this example, the client would not be eligible for another HRSN short-term grocery provision benefit until January of the following year.

A client **cannot** receive short-term grocery provisions concurrently with medically tailored meals and/or pantry stocking. A client may receive the maximum authorized amount under short-term grocery provision and then be authorized for medically tailored meals.

Documenting Eligibility and Need

After authorizing the benefit, the HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM must enter the following SER:

“Client screened eligible for Health-Related Social Needs (HRSN) short-term grocery provision. They have been authorized to receive this benefit for the full authorization allowance.”

Authorizing Short-term grocery provision in CARE

If a client has expressed interest in HRSN Nutrition Supports, a HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM should determine eligibility for short-term grocery provision.

- Enrolled in Apple Health: Clients with Current CARE Assessments will be open on Apple Health.
 - This can be confirmed in ACES or in CARE by clicking on “Client Details” → “Demographics” → “View ProviderOne details” → “Managed Care”. This will show the client is actively enrolled with one of the five Managed Care Organizations in WA.
- Meets the USDA definition of low food security or very low food security.
 - The USDA definitions of low or very low food security are listed below. Client can verbally self-attest to meeting this criteria by answering yes to one of the following:
 - Do you lack access to quality, variety, or desired food?
 - If yes, meets USDA definition of low food security.
 - Have you skipped meals or eaten less food to try and conserve food due to lack of money or access to food?



- If yes, meets USDA definition of very low food security.
- Is enrolled in LTSS; and
 - Client has a Current CARE Assessment.
- Has been or is being discharged within 6 months from the hospital or skilled nursing facility; **OR**
 - This can be confirmed in CARE by checking the following screens: Contact details – Residence address or Historical residence address, Acute Hospital, NF Case Management, and/or State Hospital/Hospital/E&T
- Is at high risk of hospitalization or nursing facility placement.
 - HCLA considers Apple Health (Medicaid) clients who meet the USDA definition of low or very low food security and have a chronic condition at high risk of hospitalization due to living with a chronic condition without the ability to manage nutritional needs.
 - Home and Community-Based Services (HCBS) provides care for individuals in their desired setting who would otherwise require institutional care.

Documenting Eligibility in CARE

After confirming eligibility and verifying the client would like to be authorized for HRSN Short Term Grocery Provisions:

- Open the Sustainability Goals screen in CARE
- Add to the Goal List
- Under “Goals detail” select the drop down for Goal short description
- Select “Manage nutritional needs”
- Select the Status “On going”
- For HCS clients, In the Goal description type “Client meets USDA low or very low food security. Client is eligibility for HRSN Nutrition Supports and has requested referral for HRSN short-term grocery provision.”
- For DDA clients, in the Goal description type “Client meets USDA low or very low food security. Client is eligible for HRSN Nutrition Supports and has requested referral for [enter specific HRSN Nutrition Support benefit and (Client) approved for (amount) from (start) to (end)].”

Contacting a Provider and Authorizing Services

HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM should confirm a client has signed a DSHS Consent Form 14-012 in which the client consented to share information with “Other DSHS contracted providers”. If that box is not selected, ask the client if they are willing to check that box and update the DSHS Consent Form. Once confirmation of consent is verified, HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM should review the [HRSN Contracted Provider Spreadsheet](#) and confirm which provider a client would like to be referred to. Once selected, fill out and send [DSHS Form 11-200](#) to the provider to determine capacity and ability to provide HRSN Short-Term Grocery Provision services. Contractually a provider has two business days to respond to a referral. If the provider declines a referral, re-review the [HRSN Contracted Provider Spreadsheet](#) with a client to look for alternative options.



Please note, the service code used to authorize HRSN Short-Term Grocery Provision is temporary unable to be placed in "reviewing" status. This means, an authorization should not be entered until the HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM has received an invoice. Waiting until the invoice is received with the exact amount billed will minimize likelihood of overpayment. Once a provider has submitted an invoice for payment, the HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM should:

Open RAC Eligibility screen.

- Add new RAC – "3132 – HRSN" for HCS or "3532 – HRSN" for DDA
 - Please note that an Assessment must be Current to authorize HRSN RAC 3132 (HCS)
 - For DDA HRSN RAC 3532, an assessment is not needed
- Start Date: enter date service is authorized to start
 - End Date: 30 days from start date

Open Authorization Screen

- Select "Create new service Line"
- Enter SA420,U1 (Panty Stocking* Federal Match) in the "search service code box" and select service code.
- An "edit Line Data" screen will appear. Enter the following information:
- Start Date: enter date the service is authorized to start
- End Date: 30 days from the start date
- # of units and Rate: confirm on [HRSN Contracted Provider Spreadsheet](#)
- Business status- select "Reviewing"
- Reason code: "No reason code needed"
- Comment: Type in "HRSN short-term grocery provision"
- Select submit
- Submit receipts/invoices to Barcode using DSHS form 02-615

Please note: when creating a Provider Authorization, once you select the provider make sure to select a location that lists "HRSN". For example, when authorizing PurFoods LLC, you would want to select the location name "HRSN -Mom's Meals - 05"

Please note: Short-term grocery provision shares a service code with other pantry stocking benefits. Therefore, the name of the service code is "Pantry Stocking Federal Match."

Enter a SER.

- Select Contact method "Admin Task/Email/Fax/Mail".
- Select Purpose "Care Plan Implementation".
- Enter the date and Subject "HRSN Authorization".
- Enter a SER that client requested "HRSN Nutrition Supports", was screened eligible, and authorized.

Medically Tailored Meals (MTMs)

Medically Tailored Meals (MTMs) is an evidence-based intervention that provides meals tailored to support individuals with chronic health conditions for which nutrition supports would improve health outcomes. The primary goal of MTMs is to improve the health of individuals living with chronic health conditions, prevent unnecessary (re)hospitalizations, and ensure access to essential nutrition. HRSN MTMs allow for up to 3 meals a day within a 6-month authorization period. Each meal must contain sufficient food to support approximately one-third of an individual's daily nutritional need as indicated by the Dietary Reference Intakes and Dietary Guidelines. The meal may also include an accompanying fluid/drink and/or a supplementary food item to support meeting a client's nutrition needs between meals if medically appropriate (for example, to provide access to fluids and/or support taking medication accompanied by food). Meals may consist of fresh or frozen food.

Please note: Authorization of Medically Tailored Meals (MTMs) does **not** require a reduction in personal care hours. MTMs operate under a different waiver authority than HCS COPES Home Delivered Meals, have different eligibility criteria, and intention in services.

This service consists of the following:

- The preparation and provision of meals
- Unless otherwise obtained, an initial assessment by a RD/RDN/PCP to develop a medically appropriate nutrition plan.
 - HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA should submit a record of the completed nutrition plan to Barcode for compliance purposes.
 - A reassessment, if needed. Reassessments are required at the time of reauthorization or a change in the Client's medical condition necessitating a new nutrition plan.
- Delivery of the meal.

Eligibility

- Enrolled in Apple Health (Medicaid); and
- Meets the USDA definition of low food security or very low food security; and
- Has a chronic condition; and
- Has been or is being discharged from institutional care, a hospital, or congregate settings, within 6 months, **OR**
- Is at high risk of hospitalization or nursing facility placement.

Pregnancy/Postpartum

If the client is a pregnant/postpartum person, then they may receive these HRSN MTMs either throughout their pregnancy and up to 12 months postpartum. The timing of eligibility determination during pregnancy or postpartum period does not affect the allowable duration of benefit. The intervention may apply to subsequent pregnancies/postpartum periods during the demonstration



period if the client meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods.

Provider Type

The development of a medically appropriate nutrition plan requires a Registered Dietitian (RD), Registered Dietitian Nutritionist (RDN) (preferred), or, if not available, a primary care provider.

Duration, Frequency, and Payment Rate

A client who has met the eligibility criteria for HRSN MTM's may receive up to 3 HRSN MTMs a day for a 6-month authorization period. HRSN MTMs can be renewed for additional 6-month periods if eligibility and the need continue.

If a client is eligible for MTM and meets the following criteria:

- The client is a child/adolescent (0-21 years of age); and/or
- The client is pregnant/post-partum (An individual who is currently pregnant or up to 12 months postpartum)

Then their household* may receive up to 3 additional meals a day, for a total of 6 meals per day. If the client is eligible for household meals, the HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM should ask the client if they would like to receive these additional meals. If so, these can be authorized through S5170,u8 with the appropriate Reason Code to document eligibility.

*household = any Medicaid enrolled individual living in the home with the eligible client.

For example: If the client is a 15-year-old who receives 3 MTM's per day, and the client's mother is also a Medicaid recipient and lives with the client, the mother may also receive up to 3 MTM's per day, for a total of 6 MTMs per day for the household.

A client **cannot** receive medically tailored meals concurrently with pantry stocking and/or short-term grocery provision.

Documenting Eligibility and Need

After authorizing the benefit, the HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM must enter the following SER:

"Client screened eligible for Health-Related Social Needs (HRSN) Medically Tailored Meals. They have been authorized to receive this benefit for the full authorization allowance."

Authorizing MTM provision in CARE

If a client has expressed interest in HRSN Nutrition Supports, a HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM determine eligibility for MTMs.

- Enrolled in Apple Health: Active CARE clients will be open on Apple Health.
 - This can be confirmed in ACES or in CARE by clicking on “Client Details” → “Demographics” → “View ProviderOne details” → “Managed Care”. This will show the client is actively enrolled with one of the five Managed Care Organizations in WA.
- Meets the USDA definition of low food security or very low food security.
 - The USDA definitions of low or very low food security are listed below. Client can verbally self-attest to meeting this criteria by answering yes to one of the following:
 - Do you lack access to quality, variety, or desired food?
 - If yes, meets USDA definition of low food security.
 - Have you skipped meals or eaten less food to try and conserve food due to lack of money or access to food?
 - If yes, meets USDA definition of very low food security.
- Has a chronic condition; and
 - This can be confirmed in CARE by opening the Current Assessment, clicking on “Medical” and reviewing for diagnosis(es).
 - **Chronic Condition(s):** When assessing "chronic" an individual's self-attestation can be accepted and we are typically referring to any medical or behavioral health condition that persists over time, or does not quickly resolve itself, or require continuous management.
 - We are including these examples to assist with eligibility, but please note that these are just examples and if the individual has a chronic condition(s) not included here, they still meet this requirement.
 - Examples of chronic condition(s) include but are not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders, neurodevelopmental disorders and chronic behavioral health conditions, including substance use disorder.
- Has been or is being discharged from institutional care, a hospital, or congregate settings, within 6 months, **OR**
 - This can be confirmed in CARE by checking the following screens: Contact details – Residence address or Historical residence address, Acute Hospital, NF Case Management, and/or State Hospital/Hospital/E&T
- Is at high risk of hospitalization or nursing facility placement.
 - HCLA considers Apple Health (Medicaid) clients who meet the USDA definition of low or very low food security and have a chronic condition at high risk of hospitalization due to living with a chronic condition without the ability to manage nutritional needs.
 - Home and Community-Based Services (HCBS) provides care for individuals in their desired setting who would otherwise require institutional care.

Documenting Eligibility in CARE

After confirming eligibility and verifying the client would like to be authorized for HRSN MTMs:

- Open the Sustainability Goals screen in CARE



- Select add to the Goal List
- Under “Goals detail”
- Select the drop down for Goal short description
- Select “Manage nutritional needs”
- Select the Status “On going”
- For HCS clients, in the Goal description type “Client meets USDA low or very low food security. Client is eligibility for HRSN Nutrition Supports and has requested referral for Medically Tailored Meals.”
- For DDA clients, in the Goal description type “Client meets USDA low or very low food security. Client is eligible for HRSN Nutrition Supports and has requested referral for [enter specific HRSN Nutrition Support benefit and (Client) approved for (amount) from (start) to (end)].”

Contacting a Provider and Authorizing Services

HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA should confirm a client has signed a DSHS Consent Form 14-012 in which the client consented to share information with “Other DSHS contracted providers”. If that box is not selected, ask the client if they are willing to check that box and update the DSHS Consent Form. Once confirmation of consent is verified, HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA should review the [HRSN Contracted Provider Spreadsheet](#) and confirm which provider a client would like to be referred to. Once selected, fill out and send [DSHS Form 11-200](#) to the provider to determine capacity and ability to provide Medically Tailored Meals services. If the client is eligible to receive an additional three meals per day for the household, list six meals per day on the referral form and make note in the Special Deliver Notes section. Contractually a provider has two business days to respond to a referral. If the provider declines a referral, re-review the [HRSN Contracted Provider Spreadsheet](#) with a client to look for alternative options.

Once a provider has accepted a referral, the HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM should:

Open RAC Eligibility screen

- Add new RAC – “3132 – HRSN” for HCS or “3532 – HRSN” for DDA
 - Please note that an Assessment must be Current to authorize HRSN RAC 3132 (HCS)
 - For DDA HRSN RAC 3532, an assessment is not needed
- Start Date: enter date service is authorized to start
- End Date: six months from start date

Open Authorization Screen

- Select “Create new service Line”
- Enter S5170,u7 (Home Delivered Meals - Medically Tailored Meal Federal Match) in the “search service code box” and select service code.
- An “edit Line Data” screen will appear. Enter the following information:
- Start Date: enter date the service is authorized to start



- End Date: six months from the start date
- Enter number of units based on how many meals are being authorized
 - The units should not exceed three meals per day/93 meals per month
 - If authorizing additional household meals, use S5170,u8
- Rate: confirm on [HRSN Contracted Provider Spreadsheet](#)
- Select submit

If the household is eligible for additional meals, open Authorization Screen

- Select “Create new service Line”
- Enter S5170,U8 (Home Deliver Meals – Additional Household Member Federal Match) in the “search service code box” and select service code.
- An “edit Line Data” screen will appear. Enter the following information:
- Start Date: enter date the service is authorized to start
- End Date: six months from the start date
- Enter number of units based on how many meals are being authorized
- Rate: confirm on [HRSN Contracted Provider Spreadsheet](#)
- Reason code: select the appropriate situation of the eligible member that allows the household to receive additional meals:
 - “Child (0-20)”
 - “Pregnant Person”
- Select submit

Enter a SER

- Select Contact method “Admin Task/Email/Fax/Mail”.
- Select Purpose “Care Plan Implementation”.
- Enter the date and Subject “HRSN Authorization”.
- Enter a SER that client requested “HRSN Nutrition Supports”, was screened eligible, and authorized.
 - If the household has been authorized meals, note this in the SER.

Note: In the unfortunate event that a client passes away after a week(+) worth of MTMs were delivered, the HRSN SSS2/ HCS, AAA CM, or DDA HRSN CRM should work with their JRP/supervisor/program manager/payment specialist to determine what option is best regarding the services provided after the client passed away.

HOME ACCESSIBILITY, REMEDIATION, AND ADAPTATION DEVICES

Please note: HRSN Home Accessibility services are anticipated to be available for HCS Summer 2026. General information on this benefit is included here. More information on how to verify eligibility and authorize these benefits will be provided once the benefit has been launched.



Provide professional and safe Accessibility Modifications, Remediations, and Adaptation Devices to eliminate known home-based health and safety risks and ensure the occupants' health and safety in the living environment. Services will be person centered to address social and environmental factors to improve health and wellbeing and support Clients to remain in their homes and communities.

Note: HRSN is a waiver service and is by nature designed to offer innovative services to support clients in ways that they may have not had access to prior to this. If you are unsure as to whether a service would be approved by HRSN, we encourage you to ask the OAS HRSN Team! We are constantly surprised by the flexibility this program offers.

Accessibility Modifications

The provision of accessibility modification services to address known home-based health and safety risks to support the occupants' health and safety in the living environment.

This service may consist of, but is not limited to, the following:

- Ramps and grab-bars
- Wheelchair access improvements like doorway widening, stair lifts, and roll-in showers
- Installation of specialized electric and plumbing systems to accommodate medical equipment
- Door and cabinet handles
- Non-skid surfaces
- Sound proofing
- Overhead track systems
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower)
- Microwaves

Eligibility

- Enrolled in Apple Health (Medicaid); and
- Requires a clinically appropriate home modification service;
- Lives in housing that is physically inaccessible or unsafe due to a disability or medical condition;
OR
- Lives in housing that negatively impacts their health; **AND**
- Has a chronic condition(s) causing physical limitations with inaccessible living environments.
 - **Chronic Condition(s):** When assessing "chronic" an individual's self-attestation can be accepted and we are typically referring to any medical or behavioral health condition that persists over time, or does not quickly resolve itself, or require continuous management.



- We are including these examples to assist with eligibility, but please note that these are just examples and if the individual has a chronic condition(s) not included here, they still meet this requirement.
- Examples of chronic condition(s) include but are not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders, neurodevelopmental disorders and chronic behavioral health conditions, including substance use disorder.

When authorizing services, HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA must include a SER in CARE documenting a referral has been sent to a provider detailing the specific service requested and include in the SER how the service meets the need of the individual, e.g. mold removal to improve client's asthma.

This service may be provided in the following locations:

- In a home that is owned, rented, leased, or occupied by the client or their caregiver. For a home that is not owned by the individual, the homeowner must provide written consent for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).
 - If client is renting or leasing their home, there must be written documentation from the landlord prior to construction. HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA must get this documentation prior to authorization and document in a SER and submit a record of documented approval to Barcode for compliance purposes.
- Home visits are required for accessibility modifications. The contracted provider must perform an on-site assessment to complete the bid. The DSHS or AAA case manager may support the enrollee through the choice and construction of services.
 - A SER must also be added upon the provider completing a home visit to determine the suitability of the requested service.
- DDA may provide this service to clients in the Alternative Living (AL) Program.

Duration, Frequency, and Payment Rate

HRSN Accessibility Modifications are payable up to \$5,000 per instance with a \$7,500 lifetime maximum. A client may receive an exception to the maximum, up to \$60,000, if their physical condition or living situation has changed, resulting in the need for additional modifications.

Process for Exceeding the Maximum

HRSN Accessibility Modifications will be using a "forced error" in CAREWeb.

1. Level of review for Accessibility Modifications:
 - a. Above \$5,000/instance or \$7,500/1115 waiver up to \$15,000: CM/CRM à Supervisor approves



- b. \$15,001-\$60,000: CM/CRM à Headquarters/Specialist approves
- 2. A SER must be entered above \$5,000/instance and/or above \$7,500/1115 waiver with the following language depending on which criterion is met by the client's circumstances:
 - a. Client meets WAC 388-106H-4060 3(a): The individual's physical condition or living situation has changed so significantly that additional accessibility modifications or remediations are necessary to support their health, welfare, or independence
 - b. Client meets WAC 388-106H-4060 3(b): Because of the individual's particular circumstances, the accessibility modifications and remediations cannot be reasonably purchased within the maximum.

Bids

- **HRSN Program policy:** The HRSN Program will only require CMs to receive one bid for Accessibility Modifications, but more than one bid is encouraged. This will be reassessed as the program is implemented to determine whether a different approach to bids should be explored.
- **Other DSHS programs** require CMs to receive multiple bids. Program managers have communicated both the benefits and challenges of receiving more than one bid.
 - Benefits:
 - Ensuring pricing is competitive across providers.
 - Comparing and encouraging different options that can support the client.
 - Options for timeframes, one contractor may have sooner availability.
 - Client choice.
 - Challenges:
 - Often, there are not multiple providers available and capable of doing the work especially in more rural areas of WA.
 - Bid may include very different proposed work, making it hard to determine the most appropriate bid.

Note: The HRSN Program will support the client's desired materials for a project so long as they are cost-effective at keeping the client in their home and fall with the budget and scope of allowable services under the 1115 waiver.

What if my client needs something not on the list, is it covered?

The HRSN Accessibility Modifications allowable services are not an exhaustive list and if the CM wishes to provide a client with a service not explicitly listed, follow these steps:

1. CM identifies a client's need for Accessibility Modifications not listed as an example service.



2. CM writes up a statement of Medical Necessity specifying the condition and exact service the client requires.
3. CM reviews the statement of Medical Necessity with their supervisor.
4. CM submits the statement of Medical Necessity to the OAS HRSN Team at HRSN@dshs.wa.gov for approval.
5. The OAS HRSN Team will send a decision to the CM and their supervisor within 3 business days. If the OAS HRSN Team requires more time, they will let the CM and their supervisor know within those 3 business days.
6. If approved, CM will look at the contracted provider list and call potential providers to ensure there is provider capacity and expertise to complete the work. CM will reach out to the OAS HRSN Team at HRSN@dshs.wa.gov if no contracted provider exists in network to complete the desired work.

Note: If you are unsure whether something will be covered, the HRSN Team recommends asking! Due to the flexibility of this program, we have a lot of room to make things work.

Medicaid Coverage

1. HRSN Accessibility Modifications can take several months to complete and to reduce the likelihood of a client losing Medicaid coverage during service provision:
 - a. The CM should authorize the work following an initial or annual assessment; and
 - b. All Accessibility Modifications and projects should include the purchase of needed materials in the first month of the project, when possible, to ensure ability to leverage Medicaid funding in case a client loses Medicaid.

Note: In the unfortunate event that a client passes away or loses Medicaid coverage during the provision of services, Medicaid funds cannot be used to pay the remaining balance to the contractor. In either of these circumstances, the CM should work with their JRP/supervisor/program manager to determine what option is best regarding the services provided after the client passed away or lost Medicaid coverage.

For additional information, reference Appendices I and II, which include the eligible and ineligible ACES and RACs for HRSN Program services.

Determining Medical Necessity

The HRSN Team considers Accessibility Modifications medically necessary for the client when they meet program eligibility requirements. Once the CM determines that the HRSN Accessibility Modification is medically necessary for the client, based on the above criteria, the CM will:

1. Complete a SER documenting that a referral has been sent to a provider detailing the specific service requested and how the service meets the need(s) of the individual (this is called a Medical Necessity Statement); and

- a. Examples:
 - i. The client has Dementia and cannot use the oven without the risk of setting fire, and a microwave is a safer solution for cooking.
 - ii. Client suffers from severe and debilitating Migraine headaches and their doctor has recommended blackout curtains for the bedroom at least as an accessibility modification.
 - iii. Client listens to loud music to drown out voices in head from their Schizophrenia and is at risk of losing housing due to neighbor complaints, home accessibility requested to soundproof unit.
2. Complete a SER documenting that the contracted provider completed a home visit to determine the suitability of the requested service.

Remediations

The provision of remediation services to address known home-based health and safety risks to support the occupants' health and safety in the living environment.

This service may consist of, but is not limited to, the following:

- Allergen-impermeable mattress and pillow dustcovers
- Ventilation improvements and air filters
- Integrated Pest Management (IPM) services
- De-humidifiers
- Minor mold removal and remediation services
- Carpet replacement
- Housing safety inspections
- Installation of washable curtains or synthetic blinds to prevent allergens
- Hoarding cleanup services

Eligibility

- Enrolled in Apple Health (Medicaid); and
- Requires a clinically appropriate remediation service;
- Lives in housing that is physically inaccessible or unsafe due to a disability or medical condition,
OR
- Lives in housing that negatively impacts their health; and
- Has a chronic condition(s) for which remediation may be reasonably expected to improve health outcomes, **examples** include:
 - Poorly controlled asthma;
 - Chronic obstructive pulmonary disease (COPD);
 - Cystic fibrosis; or



- Interstitial lung disease.

Note: If a client has a chronic condition(s) not listed here for which remediation could improve health outcomes, they meet the criteria.

When authorizing services, HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA must include a SER in CARE documenting a referral has been sent to a provider detailing the specific service requested and include in the SER how the service meets the need of the individual, e.g. mold removal to improve client's asthma.

Services may be provided in the following locations:

- In a home that is owned, rented, leased, or occupied by the client or their caregiver. For a home that is not owned by the individual, the homeowner must provide written consent for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).
 - If client is renting or leasing their home, there must be written documentation from the landlord prior to construction. HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA must get this documentation prior to authorization and document in a SER and submit a record of documented approval to Barcode for compliance purposes.
- Home visits are required for remediation. The contracted provider must perform an on-site assessment to complete the bid. The DSHS or AAA case manager may support the enrollee through the choice and construction of services.
 - A SER must also be added upon the provider completing a home visit to determine the suitability of the requested service.
- DDA may provide this service to clients in the Alternative Living (AL) Program.

Duration, Frequency, and Payment Rate

HRSN Remediations are payable up to \$5,000 per instance with a \$7,500 lifetime maximum. A client may receive an exception to the maximum, up to \$60,000, if their physical condition or living situation has changed, resulting in the need for additional remediations.

Process for Exceeding the Maximum

HRSN Remediations will be using a "forced error" in CAREWeb.

1. Level of review for Remediations:
 - a. Above \$5,000/instance or \$7,500/1115 waiver up to \$15,000: CM/CRM à Supervisor approves
 - b. \$15,001-\$60,000: CM/CRM à Headquarters/Specialist approves
2. A SER must be entered above \$5,000/instance and/or above \$7,500/1115 waiver with the following language depending on which criterion is met by the client's circumstances:

- a. Client meets WAC 388-106H-4060 3(a): The individual's physical condition or living situation has changed so significantly that additional accessibility modifications or remediations are necessary to support their health, welfare, or independence
- b. Client meets WAC 388-106H-4060 3(b): Because of the individual's particular circumstances, the accessibility modifications and remediations cannot be reasonably purchased within the maximum.

Bids

- **HRSN Program policy:** The HRSN Program will only require CMs to receive one bid for Remediations, but more than one bid is encouraged. This will be reassessed as the program is implemented to determine whether a different approach to bids should be explored.
- **Other DSHS programs** require CMs to receive multiple bids. Program managers have communicated both the benefits and challenges of receiving more than one bid.
 - Benefits:
 - Ensuring pricing is competitive across providers.
 - Comparing and encouraging different options that can support the client.
 - Options for timeframes, one contractor may have sooner availability.
 - Client choice.
 - Challenges:
 - Often, there are not multiple providers available and capable of doing the work especially in more rural areas of WA.
 - Bid may include very different proposed work, making it hard to determine the most appropriate bid.

Note: The HRSN Program will support the client's desired materials for a project so long as they are cost-effective at keeping the client in their home and fall with the budget and scope of allowable services under the 1115 waiver.

What if my client needs something not on the list, is it covered?

The HRSN Remediations allowable services are not an exhaustive list and if the CM wishes to provide a client with a service not explicitly listed, follow these steps:

1. CM identifies a client need for a Remediation not listed as an example service.
2. CM writes up a statement of Medical Necessity specifying the condition and exact service the client requires.
3. CM reviews the statement of Medical Necessity with their supervisor.
4. CM submits the statement of Medical Necessity to the OAS HRSN Team at HRSN@dshs.wa.gov for approval.



5. The OAS HRSN Team will send a decision to the CM and their supervisor within 3 business days. If the OAS HRSN Team requires more time, they will let the CM and their supervisor know within those 3 business days.
6. If approved, CM will look at the contracted provider list and call potential providers to ensure there is provider capacity and expertise to complete the work. CM will reach out to the OAS HRSN Team at HRSN@dshs.wa.gov if no contracted provider exists in network to complete the desired work.

Note: If you are unsure whether something will be covered, the HRSN Team recommends asking! Due to the flexibility of this program, we have a lot of room to make things work.

Medicaid Coverage

1. HRSN Accessibility Modifications can take several months to complete and to reduce the likelihood of a client losing Medicaid coverage during service provision:
 - a. The CM should authorize the work following an initial or annual assessment; and
 - b. All Accessibility Modifications and projects should include the purchase of needed materials in the first month of the project, when possible, to ensure ability to leverage Medicaid funding in case a client loses Medicaid.

Note: In the unfortunate event that a client passes away or loses Medicaid coverage during the provision of services, Medicaid funds cannot be used to pay the remaining balance to the contractor. In either of these circumstances, the CM should work with their JRP/supervisor/program manager to determine what option is best regarding the services provided after the client passed away or lost Medicaid coverage.

For additional information, reference Appendices I and II, which include the eligible and ineligible ACES and RACs for HRSN Program services.

Determining Medical Necessity

The HRSN Team considers Remediations medically necessary for the client when they meet program eligibility requirements. Once the CM determines that the HRSN Remediation is medically necessary for the client, based on the above criteria, the CM will:

1. Complete a SER documenting that a referral has been sent to a provider detailing the specific service requested and how the service meets the need(s) of the individual (this is called a Medical Necessity Statement); and
 - a. Examples:
 - i. Mold removal was requested to improve the client's Asthma.
 - ii. Client with paraplegia who utilizes a wheelchair requested mold remediation and floor replacement in RV to support continued RV accessibility.



- iii. A therapeutic deep clean requested for a client living with hoarding behaviors and Rheumatoid Arthritis.
 - iv. Client in their 90s requested carpet cleaning due to having allergies that affect their breathing, which are worsened by the condition of the carpet.
 2. Complete a SER documenting that the contracted provider completed a home visit to determine the suitability of the requested service.

Adaptation Devices

The provision, service delivery, and installation as needed of a home device to individuals for whom such equipment is clinically appropriate as a component of treatment or prevention for a home-device specific medical indication (e.g., air conditioner for individuals at health risk due to significant heat or heaters for individuals at increased health risk due to significant cold).

Eligibility

- Enrolled in Apple Health (Medicaid);
- At risk for institutionalization due to inaccessible living environments; **AND**
- Has a chronic condition(s) for which devices may be expected to improve health outcomes, including, but not limited to:
 - Air filtration devices for people at health risk due to compromised air quality;
 - Refrigeration units for adequate medication storage needs; or
 - Portable power supplies for people who need access to electricity-dependent equipment (e.g. ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication issues, etc.).
 - **Chronic Condition(s):** When assessing "chronic" an individual's self-attestation can be accepted and we are typically referring to any medical or behavioral health condition that persists over time, or does not quickly resolve itself, or require continuous management.
 - We are including these examples to assist with eligibility, but please note that these are just examples and if the individual has a chronic condition(s) not included here, they still meet this requirement.
 - Examples of chronic condition(s) include but are not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders, neurodevelopmental disorders and chronic behavioral health conditions, including substance use disorder.

Services may be provided in the following locations:



- In a home that is owned, rented, leased, or occupied by the client or their caregiver. For a home that is not owned by the individual, the client must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).
 - If client is renting or leasing their home, there must be written documentation from the landlord prior to construction, as applicable for this benefit. HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA must get this documentation prior to authorization and document in a SER and submit a record of documented approval to Barcode for compliance purposes.
- Home visits are not required for HRSN adaptation devices. The DSHS or AAA case manager may support the enrollee through the choice and installation of services.
- Portable power supplies may be provided to clients in Companion Homes if they don't need the generator to power medical supplies per DDA regulations.

Duration, Frequency, and Payment Rate

- Air conditioners are payable up to \$880 per device, including sales tax and delivery
- Air filtration devices are payable up to \$500 per device, including sales tax and delivery
- Air filter replacements are payable up to \$80 per device, including sales tax and delivery
- Portable power supplies are payable up to \$1,400 per device, including sales tax and delivery
- Heaters are payable up to \$220 per device, including sales tax and delivery
- Mini refrigerators are payable up to \$300 per device, including sales tax and delivery

Please note: The cost of installation should be built into the rate/quote for HRSN adaptation devices, if installation is necessary.

On 'edit line data' screen, in 'comments' section, write which adaptation device is being authorized.

What if my client needs something not on the list, is it covered?

The items covered under HRSN Adaptation Devices are exhaustive and no other devices will be approved during MTP 2.0 for this benefit. There might be some devices which can be covered under HRSN Accessibility Modifications or Remediations. Please reach out to the OAS HRSN Team in this circumstance via hrsn@dshs.wa.gov.

Determining Medical Necessity

The HRSN Team considers Adaptation Devices medically necessary for the client when they meet program eligibility requirements. Once the CM determines that the HRSN Adaptation Device is medically necessary for the client, based on the above criteria, the CM will:

1. Complete a SER documenting that a referral has been sent to a provider detailing the specific service requested and how the service meets the need(s) of the individual (this is called a Medical Necessity Statement); and
 - a. Examples:



- i. Client with Graves' Disease living in Walla Walla requested an air conditioner to reduce risk of heat related flare ups.
 - ii. Client living with hoarding behaviors and Rheumatoid Arthritis received therapeutic deep clean requested an air filtration device and air filter replacements to reduce allergen build up following the deep clean.
2. Complete a SER documenting that the contracted provider completed a home visit to determine the suitability of the requested service.
- 3.

CAREGIVER RESPITE SERVICES

Please note: HRSN caregiver respite services are anticipated to be available January 2027. General information on this benefit is included here as this is a HRSN Phase 2 benefit. More information will be added to this section once the benefit has been launched.

HRSN caregiver respite services are available to provide intermittent temporary supervision on a short-term basis for clients with an unpaid caregiver. Services provided to the individual are primarily nonmedical and may include attending to the individual's basic self-help needs and other activities of daily living (ADLs), including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by the client's unpaid caregiver. Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional placement.

Eligible individuals may receive up to 336 hours of services per calendar year. The limit is inclusive of all in-home and in-facility services. Additional hours can be approved if the need continues.

Eligibility

- Enrolled in Apple Health (Medicaid); and
- The **unpaid caregiver** requires relief to avoid the client being placed in an institution; and
- The **unpaid caregiver** has self-identified:
 - Stress, fatigue, or competing time commitments or vacations; and
 - Challenges in finding or affording alternative care.
- The **client** must meet one of the following:
 - Have a clinical or physical decline that increases medical or physical needs;
 - Have a complex clinical or behavioral need or placement on hospice;
 - Be pregnant or recently postpartum; or
 - Repeated emergency department use or multiple crisis encounters.
- The **unpaid caregiver** must meet one of the following:
 - The client lives in the community and is compromised in their activities of daily living or has a behavioral health need that requires supervision;
 - Have medical needs including, but not limited to: medical appointments, chronic stress, or a contagious condition;
 - Needs additional rest to recover from a medical condition;

- Requires services provided on an hour-by-hour basis due to absence; or
- Requires services provided during the day or overnight on a short-term basis due to absence.

PLANNED ACTION NOTICE (PAN)

The HRSN Program leverages Medicaid Transformation Project (MTP) 2.0 funding and must remain consistent with federal Medicaid requirements, such as sending a Planned Action Notice (PAN). SSS2/HCS or AAA CM/CRM must send a PAN for HRSN authorized services consistent with notification requirements:

- HCS and AAA CM, follow the guidance in the [Long-Term Care \(LTC\) Manual Chapter 27](#).
- DDA CRM, follow the guidance in Policy [5.07](#).

If a contracted provider does not have capacity to serve an eligible client and there are no other providers available, a denial PAN needs to be sent. Verbal notification about other care options for the client's care plan is appropriate. This conversation should be documented by the SSS2/HCS or AAA CM/CRM in a SER in CARE.

When creating a PAN, there is no drop-down option to select HRSN when filling out "Add a PAN service line". You must type information on HRSN in. When adding a PAN service line, please follow these instructions:

- Program: Click the drop-down arrow and select "Other HCS Program"
- Other Program Name: type in "Health-Related Social Needs (HRSN)"
- Service: Click the drop-down arrow and select "Other HCS Service"
- Other Service Name: type in "HRSN [*insert specific service authorizing, e.g. short-term grocery provision; fruit and vegetable provision*]"
- Click "✓ Add service/support" on the bottom right.

RESOURCES

RAC 3132 (HCS)/RAC 3532 (DDA) : Health Related Social Needs – Federal, HCS

HRSN Temporary Housing/Rent Related:

Motel Interim Stay for Transitions (MIST) SA294u1

Motel Interim Stay for Transitions (MIST) is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase a client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period at a time. Federal MIST is funded via the 1115 waiver in which the Washington State Health Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical

services to address an individual's unmet, adverse social conditions that contribute to poor health. This includes temporary housing.	
Who is eligible for federal MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: HCS Subsidy (Bridge & Acute Care Hospital) - Bridge Subsidy: HCS clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. - Acute Hospital Care (ACH) Subsidy: HCS clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. GOSH Program: HCS clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. Other Housing Resource: - HCS clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VA, etc. - HCS clients who have been approved for a project-based resource <u>and</u> have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. In-Home Short-Term Displacement: HCS clients who have their own home <u>and</u> a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding. Experiencing Homelessness: HCS clients experiencing homelessness. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u1?	- Payment for up to 6-month period for a Medicaid HCS client to stay at a motel/hotel. - Damages upon HQ approval- Please contact Supportive Housing Program Manager
What is not covered under MIST 294u1?	Deposits
How much can I spend?	Up to \$4,000 per month for a total of 6 months. Note: not to exceed 6 months



Do I need to use a contracted provider?	Yes. 1. The HCS/AAA CM will need to coordinate with the Contracted Provider and notify them that the client has been authorized for Motel Interim Stay for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed.
How do I authorize federal MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM should open RAC 3132 (HCS)/RAC 3532 (DDA) . 2. Use Service Code SA294,U1 to reimburse the contracted provider for the expenses incurred. 3. HCS/AAA CM will reimburse contracted provider on a two-week timeline for a period of up to six months. Note: do not submit authorization to ProviderOne until receipt/s have been received.
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for federal MIST?	No. 1. When the approved MIST amount is above \$2,000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially. Federal Emergency Rental Assistance is funded via the 1115 waiver, in which the Washington State Health Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. These includes rent.	
Who is eligible for federal ERA?	1. A LTSS client who is experiencing or at risk of experiencing homelessness, including facing immediate eviction due to non-payment of rent.

What is covered under federal ERA?	1. A one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent.
What is not covered under federal ERA?	1. ERA does not include pre-tenancy deposits or move-in costs required at move in. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent.
When do I need a provider contract?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide or GOSH Supportive Housing Provider) to make the ERA payment on the clients' behalf.
How do I authorize federal ERA	1. Use RAC 3132 (HCS)/RAC 3532 (DDA) . 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Housing Program Manager.
Are ETRs allowed for the federal ERA?	No. 1. Note: When the approved ERA amount is above \$4,000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

HRSN Nutrition Supports Related:

Nutrition Counseling H2014, U4

Who is eligible for HRSN Nutrition Counseling	- Enrolled in Apple Health (Medicaid); and - Meets the USDA definition of low food security or very low food security; and - Has a chronic condition.
What is covered under HRSN Nutrition Counseling?	- Provision of nutrition counseling or information to an individual or group that offers evidence based or evidence informed strategies on adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being and guidance on food and nutrition resources. - Meal preparation education in an individual or group setting.



How do I authorize HRSN Nutrition Counseling?	HCS/AAA: Use RAC 3132 (HCS)/RAC 3532 (DDA) Use Service Code H2014, U4 DDA: Use RAC 3532 Use Service Code H2014,U4
When do I authorize this service?	When a client has a Current CARE assessment, has requested this service, a HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA has verified eligibility, and a provider has accepted the referral.
Are ETRs allowed for HRS Nutrition Counseling?	No.

Nutrition Education SA080, U2

Who is eligible for HRSN Nutrition Education?	• Enrolled in Apple Health (Medicaid); and • Meets the USDA definition of low food security or very low food security; and • Has a chronic condition.
What is covered under HRSN Nutrition Education?	• Provision of nutrition education or information that offers evidence based or evidence informed strategies on adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being and guidance on food and nutrition resources. • Nutrition education services may be provided via handouts, take- home materials, newsletters, and other informational resources that support nutritional health and well-being.
How do I authorize HRSN Nutrition Education?	HCS/AAA: Use RAC 3132 (HCS)/RAC 3532 (DDA) Use Service Code SA080, U2 DDA: Use RAC 3532 Use Service Code SA080, U2



When do I authorize this service?	When a client has a Current CARE assessment, has requested this service, a HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA has verified eligibility, and a provider has accepted the referral.
Are ETRs allowed for the HRSN Nutrition Education?	No.

Fruit and Vegetable Provisions SA420, U2

Who is eligible for HRSN Fruit and Vegetable Provisions?	• Enrolled in Apple Health (Medicaid); and • Meets the USDA definition of low food security or very low food security; and • Has a chronic condition.
What is covered under HRSN Fruit and Vegetable Provisions?	Fruits and vegetables may be fresh, frozen, or canned.
What is not covered under HRSN Fruit and Vegetable Provisions?	Food and drink not categorized as fruit or vegetable.
How do I authorize HRSN Fruit and Vegetable Provisions	HCS/AAA: Use RAC 3132 (HCS)/RAC 3532 (DDA) Use Service Code SA420,U2 DDA: Use RAC 3532 Use Service Code SA420,U2
When do I authorize this service?	When a client has a Current CARE assessment, has requested this service, a HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA has verified eligibility, and a provider has accepted the referral.
Are Exceptions to Policy (ETPs) allowed for HRSN Fruit and Vegetable Provisions?	No.

Pantry Stocking SA420, U1

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Who is eligible for HRSN Pantry Stocking?	- Enrolled in Apple Health (Medicaid) and under 21 years old and/or a pregnant individual; and - Meets the USDA definition of low food security or very low food security; and - Has a chronic condition.
What is covered under HRSN Pantry Stocking?	This service allows an individual to purchase an assortment of foods aimed at promoting improved nutrition for the individual. Individuals may pick up food from food retailers or have food delivered to the individual's home or private residence if delivery service is available. Examples of allowable foods include: - Fruits and vegetables - Meat, poultry, and fish - Dairy products - Breads and cereals - Snack foods and non-alcoholic beverages - Seeds and plants
What is not covered under HRSN Pantry Stocking?	Items not eligible for purchase: - Alcoholic beverages - Tobacco Products - Non-food items - Foods containing controlled substances
How do I authorize HRSN Pantry Stocking?	HCS/AAA: Use RAC 3132 (HCS)/RAC 3532 (DDA) Use Service Code 420,U1 Use appropriate Reason Code: "child (0-20)" or "pregnant person" DDA: Use RAC 3532 Use Service Code 420,U1 Use appropriate Reason Code: "child (0-20)" or "pregnant person"
When do I authorize this service?	When a client has a Current CARE assessment, has requested this service, a HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA has verified eligibility, and a provider has accepted the referral.
Are Exceptions to Policy (ETPs) allowed for HRSN Pantry Stocking?	No.

Short-term Grocery Provision SA420, U1 with Reason Code



Who is eligible for HRSN Short-term Grocery Provision?	• Enrolled in Apple Health (Medicaid); and • Meets the USDA definition of low food security or very low food security; and • Is enrolled in LTSS; and • Has been or is being discharged within 6 months from the hospital or skilled nursing facility; OR • Is at high risk of hospitalization or nursing facility placement.
What is covered under HRSN Short-term Grocery Provision?	This service allows a client to purchase an assortment of foods aimed at promoting improved nutrition for the individual. Individuals may pick up food from food retailers or have food delivered to the individual's home or private residence if delivery service is available.
What is not covered under HRSN Short-term Grocery Provision?	Items not eligible for purchase: • Alcoholic beverages • Tobacco Products • Non-food items • Foods containing controlled substances
How do I authorize HRSN Short-term Grocery Provision?	HCS/AAA: Use RAC 3132 (HCS)/RAC 3532 (DDA) Use Service Code 420,U1 Reason Code: "No reason code needed" DDA: Use RAC 3532 Use Service Code 420,U1 Reason Code: "No reason code needed"
When do I authorize this service?	When a client has a Current CARE assessment, has requested this service, a HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA has verified eligibility, and a provider has accepted the referral.
Are Exceptions to Policy (ETPs) allowed for HRSN Short-term Grocery Provision?	No.

Medically Tailored Meals S5170, U7; S5170, U8

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Who is eligible for HRSN Medically Tailored Meals?	• Enrolled in Apple Health (Medicaid); and • Meets the USDA definition of low food security or very low food security; and • Has a chronic condition; and • Has been or is being discharged from institutional care, a hospital, or congregate settings, within 6 months, OR • Is at high risk of hospitalization or nursing facility placement.
What is covered under HRSN Medically Tailored Meals?	• Meals may consist of fresh or frozen food. • The meal may also include an accompanying fluid/drink and/or a supplementary food item to support meeting a client's nutrition needs between meals if medically appropriate. • Each meal must contain sufficient food to support approximately one-third of an individual's daily nutritional need as indicated by the Dietary Reference Intakes and Dietary Guidelines.
How do I authorize HRSN Medically Tailored Meals?	HCS/AAA: Use RAC 3132 (HCS)/RAC 3532 (DDA) Use Service Code S5170, U7 Households enrolled with Medicaid may receive an extra 3 meals/day if the MTM eligible member is: ○ A child/adolescent (0-21 years of age) or ○ Pregnant (An individual who is currently pregnant or up to 12 months postpartum.) Use Service Code S5170,U8 with the appropriate Reason Code to document eligibility. DDA: Use RAC 3532 Use Service Code S5170,U7 Households enrolled with Medicaid may receive an extra 3 meals/day if the MTM eligible member is: ○ A child/adolescent (0-21 years of age) or ○ Pregnant (An individual who is currently pregnant or up to 12 months postpartum.) Use Service Code S5170,U8 with the appropriate Reason Code to document eligibility.



When do I authorize this service?	When a client has a Current CARE assessment, has requested this service, a HRSN SSS2/ HCS, AAA CM, or HRSN CRM/DDA has verified eligibility, and a provider has accepted the referral.
Are Exceptions to Policy (ETPs) allowed for HRSN Medically Tailored Meals?	No. Note: If the individual is pregnant/postpartum or there is a child under 21 in the household, up to an additional 3 meals a day can be provided throughout the authorization period.

Programs Eligible for HRSN Services

Individuals on the following programs and associated ACES codes are eligible to receive HRSN program services at this time.

ACES Codes	RACs
C01	1000, 1001, 1002, 1003, 1004, 1005
C95	1010, 1012
C99	1010, 1012
D01	1014, 1015, 1016, 1017, 1018, 1279
D02	1019, 1020, 1021, 1022, 1023, 1280
D26	1196, 1281
F01	1024
F02	1026
F03	1027
F04	1028
F05	1029
F06	1030, 1031
F07	1032,1040
F10	1038
F99	1039
G01	1042
G02	1043, 1044, 1045
G03	1046, 1047
G95	1048, 1049
G99	1048,1049
I01	1050, 1051
K01	1052, 1053, 1055
K95	1059, 1061, 1063
K99	1059, 1061, 1063
L01	1065, 1066, 1067, 1068, 1069, 1070,1168,1169

L02	1071, 1072, 1073, 1074, 1075, 1076, 1162, 1163, 1164, 1165
L21	1146, 1147, 1152, 1153, 1218, 1219, 1220, 1221
L22	1148, 1149, 1150, 1151, 1174, 1175, 1222, 1223, 1224, 1225
L31	1226, 1227, 1228, 1229, 1236, 1237, 1238, 1239
L32	1230, 1231, 1232, 1233, 1234, 1235, 1240, 1241, 1242, 1243
L41	1260, 1261, 1262, 1263
L42	1264, 1265, 1266, 1267, 1268, 1269
L51	1104, 1105, 1106, 1107, 1244, 1245, 1246, 1247
L52	1046, 1047, 1108, 1109, 1110, 1111, 1248, 1249, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259
L95	1083, 1084, 1086, 1154, 1156, 1166
L99	1083, 1084, 1086, 1088, 1089, 1091, 1154, 1156, 1167
P02	1095, 1096
P04	1096
P99	1101, 1102
R01	1103
R02	1103
S01	1104, 1105, 1106, 1107, 3170
S02	1108, 1109, 1110, 1111, 3170
S08	1121, 1134, 1271, 3170
S30	1122, 3170
S32	1286, 1287
S95	1124, 1126
N01	1197, 3170
N02	1198, 3170
N03	1199, 1200, 3170
N04	1274, 1275
N05	1201, 1217, 3170
N07	1276
N10	1202
N11	1203, 1204, 1205
N13	1206, 1207
N23	1209

Related WACs:

[WAC 388-106H](#): Health-Related Social Needs

[WAC 388-106H-0100](#) through [WAC 388-106H-0130](#): Rent/Temporary Housing



[WAC 388-106H-2000](#) through [WAC 388-106H-2040](#): Nutrition Supports
[WAC 388-106H-3000](#) through [WAC 388-106H-3040](#): Caregiver Respite Services
[WAC 388-106H-4000](#) through [WAC 388-106H-4050](#): Home Accessibility, Remediation, and Adaptation Devices

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
04/2026	WHITNEY JOY HOWARD	Established	H26-019
08/2026	LINDSEY LOZOSKIE	- Included specific processes for DDA to authorize HRSN - Updated Home Accessibility, Remediations, and Adaptation Devices section to reflect the authorization process	

Judicial Involved Transitions

The purpose of this chapter is to provide information about the Civil Transitions Program (CTP), Extraordinary Medical Placement (EMP), and Special Commitment Center (SCC) programs. This chapter addresses eligibility, service availability and provides a description of how clients in these circumstances are supported by these programs.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Phyllis Moffatte-Clark Community Support Program Manager
360-764-0481
phyllis.moffatte-clark@dshs.wa.gov

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CIVIL TRANSITIONS PROGRAM

Background

The Trueblood Settlement establishes a plan for providing services to individuals involved in the criminal court system, as well as providing treatment to people when needed in a focused effort to reduce recidivism.

The Civil Transitions Program (CTP) program was established in 2023 as a response to the mandate in Engrossed Second Substitute Senate Bill 5440. Home and Community Living Administration (HCLA) developed a process for connecting individuals found not competent to stand trial and not restorable due to an intellectual or developmental disability, dementia, or traumatic brain injury to available wraparound services and supports in the community. When a referral is screened in, Home and Community Services (HCS) will offer services to individuals, even those who are not traditionally eligible based on functional and financial criteria. Clients may be in jail, the community, or a state hospital. Individuals may have an assigned Forensic Navigator through the Behavioral Health and Habilitation Administration (BHHA) to coordinate with the HCS case manager.

Referral Process for Civil Transitions Program

Individuals must be referred to HCLA from the BHHA. These individuals have been forensically evaluated and determined to be not competent to stand trial and not restorable due to the diagnosis of intellectual or development disability, dementia, or traumatic brain injury.

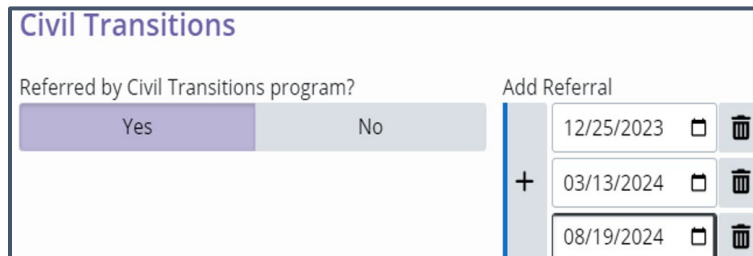
- BHHA sends referrals to HCLA. HCS processes referrals with diagnosis of dementia or traumatic brain injury. DDCS process referrals with intellectual or developmental disability. Referrals are triaged by the program manager or designee.
- If the client is active on services, the assigned case manager and supervisor will be notified of the CTP referral by email.
- The case manager will determine if the referral is related to or affecting current services that would warrant a significant change assessment and/or additional wrap-around services or a program change.
- If the client is in jail, the case manager will coordinate with current providers to determine if the client can return to the same residential facility or utilize the same in-home provider. The case manager will connect with the BHHA Forensic Navigator to determine if the client is eligible for any additional services as a Trueblood class member.
- If the referral is for an inactive or new client, the program manager or designee will email the referral to the regional designee and/or intake. The HCS case manager will then contact the client to offer Long Term Services and Support (LTSS). If the client is homeless or at risk of

homelessness, supportive housing can be offered prior to the Client Assessment Reporting and Evaluation (CARE) assessment. Once the CARE assessment is completed:

- If client is found to be financially and functionally eligible, HCS Case manager will continue with traditional services (MPC, CFC, COPES, RSW) and follow normal procedures.
- *If the client is found not to be financially or functionally eligible, they may be eligible for a conditional service package.*
- The case manager will connect with the Forensic Navigator to determine if the client is eligible for any additional services as a Trueblood class member.

CARE Demographics Screen

The intake team will complete the CARE Demographics screen when processing the referral in CARE. If the individual is already on services, the Community Support Program Manager or designee will assist the case manager to complete the screen.



HCS Response Time Frames

Once a referral has been received by intake, follow the regular intake process see [Chapter 3](#).

Housing Supports for CTP Clients

For individuals with an immediate need for housing, a referral for housing services may be submitted without a CARE assessment or Medicaid application being submitted. Case managers will contact the Housing Special Projects Program Manager. A supportive housing specialist will assist a client to connect with community resources, assist with housing search, transition and sustainability services, other benefits, as well as funding for motel stays. For more information see [Chapter 6b](#) for HCLA clients.

WHAT ARE CONDITIONAL SERVICES?

Conditional services are limited services developed for CTP clients that meet diagnostic criteria and are not functionally nor financially eligible. *These services are subject to available funds under the Civil Transitions Program.* Conditional services are offered only for in-home or interim settings while clients work to secure permanent housing.

How Will I Know if my Client Meets Criteria for Conditional Services?

After the HCS case manager has completed the CARE assessment and the client has been determined not functionally nor financially eligible, do not deny services or close the case. Contact the Community Support Program Manager or designee to assess for conditional services.

Conditional Service Packages

If the client meets functional eligibility for nursing facility level of care (NFLOC) under Community First Choice (CFC) but is not financially eligible, they may receive the following conditional services if included in their care plan:

- Personal Care
- Nurse Delegation
- Assisted Technology
- Personal Emergency Response System (PERS)
- Community Transition Service
- Supportive Housing
- WA Roads

If the client meets functional eligibility for Medicaid personal care (MPC) but is not financially eligible, they may receive the following conditional services if included in their plan of care:

- Personal Care
- Supportive Housing
- WA Roads

If the client is only financially eligible and not functionally eligible, they may receive the following conditional services:

- Supportive Housing
- WA Roads

If the client does not meet functional eligibility for CFC or MPC and is not financially eligible, they may receive the following conditional services:

- Supportive Housing
- WA Roads

Duration of CTP Conditional Services

Conditional services will only be authorized for six months regardless of whether a client is only functionally eligible, only financially eligible, or neither. The six-month timeframe will start on the first day of the service authorization. CTP cases will be case managed by HCS regional offices and not transferred to the AAA. Cases will be reviewed by the case manager at 90 days to determine if there

have been functional and/or financial changes that would allow for the conversion to traditional services. The client may then choose a residential setting.



Exception: For those at risk of homelessness, housing services will be reviewed at six months with the ability to re-authorize for up to two years

HOW TO DOCUMENT IN CARE

Service Episode Record

When writing service episode records (SER), the Civil Transitions Program (5440) code is to be used to document actions related to CTP referral information, service discussion and planning, and with Forensic Navigators.

Care Plan

For clients meeting the eligibility criteria for conditional services, the case manager will select Civil Transitions Program in the drop-down list under Client chosen program instead of MPC or CFC. Only clients under Civil Transitions Program can utilize this drop down.

Recipient Aid Categories (RACS) for CTP Services

Each RAC coincides with the Conditional services that the client is eligible to receive. CTP RACs require an override.

- 3491 - Civil Transitions Program not otherwise eligible (Only Financially Eligible and Neither Functionally nor Financially Eligible)
- 3492 - Civil Transitions Program Functionally eligible not financially eligible (NFLOC)
- 3493- Civil Transitions Program Functionally Eligible MPC not financially Eligible

Financial Eligibility

Collaboration with the Financial Eligibility & Policy Unit and designated Public Benefit Specialist (PBS) staff in each region will ensure timely and accurate determination of financial eligibility. Clients who are not financially eligible for other federal or state Apple Health coverage will be eligible for state-funded medical coverage for 6 months.

14-443

Select Civil Transitions Program on the 14-443 which triggers the public benefit specialist to communicate with the Financial Eligibility & Policy Unit to have the special state funded medical coverage turned on. There is no open coverage group in ACES so Provider One process, participation, letters, and time frames will all need to be manually constructed.

Assessment Data and Reporting

CTP clients will be tracked in CARE under the State Hospital Screen. This screen will be completed regardless of client eligibility outcome.

How to Complete the CARE State Hospital Screen

- Click the plus button to open an entry.
- Facility: Choose County Jail
- Place of Detention: This is a free text box. Write the name of the jail, Out of jail/PR, WSH, ESH
- Admit date and referral will be the same--which is the date the case manager receives the referral. Discharge Status: choose 'Active' if the assigned case manager is/will be assessing the client. Choose 'Inactive' if the case manager was unable to reach the client or they were not interested in service. If the client is discharged with services, the discharge date will be enabled. The discharge date is the date the individual's services began.
- Comment box: provide a short summary of the outcome of selections made.

EXTRAORDINARY MEDICAL PLACEMENT

WHAT IS EXTRAORDINARY MEDICAL PLACEMENT?

Extraordinary Medical Placement (EMP) is a Department of Corrections (DOC) program that enables incarcerated individuals who have been determined to meet specific criteria in [RCW 9.94A.728](#) to be released before the end of their sentence to the community. The individual will remain under the supervision and authority of DOC. HCLA collaborates with the DOC EMP through an interagency agreement to assist those who are seeking long term care. DOC regulates if the client can reside in home with family or in a residential setting.

REFERRAL PROCESS FOR EMP

Referrals are initiated by DOC's Headquarters team and sent to the HCS Community Support Program Manager. After the referral is received and triaged, it is routed to the HCS Field Service Administrator (FSA) in the region where the incarcerated individual is located. The FSA will assign the client to a case manager and inform HCS Headquarters of said assignment. DOC Headquarters or their representative will submit the LTC Medicaid Application.

WHAT IS THE ROLE OF CASE MANAGERS IN EMP CASES?

Case managers will:

- Conduct an on-site assessment where the DOC incarcerated individual is located (including a prison or hospital setting) and provide them with information and choices regarding services and referrals. If the client refuses to participate inform HCS Headquarters Community Support Program Manager.
- Contact the prison in advance to coordinate and schedule the CARE assessment. *EMP assessments should occur within two weeks of the referral.* When coordinating the assessment, the HCS case manager should request that specific information be available at the time of assessment (for example: medication administration record, medical records, mental health records, etc.). Conduct the assessment with the client and a DOC staff person who can provide information on the offender's:
 - County of origin, or counties the client must avoid
 - Criminal history
 - Active restraining orders
 - Incarceration dates
 - Infraction and behavior history while incarcerated
 - Parole or supervision requirements that will be required once the offender is in the community (Judgement and Sentence, Conditions of Release and/or Stipulations)
 - The name and contact of the incarcerated individuals Community Corrections officer or Community Correction Specialist
 - Information on the individual's family, Power of Attorney or Guardian (if applicable)
 - Medical and mental Health diagnosis
 - Behaviors and triggers to behaviors
 - Any propensity to violence
 - Medication manager (does the individual follow medication regime)
 - Suicide risk, and
 - Strategies that work best with the client
- Include input from DOC Psychiatric Social Worker, Mental Health Counselor, Physician, Physician Assistance, Nurses, and or Psychologist who have been working with the incarcerated individual into the CARE assessment.
- Assist DOC to connect with the Public Benefit Specialist to ensure the client long-term care (LTC) Medicaid application processes timely.

DOCUMENTATION IN CARE

Behavior Screen

- Select Law breaking activity and list the index crime that brought the client to prison and other convictions. Provide pertinent details about the crime.
- If the client is a registered sex offender (RSO) select 'deliberate sexual violence' and provide the client's RSO level and convictions/offenses. Provide a victim profile, whenever possible (for example male, female, child, adult).
- Follow RSO process in [Chapter 3](#).

Safety Screen

- Under legal issues choose parole and probation
- In the legal issues comment box add canned language for EMP clients.
- Client has been approved to be released under Department of Corrections Emergency Medical Placement due to their medical condition. The client is required to wear an ankle bracelet/GPS monitor in an approved placement by DOC for the remaining of their sentence which will expire (add month and date). Client will be supervised by a Community Corrections Specialist and monitored by an EMP Nurse.

TRANSITION PLANNING

The HCS Headquarters and DOC Headquarters teams work closely in transition planning. The HCS Headquarters team also works closely with and supports the HCS regional case manager throughout the assessment and transition planning processes. After the client has been found functionally eligible for long-term care services, HCS staff can begin to search for a community setting. If DOC staff are aware of potential residential transition options, they will coordinate with HCS case manager to send the CARE assessment to the potential providers. If the provider is interested in accepting the client, arrangements should be made by the Prison Social Worker for the potential provider to meet the incarcerated individual. The HCS case manager is to work with the residential care case manager (RCCM) assigned to the potential home to ensure that the home is a good fit for the client. Once a provider has accepted the client, the address of the facility is provided to DOC staff to investigate the home and explain EMP. If DOC accepts the facility, the Secretary of DOC must give final approval authorizing the EMP setting. There are instances where the EMP is denied.

Once the client has been approved for EMP, a transition date can be set. If the client needs equipment, DOC can work with the client to select a Manage Care Organization (MCO). Managed Care Organization have Justice Involved/Jail transition Coordinators that work with the incarcerated clients and can assist with coordination of their care needs.

<u>Region</u>	<u>Name of Prisons</u>
<u>Region 1</u>	<u>Airway Heights Corrections Center (AHCC)</u>
	<u>Coyote Ridge Corrections Center (CRCC)</u>
	<u>Washington State Penitentiary (WSP)</u>
<u>Region 2</u>	<u>Monroe Correctional Complex (MCC)</u>
<u>Region 3</u>	<u>Stafford Creek Corrections Center</u>
	<u>Washington Corrections Center</u>
	<u>Washington Corrections Center for Women</u>

SPECIAL COMMITMENT CENTER

WHAT IS THE SPECIAL COMMITMENT CENTER?

The Special Commitment Center (SCC) program provides specialized mental health treatment for civilly committed sex offenders who have completed their prison sentences. Each SCC resident has a constitutional right to an annual review hearing before the court of commitment to evaluate progress they've made in treatment. If the court finds the resident has made progress to the point that the resident can be safely managed in the community, the court may order the resident's conditional release to a Least Restrictive Alternative (LRA) community placement or the resident has the right to request to the court to be released unconditionally. Former residents no longer have SCC oversight.

WHAT IS HCS ROLE?

HCS facilitates community transitions for clients seeking long-term services and support when they are being unconditionally released from total confinement at the SCC or from SCC's community LRA housing facilities.

Referral Process

Referrals are submitted by the SCC's Psychiatric Social Workers or the Office of Public Defense (OPD) to the HCS Community Support Program Manager. The Community Support Program Manager meets with the referent to gather background information, proposed plan, and court time frames.

- In Region 3, referrals are emailed to Intake, SHDD Program Manager, and supervisor. Region 3 has a dedicated full-time equivalent (FTE) staff member for this work.
- In Regions 1 and 2, the referral is emailed to the FSA who then routes the referral to be processed and assigned to a case manager.

The HCS Community Support Program Manager will meet with the case manager to discuss the referral prior to the assessment.

WHAT IS ROLE OF THE HCS CASE MANAGER?

The HCS case manager is to coordinate with the SCC Social Worker and/or the OPD transitions specialist when setting up the assessment.

The assessment is to be conducted at the facility where the client resides and should include:

- Request annual evaluations/reviews
- Criminal history
- Sexual offense history, any violation while at the SCC
- Medical records
- Mental health records
- Behaviors and triggers



- Contact information for all Residential Community Treatment Team (RCTT)
- If the client is residing in LRA housing, the case manager will contact the Sex Offender Treatment Provider or community corrections specialist to gather information on the client progress while in the community.

DOCUMENTATION IN CARE

Safety Screen

- Select registered sex offender level (all individuals from SCC are level 3)
- Follow the RSO process that is in [Chapter 3](#)
- If the client is unconditionally released add in the legal comment box that the client will not be under DOC supervision.

Behavior Screen

- Select Deliberate sexual violence and document the RSO level and convictions/offenses. Provide victim profile (male, female, child, adult)
- Select Law breaking activity and list convictions. Provide pertinent details about the crime.

TRANSITION PLANNING

The transition process can be lengthy when transitioning a client from SCC total confinement or in LRA housing. The HCS Community Support Program Manager will work closely with the HCS case manager, SCC, and OPD transition specialist to navigate the process. Prior to being released unconditionally, clients in SCCs will complete evaluations and then attend the necessary court proceedings.

As the search for a facility begins, communication with the potential ongoing residential case manager is imperative. Case managers are to ensure the home is a good fit for any client who is a registered sex offender—meaning that the provider can meet the client’s care needs while also considering the risk and safety of all who reside in or enter the facility. In many instances the OPD transition specialist will identify an adult family home (AFH) that may be interested in supporting the client. The HCS case manager needs to communicate with the potential AFH to provide them with the CARE assessment and ensure they are aware of the length of time transitioning clients in SCC may take.

After a facility has been selected, SCC or OPD can then provide a transition plan to the court. Once the client is approved for release, follow the process as usual.

ESCALATION PATH AND PROCESS

For Escalation Path Process Guidance see [Chapter 9](#).

RESOURCES

Related WACs and RCWs

WAC 388-106-2000- 2050	Civil Transitions Program
RCW 9.94A.728:	Release Prior to Expiration of Sentence

Acronyms

AAA	Area agencies on again
BHHA	Behavioral Health and Habilitation Administration
CARE	Client Assessment Reporting Evaluation
CFC	Community First Choice
COPES	Community Options Program Entry System
CTP	Civil Transitions Program
DDCS	Developmental Disabilities Community Services
DOC	Department of Corrections
EMP	Extraordinary Medical Placement
GPS	Global positioning system
HCLA	Home and Community Living Administration
HCS	Home and Community Services
LRA	Least restrictive alternative
LTSS	Long-term services and support
MCO	Managed Care Organizations
MPC	Medicaid Personal Care
NFLOC	Nursing facility level of care
OPD	Office of Public Defense
PBS	Public Benefits Specialist
PERS	Personal Emergency Response System
RAC	Recipient Aid Category
RSO	Registered Sex Offender
RSW	Residential Support Waiver
SCC	Special Commitment Center

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
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| 4/01/2026 | Phyllis
Moffatte-
Clark | <ul style="list-style-type: none">• Updated chapter links• Highlighted instructions for How do I know if my client meets criteria for Conditional Services.• Grammar and word clarification |
|-----------|-------------------------------|---|

APPENDIX

Conditional Services

**Only Functionally
Eligible (NFLOC)**

Conditional Services

- Personal Care
- Nurse Delegation
- Assisted Technology
- PERS
- Community
Transition Service
- Supportive Housing
- WA Roads

**Only Functionally
Eligible (MPC)**

Conditional Services

- Personal Care
- Supportive Housing
- WA Roads

**Only Financially
Eligible**

Conditional Services

- Supportive Housing
- WA Roads

**Neither Functionally
nor Financially Eligible**

Conditional Services

- Supportive Housing
- WA Roads