Chapter 388-106 WAC
LONG-TERM CARE SERVICES

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WAC

SCOPE AND DEFINITIONS

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-106-0126 If I am under age twenty-one, how does CARE use criteria to place me in a classification group for in-home care? [Statutory Authority: RCW 74.08.090, 74.09.520, 2009 c 564 § 206(5). WSR 10-11-050, § 388-106-0126, filed 5/12/10, effective 6/12/10.] Repealed by WSR 12-14-064, filed 6/29/12, effective 7/30/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0213 How are my needs assessed if I am a child applying for MPC services? [Statutory Authority: RCW 74.08.090, 74.09.520. WSR 07-24-026, § 388-106-0213, filed 11/28/07, effective 1/1/08; WSR 07-10-024, § 388-106-0213, filed 4/23/07, effective 6/1/07. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0213, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0213, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-14-064, filed 6/29/12, effective 7/30/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0400 What services may I receive under medically needy residential waiver (MNRW)? [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0400, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0400, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0410 Am I eligible for MNRW-funded services? [Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. WSR 08-11-047, § 388-106-0410, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0410, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0415 When do MNRW services start? [Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0415, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0420 How do I remain eligible for MNRW? [Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0420, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0425 How do I pay for MNRW services? [Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0425, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0430 Can I be employed and receive MNRW? [Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0430, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0435 Are there waiting lists for MNRW? [Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0435, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0500 What services may I receive under medically needy in-home waiver (MNIW)? [Statutory Authority: RCW 74.08.090, 74.09.520. WSR 07-24-026, § 388-106-0500, filed 11/28/07, effective 1/1/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0500, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0500, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0510 Am I eligible for MNIW-funded services? [Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. WSR 08-11-047, § 388-106-0510, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0510, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0515 When do MNIW services start? [Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0515, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0520 How do I remain eligible for MNIW? [Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0520, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0525 How do I pay for MNIW? [Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0525, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0530 Can I be employed and receive MNIW? [Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0530, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0535 Are there waiting lists for MNIW? [Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0535, filed 5/17/05, effective 6/17/05.] Repealed by WSR 12-16-026, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0720 What services may I receive under MMIP? [Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438. WSR 05-19-045, § 388-106-0720, filed 9/15/05, effective 10/16/05.] Repealed by WSR 08-12-023, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0725 Am I eligible for MMIP services? [Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438. WSR 05-19-045, § 388-106-0725, filed 9/15/05, effective 10/16/05.] Repealed by WSR 08-12-023, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0730 How do I pay for MMIP services? [Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438. WSR 05-19-045, § 388-106-0730, filed 9/15/05, effective 10/16/05.] Repealed by WSR 08-12-023, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0735 How do I disenroll from MMIP? [Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438. WSR 05-19-045, § 388-106-0735, filed 9/15/05, effective 10/16/05.] Repealed by WSR 08-12-023, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0740 What is the fair hearing process for enrollee appeals of managed care organization actions? [Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438. WSR 05-19-045, § 388-106-0740, filed 9/15/05, effective 10/16/05.] Repealed by WSR 08-12-023, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-106-0745 What services may I receive under WMIP? [Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438. WSR 06-18-058, § 388-106-0745, filed 8/31/06, effective 10/1/06.] Repealed by WSR 14-15-091, filed 7/18/14, effective 8/18/14. Statutory Authority: RCW 74.08.090, 74.09.520.

388-106-0750 Am I eligible to enroll in WMIP? [Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438. WSR 06-18-058, § 388-106-0750, filed 8/31/06, effective 10/1/06.] Repealed by WSR 14-15-091, filed 7/18/14, effective 8/18/14. Statutory Authority: RCW 74.08.090, 74.09.520.

388-106-0755 How do I pay for WMIP services? [Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438. WSR 06-18-058, § 388-106-0755, filed 8/31/06, effective 10/1/06.] Repealed by WSR 14-15-091, filed 7/18/14, effective 8/18/14. Statutory Authority: RCW 74.08.090, 74.09.520.

388-106-0760 How do I disenroll from WMIP? [Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438. WSR 06-18-058, § 388-106-0760, filed 8/31/06, effective 10/1/06.] Repealed by WSR 14-15-091, filed 7/18/14, effective 8/18/14. Statutory Authority: RCW 74.08.090, 74.09.520.

388-106-0765 What is the fair hearing process for enrollee appeals of managed care organization actions? [Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438. WSR 06-18-058, § 388-106-0765, filed 8/31/06, effective 10/1/06.] Repealed by WSR 14-15-091, filed 7/18/14, effective 8/18/14. Statutory Authority: RCW 74.08.090, 74.09.520.

388-106-1500 What is the department's chronic care management program? [Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 11-22-043, § 388-106-1500, filed 10/27/11, effective 11/27/11.] Repealed by WSR 14-13-060, filed 6/12/14, effective 7/13/14. Statutory Authority: RCW 74.08.090, 74.09.520.

388-106-1505 What services may I receive under the chronic care management program? [Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 11-22-043, § 388-106-1505, filed 10/27/11, effective 11/27/11.] Repealed by WSR 14-13-060, filed 6/12/14, effective 7/13/14. Statutory Authority: RCW 74.08.090, 74.09.520.

388-106-1510 Who provides chronic care management services to medical assistance clients receiving long-term care services and supports? [Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 11-22-043, § 388-106-1510, filed 10/27/11, effective 11/27/11.] Repealed by WSR 14-13-060, filed 6/12/14, effective 7/13/14. Statutory Authority: RCW 74.08.090, 74.09.520.

388-106-1515 Am I eligible to enroll in the chronic care management program? [Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 11-22-043, § 388-106-1515, filed 10/27/11, effective 11/27/11.] Repealed by WSR 14-13-060, filed 6/12/14, effective 7/13/14. Statutory Authority: RCW 74.08.090, 74.09.520.

388-106-1520 How do I enroll in the chronic care management program? [Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 11-22-043, § 388-106-1520, filed 10/27/11, effective 11/27/11.] Repealed by WSR 14-13-060, filed 6/12/14, effective 7/13/14. Statutory Authority: RCW 74.08.090, 74.09.520.

388-106-1525 How long can I participate in the chronic care management program? [Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 11-22-043, § 388-106-1525, filed 10/27/11, effective 11/27/11.] Repealed by WSR 14-13-060, filed 6/12/14, effective 7/13/14. Statutory Authority: RCW 74.08.090, 74.09.520.

388-106-1530 Is there a cost to me for participating in the chronic care management program? [Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 11-22-043, § 388-106-1530, filed 10/27/11, effective 11/27/11.] Repealed by WSR 14-13-060, filed 6/12/14, effective 7/13/14. Statutory Authority: RCW 74.08.090, 74.09.520.

388-106-1535 Do I have a right to a fair hearing while receiving chronic care management services? [Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 11-22-043, § 388-106-1535, filed 10/27/11, effective 11/27/11.] Repealed by WSR 14-13-060, filed 6/12/14, effective 7/13/14. Statutory Authority: RCW 74.08.090, 74.09.520.

388-106-1740 What are my rights when I receive supportive housing services in a setting owned by a service provider? [Statutory Authority: RCW 74.08.090, 74.08.283 and 74.08.390. WSR 17-11-016, § 388-106-1740, filed 5/9/17, effective 6/9/17.] Repealed by WSR 25-20-014, filed 9/19/25, effective 10/20/25. Statutory Authority: RCW 74.08.090, 74.08.283, and 74.08.390.

388-106-1760 Do I have the right to an administrative hearing regarding supportive housing services? [Statutory Authority: RCW 74.08.090, 74.08.283 and 74.08.390. WSR 17-11-016, § 388-106-1760, filed 5/9/17, effective 6/9/17.] Repealed by WSR 25-20-014, filed 9/19/25, effective 10/20/25. Statutory Authority: RCW 74.08.090, 74.08.283, and 74.08.390.

SCOPE AND DEFINITIONS

WAC 388-106-0005 What is the purpose and scope of this chapter? This chapter applies to applicants and recipients of long-term care services.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0005, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0010 What definitions apply to this chapter? "Ability to make self understood" means how you made yourself understood to those closest to you in the last seven days before the assessment; expressed or communicated requests, needs, opinions, urgent problems, and social conversations, whether in speech, writing, sign language, symbols, or a combination of these including use of an alternative communication method:

(1) Understood: You expressed ideas clearly;

(2) Usually understood: You had difficulty finding the right words or finishing thoughts, resulting in delayed responses, or you required some prompting to make self understood;

(3) Sometimes understood: You had limited ability, but were able to express concrete requests regarding at least basic needs (such as food, drink, sleep, toilet);

(4) Rarely/never understood: At best, understanding was limited to caregiver's interpretation of client specific sounds or body language (such as indicated presence of pain or need to toilet);

(5) Child under three: Proficiency is not expected of a child under three and a child under three would require assistance with communication with or without a functional disability. Refer to the developmental milestones table in WAC 388-106-0130.

"Active range of motion" means exercises performed by the client to maintain their joint function to the joint's optimal range. Exercises may be performed with the assistance of cueing or reminders by caregivers. A formal, active range of motion program needs to be first established by a qualified registered nurse or therapist. Range of motion may be self-directed based upon an occupational or physical therapist assessment and continued without occupational or physical therapist supervision.

"Activities of daily living (ADL)" means the following:

(1) Bathing: How you took a full-body bath/shower, sponge bath, and transferred in/out of tub/shower.

(2) Bed mobility: How you moved to and from a lying position, turned side to side, and positioned your body while in bed, in a recliner, or other type of furniture you slept in.

(3) Dressing: How you put on, fastened, and took off all items of clothing, including donning/removing prosthesis, splints, either braces or orthotics, or both.

(4) Eating: How you ate and drank, regardless of skill. Eating includes any method of receiving nutrition, such as, by mouth, tube, or through a vein. Eating does not include any set up help you received, such as bringing food to you or cutting it up in smaller pieces.

(5) Locomotion in room and immediate living environment: How you moved between locations in your room and immediate living environment. If you are in a wheelchair, locomotion includes how self-sufficient you were once in your wheelchair.

(6) Locomotion outside room: How you moved to and returned from your immediate living environment, outdoors, and more distant areas. If you are living in a contracted assisted living, enhanced services facility, adult residential care, enhanced adult residential care, enhanced adult residential care-specialized dementia care facility, or nursing facility (NF), this includes areas set aside for dining, activities, etc. If you are living in your own home or in an adult family home, locomotion outside immediate living environment including outdoors, includes how you moved to and returned from a patio or porch, backyard, to the mailbox, to see the next-door neighbor, or when accessing your community.

(7) Walk in room, hallway, and rest of immediate living environment: How you walked between locations in your room and immediate living environment.

(8) Medication management: Describes the amount of assistance, if any, required to receive prescription medications, over the counter medications, or herbal supplements.

(9) Toilet use: How you eliminated or toileted, used a commode, bedpan, or urinal, transferred on/off toilet, cleansed, changed pads, managed ostomy or catheter, and adjusted clothes. Toilet use does not include emptying a bedpan, commode, ostomy, or catheter bag. This type of set up assistance is considered under the definition of support provided.

(10) Transfer: How you moved between surfaces, such as, to/from bed, chair, wheelchair, standing position. Transfer does not include how you moved to/from the bath, toilet, or got in/out of a vehicle.

(11) Personal hygiene: How you maintained personal hygiene tasks, such as combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands (including nail care), and perineum, including menses care. Personal hygiene does not include hygiene tasks completed in baths and showers.

"Age appropriate" proficiency in the identified task is not expected of a child that age and a child that age would require assistance with the task with or without a functional disability. Refer to the developmental milestones table in WAC 388-106-0130 for the specific ages.

"Aged person" means a person 65 years of age or older.

"Agency provider" means a licensed home care agency or a licensed home health agency having a contract to provide long-term care personal care services to you in your own home.

"Alternative benefit plan" means the scope of services described in WAC 182-501-0060 available to persons eligible to receive health care coverage under the Washington apple health modified adjusted gross income (MAGI)-based adult coverage described in WAC 182-505-0250.

"Application" means a written request for medical assistance or long-term care services submitted to the department by the applicant, the applicant's authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant must submit the request on a form prescribed by the department.

"Assessment details" means a printed record of information that the department entered into the CARE assessment describing the assistance you may need.

"Assessment or reassessment" means an inventory and evaluation of strengths and limitations based on an in-person interview in your own home or another location that is convenient to you, using the department's comprehensive assessment reporting evaluation (CARE) tool.

"Assistance available" means the amount of assistance that will be available for a task if status is coded:

Partially met due to availability of other informal support. The department determines the amount of the assistance available using one of four categories:

(1) Less than one-fourth of the time;

(2) One-fourth to one-half of the time;

(3) Over one-half of the time to three-fourths of the time; or

(4) Over three-fourths but not all of the time.

"Assistance with body care" means you received or need assistance with:

(1) Application of ointment or lotions;

(2) Trimming of toenails;

(3) Dry bandage changes; or

(4) Passive range of motion treatment.

"Authorization" means an official approval of a departmental action, for example, a determination of client eligibility for service or payment for a client's long-term care services.

"Blind person" means a person determined blind as described under WAC 182-500-0015 by the division of disability determination services of the health care authority.

"Body care" means how you perform with passive range of motion, applications of dressings and ointments or lotions to the body, and pedicure to trim toenails and apply lotion to feet. In adult family homes, enhanced services facilities, contracted assisted living, enhanced adult residential care, and enhanced adult residential care-specialized dementia care facilities, dressing changes using clean technique and topical ointments must be performed by a licensed nurse or through nurse delegation in accordance with chapter 246-840 WAC. Body care excludes:

(1) Foot care if you are diabetic or have poor circulation; or

(2) Changing bandages or dressings when sterile procedures are required.

"Bowel program" means a regular, ongoing program, other than oral medications, that must include interventions such as rectal stimulation using the finger, over the counter suppositories, or enemas to facilitate evacuation of your bowels. Regimens only promoting bowel regularity, including oral medications or supplements, nutrition, hydration, or positioning are not considered in this definition.

"Categorically needy" means the status of a person who is eligible for medical care under Title XIX of the Social Security Act. See WAC 182-512-0010 and chapter 182-513 WAC.

"Child" means an individual less than 18 years of age.

"Client" means an applicant for service or a person currently receiving services from the department.

"Current behavior" means a behavior occurred within seven days of the CARE assessment date, including the day of the assessment. Behaviors that the department designates as current must include information about:

(1) Whether the behavior is easily altered or not easily altered; and

(2) The frequency of the behavior.

"Decisions" means your ability (verbally or nonverbally) to make, and actual performance in making, everyday decisions about tasks of daily living in the last seven days before the assessment. The department codes your ability to make decisions as one of the following:

(1) Independent: Decisions about your daily routine were consistent and organized; reflecting your lifestyle, choices, culture, and values;

(2) Difficulty in new situations: You had an organized daily routine, were able to make decisions in familiar situations, but experienced some difficulty in decision making when faced with new tasks or situations;

(3) Poor decisions; unaware of consequences: Your decisions were poor and you required reminders, cues, and supervision in planning, organizing, and correcting daily routines. You attempted to make decisions, although poorly;

(4) No or few decisions: Decision making was severely impaired; you never/rarely made decisions;

(5) Child under 12: Proficiency in decision making is not expected of a child under 12 and a child under 12 would require assistance with decision making with or without a functional disability. Refer to the developmental milestones table in WAC 388-106-0130.

"Department" means the state department of social and health services, home and community living administration or its designee.

"Designee" means area agency on aging or federally recognized Indian tribe.

"Developmental milestones table" is a chart showing the age range for which proficiency in the identified task is not expected of a child and assistance with the task would be required whether or not the child has a functional disability.

"Disability" is described under WAC 182-500-0025.

"Disabling condition" means you have a medical condition which prevents you from self-performance of personal care tasks without assistance.

"Estate recovery" means the department's process of recouping the cost of medicaid and long-term care benefit payments from the estate of the deceased client. See chapter 182-527 WAC.

"Health action plan" means an individual plan, which identifies health-related problems, interventions, and goals.

"Home health agency" means a licensed:

(1) Agency or organization certified under medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence and reimbursed through the use of the client's medical identification card; or

(2) Home health agency, certified or not certified under medicare, contracted and authorized to provide:

(a) Private duty nursing; or

(b) Skilled nursing services under an approved medicaid waiver program.

"Income" means income as defined under WAC 182-509-0001.

"Individual provider" under RCW 74.39A.240 means a person, including a personal aide, who, under an individual provider contract with the department, or as an employee of a consumer directed employer, provides personal care or respite care services to persons who are functionally disabled or otherwise eligible under programs authorized

and funded by the medicaid state plan, medicaid waiver programs, or similar state-funded in-home care programs.

"Informal support" means:

(1) Assistance that will be provided with the client's agreement as expressed in the assessment process without home and community-based services funding, except as allowed in subsection (3) of this definition. The person providing the informal support must be age 18 or older. Sources of informal support include but are not limited to: Family members, friends, housemates/roommates, neighbors, school, childcare, after school activities, church, and community programs.

(2) The department will not consider an individual provider to be a source of informal support.

(3) Adult day health and adult day care is coded in the assessment as a source of informal support, regardless of funding source.

(4) Informal support does not include age appropriate functioning.

"Institution" means medical facilities, nursing facilities, and institutions for the intellectually disabled. It does not include correctional institutions. See medical institutions in WAC 182-500-0050.

"Instrumental activities of daily living (IADL)" means routine activities performed around the home or in the community in 30 days prior to the assessment and includes the following:

(1) Meal preparation: How meals were prepared (such as, planning meals, cooking, assembling ingredients, setting out food, utensils, and cleaning up after meals). NOTE: The department will not authorize this IADL to only plan meals or clean up after meals. You must need assistance with other tasks of meal preparation.

(2) Ordinary housework: How ordinary work around the house was performed (such as, doing dishes, dusting, making bed, cleaning the bathroom, tidying up, laundry).

(3) Essential shopping: How shopping was completed to meet your health and nutritional needs (such as, selecting items). Shopping is limited to brief, occasional trips in the local area to shop for food, medical necessities, and household items required specifically for your health, maintenance, or well-being. This includes shopping with or for you.

(4) Wood supply: How wood or pellets were supplied (such as, splitting, stacking, or carrying wood or pellets) when you use wood, pellets, or a combination of both, as the only source of fuel for heating or cooking.

(5) Travel to medical services: How you traveled by vehicle to a physician's office or clinic in the local area to obtain medical diagnosis or treatment. This travel includes driving a vehicle yourself or traveling as a passenger in a car, bus, or taxi.

"Long-term care services" means the services administered directly or through contract by the department and identified in WAC 388-106-0015.

"MAGI" means modified adjusted gross income. It is a methodology used to determine eligibility for Washington apple health (medicaid), and is defined in WAC 182-500-0070.

"Medicaid" is defined under WAC 182-500-0070.

"Medically necessary" is defined under WAC 182-500-0070.

"Medically needy (MN)" or "medically needy program (MNP)" means the state and federally funded health care program available to specific groups of people who would be eligible as categorically needy (CN), except their monthly income is above the CN standard. Some long-

term care clients with income or resources above the CN standard may also qualify for MN.

"New Freedom consumer directed services (NFCDS)" means a mix of services and supports to meet needs identified in your assessment and identified in a New Freedom spending plan, within the limits of the individual budget, that provide you with flexibility to plan, select, and direct the purchase of goods and services to meet identified needs. Participants have a meaningful leadership role in:

(1) The design, delivery, and evaluation of services and supports;

(2) Exercising control of decisions and resources, and making their own decisions about health and well-being;

(3) Determining how to meet their own needs;

(4) Determining how and by whom these needs should be met; and

(5) Monitoring the quality of services received.

"New Freedom consumer directed services (NFCDS) participant" means a participant who is an applicant for or currently receiving services under the NFCDS waiver.

"New Freedom spending plan (NFSP)" means the plan developed by you, as a New Freedom participant, within the limits of an individual budget, that details your choices to purchase specific NFCDS and provides required federal medicaid documentation.

"Own home" means your present or intended place of residence:

(1) In a building that you rent and the rental is not contingent upon the purchase of personal care services as defined in this section;

(2) In a building that you own;

(3) In a relative's established residence; or

(4) In the home of another where rent is not charged and residence is not contingent upon the purchase of personal care services as defined in this section.

"Passive range of motion" means a maintenance movement exercise of each joint only to the extent the joint can move. Passive range of motion is performed by a caregiver because the client is unable to move the joint without assistance. A formal passive range of motion program needs to be first established by a qualified registered nurse or therapist. Passive range of motion may be self-directed based upon an occupational or physical therapist assessment and continue without occupational or physical therapist supervision.

"Past behavior" means the behavior did not occur in the last seven days, but did occur more than seven days from the assessment date. For behaviors indicated as past behaviors, the department documents the month and year the behavior last occurred and whether the behavior is addressed with current interventions or whether no interventions are in place.

"Personal aide" is defined in RCW 74.39.007.

"Personal care services" means 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.

"Physician" is defined under WAC 182-500-0085.

"Plan of care" means assessment details and service summary generated by CARE.

"Provider or provider of service" means an institution, agency, or person:

(1) Having a signed department contract to provide long-term care client services; and

(2) Qualified and eligible to receive department payment.

"Reasonable cost" means a cost for a service or item that is consistent with the market standards for comparable services or items.

"Representative" means a person who you have chosen, or has been appointed by a court, whose primary duty is to act on your behalf to direct your service budget to meet your identified health, safety, and welfare needs.

"Residential facility" means a licensed adult family home under department contract; a licensed enhanced services facility under department contract; or licensed assisted living facility under department contract to provide assisted living, adult residential care, or enhanced adult residential care.

"Self-performance for ADLs" means a code based on what you actually did for yourself and how much help you received with ADLs, with the exception of bathing, in the last seven days before your assessment, not what you might be capable of doing. For codes of supervision, limited assistance, and extensive assistance, self-performance for ADLs is based on your level of performance that occurred three or more times in the seven-day period. Scoring of self-performance for ADL codes of supervision, limited assistance, and extensive assistance, does not include physical assistance that occurred less than three times in the seven-day look back period, or set-up help for any self-performance ADL code.

(1) Based on information provided during your assessment, the CARE tool assigns a self-performance code to each ADL. When you received the same type of help (such as oversight, nonweight bearing, or weight bearing help) with an ADL at least three times, CARE assigns the self-performance code associated with the most dependent type of help you received at least three times. Your self-performance level code is:

(a) Independent, if you received:

(i) No help, including oversight, encouragement, or cueing, or;

(ii) Help including oversight, encouragement, or cueing only once or twice in the seven-day period;

(b) Supervision, if you received oversight (monitoring or standby), encouragement, or cueing three or more times;

(c) Limited assistance, if you were highly involved in the ADL and received assistance that involved physical, nonweight bearing contact between you and your caregiver, or guided maneuvering of limbs three or more times;

(d) Extensive assistance, if you performed part of the ADL, but on three or more occasions, you needed weight bearing help or you did not participate in a subtask of the ADL, but did participate in other subtasks of the ADL;

(e) Total dependence, if you did not participate at all in the completion of the ADL. Every time the ADL was completed during the entire seven-day period, you received complete assistance of all subtasks completed during the entire seven-day period by others; or

(f) Did not occur, if you or others did not perform the ADL over the last seven days before your assessment. This means the activity did not happen. For example, for "walk in room" to have a code of "did not occur" it means in the last seven days before your assessment, you did not walk even one time. The ADL may not have occurred because:

(i) You were not able (such as, you were not able to walk because you are paralyzed);

(ii) No provider was available to assist; or

(iii) You declined help with the task.

(2) When your self-performance code is not independent, extensive assistance, total dependence, or did not occur, and you received help with the ADL at least three times, but not three times of the same type of help, the CARE tool determines a self-performance code by:

(a) Selecting the three times where you received the most help; and

(b) Assigning a self-performance code based on the least dependent type of help of those three times.

(3) CARE assigns a self-performance code of:

(a) Supervision, if oversight, encouragement, or cueing was the least dependent type of help you received of the three times; or

(b) Limited assistance, if nonweight bearing help or guided maneuvering of your limbs was the least dependent type of help you received out of the three times.

(c) For example, if you received oversight help twice, nonweight bearing help twice, and weight bearing help twice, CARE:

(i) Selects two times of weight bearing help and one time of nonweight bearing help because these were the three times where you received the most help; and

(ii) Assigns a self-performance code of limited assistance because nonweight bearing help was the least dependent type of help you received out of the three times where you received the most help.

"Self-administration of medication" means your ability to manage your prescribed and over the counter medications. Your level of ability is coded for the highest level of need and scored as:

(1) Independent, if you remember to take medications as prescribed and manage your medications without assistance.

(2) Assistance required, if you need assistance from a nonlicensed provider to facilitate your self-administration of a prescribed, over the counter, or herbal medication, as defined in chapter 246-980 WAC. Assistance required includes reminding or coaching you, handing you the medication container, opening the container, using an enabler to assist you in getting the medication into your mouth, alteration of a medication for self-administration, and placing the medication in your hand. This does not include assistance with intravenous or injectable medications. You must be aware that you are taking medications.

(3) Self-directed medication assistance/administration, if you are an adult with a functional disability who is capable of and who chooses to self-direct your medication assistance/administration as prescribed by your medical professional.

(4) Must be administered, if you must have prescription or over the counter medications placed in your mouth or applied or instilled to your skin or mucus membrane. Administration must either be performed by a licensed professional or delegated by a registered nurse to a qualified caregiver (per chapter 246-840 WAC). Administration may also be performed by a family member or unpaid caregiver in in-home settings or in residential settings if facility licensing regulations allow. Intravenous or injectable medications may never be delegated except for insulin injections.

"Self-performance for bathing" means what you actually did in the last seven days before your assessment, not what you might be capable of doing or how well you performed the ADL of bathing. Self-performance for bathing is based on your level of performance that occurred on at least one or more occasions in the seven-day period. Scoring of self-performance for bathing does not include physical assistance that

did not occur in the seven-day look back period, or set-up help. Your self-performance level is scored as:

(1) Independent, if you received no help or oversight to complete the ADL of bathing.

(2) Supervision, if in order to bathe you received oversight (monitoring or standby), encouragement, or cueing.

(3) Physical help transfer only, if in order to bathe you had help to transfer only.

(4) Physical help, if in order to bathe you had hands on assistance with bathing, but you did not receive full caregiver performance of the ADL of bathing.

(5) Total dependence, if in order to bathe you received full caregiver performance of the ADL of bathing every time. Total dependence means complete physical nonparticipation by you in all aspects of bathing; or the ADL:

(6) Did not occur, if you or others did not perform the ADL of bathing over the last seven days before your assessment. The ADL of bathing may not have occurred because:

(a) You were not able (for example, you may be paralyzed);

(b) No provider was available to assist; or

(c) You declined because you chose not to perform the ADL.

"Self-performance for IADLs" means what you actually did in the last 30 days before the assessment, not what you might be capable of doing or how well you performed the IADL. Scoring is based on the level of performance that occurred at least one time in the 30-day period. Your self-performance is scored as:

(1) Independent, if you received no help, set-up help, or supervision;

(2) Assistance, if you received any type of help with the activity, including setup, cueing, or monitoring, or the activity was fully performed by others in the last 30 days;

(3) Total assistance, if you are a child and needed the IADL fully performed by others and you are functioning outside of typical developmental milestones; or

(4) IADL did not occur, if you or others did not perform the IADL in the last 30 days before the assessment.

"Service summary" is CARE information which includes: Contacts (such as, emergency contacts), services the client is eligible for, number of hours or residential rates, personal care tasks, the list of formal and informal providers and what tasks they will provide, a preferred schedule if identified by the client, identified referrals, and dates and agreement to the outlined services.

"SSI-related" is defined under WAC 182-512-0050.

"Status" means the level of assistance:

(1) That will be provided by informal supports; or

(2) That will be provided to a child primarily due to their age.

(3) The department determines the status of each ADL or IADL and codes the status as follows:

(a) Met, which means the ADL or IADL will be fully provided by an informal support;

(b) Unmet, which means an informal support will not be available to provide assistance with the identified ADL or IADL;

(c) Partially met, which means an informal support will be available to provide some assistance, but not all, with the identified ADL or IADL;

(d) Age appropriate or child under (age), means proficiency in the identified task is not expected of a child that age and a child

that age would require assistance with the task with or without a functional disability. The department presumes children have a responsible adult(s) in their life to provide assistance with personal care tasks. Refer to the developmental milestones table in WAC 388-106-0130; or

(e) Client declines, which means you will not want assistance with the task.

"Supplemental security income (SSI)" means the federal program as described under WAC 182-500-0100.

"Support provided" means the highest level of support provided (to you) by others in the last seven days before the assessment, even if that level of support occurred only once. The department determines support provided as follows:

(1) No set-up or physical help provided by others;

(2) Set-up help only provided, which is the type of help characterized by providing you with articles, devices, or preparation necessary for greater independence in performance of the ADL. (For example, set-up help includes but is not limited to giving or holding out an item or cutting up prepared food);

(3) One-person physical assist provided;

(4) Two- or more person physical assist provided; or

(5) ADL did not occur during entire seven-day period.

"Task" means a component of an activity of daily living. Several tasks may be associated to a single activity of daily living.

"Turning and repositioning program" is a consistent and organized method in which your caregiver must position and realign your body to prevent or treat skin breakdown. This program is needed because you are physically unable to reposition yourself while sitting or lying down.

"You/your" means the client.

[Statutory Authority: RCW 49.46.800 and 74.09.520. WSR 25-24-074, s 388-106-0010, filed 12/1/25, effective 1/1/26. Statutory Authority: 2022 c 255, RCW 74.09.520, 74.39A.009, 74.39A.090, 74.39A.095, and 74.39A.515. WSR 25-07-060, s 388-106-0010, filed 3/13/25, effective 4/13/25. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 23-16-085, § 388-106-0010, filed 7/28/23, effective 8/28/23; WSR 21-04-037, § 388-106-0010, filed 1/26/21, effective 3/1/21. Statutory Authority: RCW 74.08.090. WSR 18-16-004, § 388-106-0010, filed 7/19/18, effective 8/19/18. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-20-054, § 388-106-0010, filed 9/30/15, effective 10/31/15; WSR 14-13-060, § 388-106-0010, filed 6/12/14, effective 7/13/14; WSR 14-04-097, § 388-106-0010, filed 2/4/14, effective 3/7/14; WSR 11-22-043, § 388-106-0010, filed 10/27/11, effective 11/27/11; WSR 10-08-074, § 388-106-0010, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-0010, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0010, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0010, filed 5/17/05, effective 6/17/05.]

APPLYING FOR SERVICES

WAC 388-106-0015 What long-term care services does the department provide? The department provides long-term care services through programs that are designed to help you remain in the community. These programs offer an alternative to nursing home care (which is described in WAC 388-106-0350 through 388-106-0360). You may receive services from any of the following:

(1) **Medicaid personal care (MPC)** is a medicaid state plan program authorized under RCW 74.09.520. Clients eligible for this program may receive personal care in their own home, adult family home, or in adult residential care as defined in WAC 388-110-020.

(2) **Community options program entry system (COPES)** is a medicaid waiver program authorized under RCW 74.39A.030. Clients eligible for this program may receive personal care in their own home or in a residential facility.

(3) **Community first choice (CFC)** is a medicaid state plan program authorized under RCW 74.39A.400. Clients eligible for this program may receive services in their own home, in an adult family home, in adult residential care, enhanced adult residential care, or assisted living as defined in WAC 388-110-020.

(4) **Chore** is a state-only funded program authorized under RCW 74.39A.110. Grandfathered clients may receive assistance with personal care in their own home.

(5) **Volunteer chore** is a state-funded program that provides volunteer assistance with household tasks to eligible clients.

(6) **Program of all-inclusive care for the elderly (PACE)** is a medicaid/medicare managed care program authorized under 42 C.F.R. 460.2. Clients eligible for this program may receive personal care and medical services in their own home, in residential facilities, and in adult day health centers.

(7) **Adult day health** is a supervised daytime program providing skilled nursing and rehabilitative therapy services in addition to core services outlined in WAC 388-106-0800.

(8) **Adult day care** is a supervised daytime program providing core services, as defined under WAC 388-106-0800.

(9) **Medical care services** is a state-funded program authorized under RCW 74.09.035. Clients eligible for this program may receive personal care services in an adult family home or an adult residential care facility.

(10) **Residential care discharge allowance** is a service that helps eligible clients to establish or resume living in their own home.

(11) **Private duty nursing** is a medicaid service that provides an alternative to institutionalization in a hospital or nursing facility setting. Clients eligible for this program may receive at least four continuous hours of skilled nursing care on a day to day basis in their own home.

(12) **Senior Citizens Services Act (SCSA)** is a program authorized under chapter 74.38 RCW. Clients eligible for this program may receive community-based services as defined in RCW 74.38.040.

(13) **Respite program** is a program authorized under RCW 74.41.040 and WAC 388-106-1200. This program provides relief care for unpaid family or other caregivers of adults with a functional disability.

(14) **Programs for persons with developmental disabilities** are discussed in chapter 388-823 through 388-850 WAC.

(15) **Nursing facility.**

(16) **New Freedom consumer directed services (NFCDS)** is a medicaid waiver program authorized under RCW 74.39A.030.

(17) **Residential support** is a medicaid waiver program authorized under RCW 74.39A.030. Clients eligible for this program may receive personal care in a licensed and contracted enhanced services facility or in a licensed adult family home with a contract to provide specialized behavior services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0015, filed 1/22/16, effective 2/22/16. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-01-085, § 388-106-0015, filed 12/16/14, effective 1/16/15; WSR 14-15-092, § 388-106-0015, filed 7/18/14, effective 8/18/14; WSR 12-16-026, § 388-106-0015, filed 7/25/12, effective 8/25/12; WSR 08-12-023, § 388-106-0015, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-0015, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0015, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438. WSR 05-19-045, § 388-106-0015, filed 9/15/05, effective 10/16/05. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0015, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0020 Under the MPC, CFC, COPES, and chore programs, what services are not covered? The following types of services are not covered under MPC, CFC, COPES, and chore:

(1) Child care.

(2) Individual providers must not provide:

(a) Sterile procedures unless the provider is a family member or the client self directs the procedure;

(b) Administration of medications or other tasks requiring a licensed health professional unless these tasks are provided through nurse delegation, self-directed care, or the provider is a family member.

(3) Agency providers must not provide:

(a) Sterile procedures;

(b) Self-directed care;

(c) Administration of medications or other tasks requiring a licensed health care professional unless these tasks are provided through nurse delegation.

(4) Services provided over the telephone.

(5) Services to any person who has not been authorized by the department to receive them.

(6) Development of social, behavioral, recreational, communication, or other types of community living skills.

(7) Nursing care.

(8) Pet care.

(9) Assistance with managing finances.

(10) Respite.

(11) Yard care.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0020, filed 1/22/16, effective 2/22/16. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 12-16-026, § 388-106-0020, filed 7/25/12, effective 8/25/12; WSR

08-05-026, § 388-106-0020, filed 2/12/08, effective 3/14/08; WSR 05-11-082, § 388-106-0020, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0025 How do I apply for long-term care services? To apply for long-term care services, you must request an assessment from the department and submit a medicaid application.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0025, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0030 Where can I receive services? You may receive services:

(1) In your own home.

(2) In a residential facility, which includes licensed:

(a) Adult family homes, as defined in RCW 70.128.010; and

(b) Assisted living facilities. Types of licensed and contracted assisted living facilities include:

(i) Assisted living facilities, as defined in WAC 388-110-020;

(ii) Enhanced adult residential care facilities, as defined in WAC 388-110-020;

(iii) Enhanced adult residential care facilities-specialized dementia care, as defined in WAC 388-110-020; and

(iv) Adult residential care facilities, as defined in WAC 388-110-020.

(3) In an enhanced services facility, as defined in RCW 70.97.010(12) and chapter 388-107 WAC.

(4) In a nursing home, as defined in WAC 388-97-005.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-01-085, § 388-106-0030, filed 12/16/14, effective 1/16/15; WSR 14-15-092, § 388-106-0030, filed 7/18/14, effective 8/18/14; WSR 05-11-082, § 388-106-0030, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0033 When may I receive services in a facility contracted to provide specialized dementia care services? (1) You may be eligible to receive services in a licensed assisted living facility that has DSHS "enhanced adult residential care-specialized dementia care ("EARC-SDC")," which is defined in WAC 388-110-220. You may be eligible to receive EARC-SDC services in a licensed assisted living facility under the following circumstances:

(a) You are enrolled in CFC, as defined in WAC 388-106-0015;

(b) The department has received written or verbal confirmation from a health care practitioner that you have an irreversible dementia (such as Alzheimer's disease, multi-infarct or vascular dementia, Lewy body dementia, Pick's disease, alcohol-related dementia);

(c) You are receiving services in an assisted living facility that has a current EARC-SDC contract, and you are living in the part of the facility that is covered by the contract;

(d) The department has authorized you to receive EARC-SDC services in the assisted living facility; and

(e) You are assessed by the comprehensive assessment reporting evaluation tool ("CARE") as having a cognitive performance scale score of 3 or more; and any one or more of the following:

(i) An unmet need for assistance with the activity of daily living (ADL) of eating as defined in WAC 388-106-0010;
(ii) Inappropriate toileting menses activities;
(iii) Rummages/takes belongings of others;
(iv) Disrupts household at night when others are sleeping and requires intervention(s);
(v) Wanders/exit seeking;
(vi) Wanders/not exit seeking;
(vii) Left home and gotten lost;
(viii) Inappropriate spitting;
(ix) Inappropriate nakedness;
(x) Eats nonedible substances/objects (Pica)(persistent for at least a month);
(xi) Sexual acting out;
(xii) Delusions;
(xiii) Hallucinations;
(xiv) Assaultive (not during personal care);
(xv) Breaks, throws items;
(xvi) Combative during personal care;
(xvii) Easily irritable/agitated requiring intervention;
(xviii) Obsessive regarding own health or body functions;
(xix) Repetitive movement/pacing;
(xx) Unrealistic fears or suspicions;
(xxi) Nonhealth related repetitive anxious complaints/questions;
(xxii) Resistive to care with words/gestures (does not include informed choice);
(xxiii) Verbally abusive;
(xxiv) Yelling/screaming;
(xxv) Inappropriate verbal noises; or
(xxvi) Accuses others of stealing.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 20-23-124, § 388-106-0033, filed 11/18/20, effective 12/19/20. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0033, filed 1/22/16, effective 2/22/16. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 14-15-071, § 388-106-0033, filed 7/15/14, effective 8/15/14; WSR 14-02-094, § 388-106-0033, filed 12/31/13, effective 2/1/14.]

WAC 388-106-0035 May I receive personal care services through any of the long-term care programs when I am out of the state of Washington? (1) You may receive personal care assistance through any long-term care programs in WAC 388-106-0015 subsections (1) through (5) when temporarily traveling out of state for less than thirty days, as long as your:
(a) Individual provider is contracted with the state of Washington or an employee of the consumer directed employer;
(b) Travel plans are coordinated with your case manager prior to departure;
(c) Services are authorized on your plan of care prior to departure; and
(d) Services are strictly for your personal care and do not include your provider's travel time, expenses.
(2) You may not receive personal care services outside of the United States.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.832, 74.39A.270, 74.39A.056, 74.39A.074, 43.20A.710, 74.39A.525, 43.43.842, 74.39A.326, 74.39A.515, 74.39A.505, 18.88B.021, 43.43.837 and 2018 c 278. WSR 21-18-081, § 388-106-0035, filed 8/30/21, effective 10/1/21. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0035, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0035, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0040 Who can provide long-term care services? The following types of providers can provide long-term care services:

(1) Individual providers (IPs), who provide services to clients in their own home.

(2) Home care agencies that provide services to clients in their own home. Home care agencies must be licensed under chapter 70.127 RCW and chapter 246-335 WAC and contracted with the department.

(3) Residential providers, which include licensed adult family homes, enhanced services facilities, and assisted living facilities, that contract with the department to provide assisted living, adult residential care, and enhanced adult residential care services (which may also include specialized dementia care).

(4) Providers who have contracted with the department to perform other services.

(5) In the case of new freedom consumer directed services (NFCDS), additional providers meeting NFCDS HCBS waiver requirements contracting with a department approved provider of fiscal management services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.832, 74.39A.270, 74.39A.056, 74.39A.074, 43.20A.710, 74.39A.525, 43.43.842, 74.39A.326, 74.39A.515, 74.39A.505, 18.88B.021, 43.43.837 and 2018 c 278. WSR 21-18-081, § 388-106-0040, filed 8/30/21, effective 10/1/21. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-01-085, § 388-106-0040, filed 12/16/14, effective 1/16/15; WSR 14-15-092, § 388-106-0040, filed 7/18/14, effective 8/18/14; WSR 13-18-039 and 13-17-125, § 388-106-0040, filed 8/29/13 and 8/21/13, effective 10/1/13. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-0040, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0040, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0045 When will the department authorize my long-term care services? The department will authorize long-term care services when you:

(1) Are assessed using CARE;

(2) Are found financially and functionally eligible for services including, if applicable, the determination of the amount of participation toward the cost of your care and/or the amount of room and board that you must pay;

(3) Have given consent for services and approved your plan of care; and

(4) Have chosen a provider(s), qualified for payment.

[Statutory Authority: RCW 74.08.090. WSR 18-22-068, § 388-106-0045, filed 11/1/18, effective 12/2/18. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0045, filed 1/22/16, effective 2/22/16. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0045, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0047 When can the department terminate or deny long-term care services to me? (1) The department will deny or terminate long-term care services if you are not eligible for long-term care services pursuant to WAC 388-106-0210, 388-106-0277, 388-106-0310, or 388-106-0610.

(2) The department may deny or terminate long-term care services to you if, after exhaustion of standard case management activities and the approaches delineated in the department's challenging cases protocol, which must include an attempt to reasonably accommodate your disability or disabilities, any of the following conditions exist:

(a) After a department representative reviews with you your rights and responsibilities as a client of the department, per WAC 388-106-1300 and 388-106-1303, you refuse to accept those long-term care services identified in your plan of care that are vital to your health, welfare or safety;

(b) You choose to receive services in your own home and you or others in your home demonstrate behaviors that are substantially likely to cause serious harm to you or your care provider;

(c) You choose to receive services in your own home and hazardous conditions in or immediately around your home jeopardize the health, safety, or welfare of you or your provider. Hazardous conditions include but are not limited to the following:

(i) Threatening, uncontrolled animals (e.g., dogs);

(ii) The manufacture, sale, or use of illegal drugs;

(iii) The presence of hazardous materials (e.g., exposed sewage, evidence of a methamphetamine lab).

(3) The department may terminate long-term care services if you do not sign and return your service summary document within sixty days of your assessment completion date.

[Statutory Authority: RCW 74.08.090. WSR 18-22-068, § 388-106-0047, filed 11/1/18, effective 12/2/18. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0047, filed 1/22/16, effective 2/22/16. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-0047, filed 1/12/15, effective 2/12/15. Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 441.302(a); Social Security Act section 1915c waiver rules, 42 C.F.R. 440.180. WSR 06-16-070, § 388-106-0047, filed 7/28/06, effective 8/28/06.]

COMPREHENSIVE ASSESSMENT REPORTING EVALUATION (CARE) ASSESSMENT

WAC 388-106-0050 What is an assessment? (1) An assessment is an in-person interview in your home, current residence, or another location that is convenient to you that is conducted by the department, to inventory and evaluate your ability to care for yourself. The depart-

ment will assess you at least every twelve months, or more often when there are significant changes necessitating revisions to your CARE plan, or at your request. If your assessment did not take place in the residence where you receive services, the department must visit that residence to evaluate your living situation and environment, for you to continue to receive services.

(2) Between assessments, the department may modify your current assessment without an in-person interview in your home or place of residence. The reasons that the department may modify your current assessment without conducting an in-person interview in your home or place of residence include but are not limited to the following:

(a) Errors made by department staff in coding the information from your in-person interview;

(b) New information requested by department staff at the time of your assessment and received after completion of the in-person interview (e.g. medical diagnosis);

(c) Changes in the level of informal support available to you; or

(d) Clarification of the coding selected.

(3) When the department modifies your current assessment, it will notify you using a Planned Action Notice of the modification regardless of whether the modification results in a change to your benefits. You will also receive a new service summary and assessment details, if requested.

(4) An assessment interview does not need to be in-person under the following circumstances:

(a) You agree to the interview being conducted remotely, and have adequate support to participate in the assessment if you need it; or

(b) An in-person interview is not required by the applicable federal regulation or the requirement is waived by the centers for medicare and medicaid services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 21-08-006, § 388-106-0050, filed 3/24/21, effective 4/24/21. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0050, filed 1/22/16, effective 2/22/16. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 13-18-039 and 13-17-125, § 388-106-0050, filed 8/29/13 and 8/21/13, effective 10/1/13. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0050, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0050, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0055 What is the purpose of an assessment? The purpose of an assessment is to:

(1) Determine eligibility for long-term care programs;

(2) Identify your strengths, limitations, goals, and preferences;

(3) Evaluate your living situation and environment;

(4) Evaluate your physical health, functional, and cognitive abilities;

(5) Determine availability of informal supports and other nondepartment paid resources;

(6) Determine need for intervention;

(7) Determine need for case management activities;

(8) Determine your classification group that will set your payment rate for residential care or number of hours of in-home care;

(9) Determine need for referrals; and

(10) Develop a plan of care, as defined in WAC 388-106-0010.

(11) In the case of New Freedom consumer directed services, the purpose of an assessment is to determine functional eligibility and for the participant to develop the New Freedom spending plan, as defined in WAC 388-106-0010.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 21-04-037, § 388-106-0055, filed 1/26/21, effective 3/1/21. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0055, filed 1/22/16, effective 2/22/16. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-0055, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0055, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0060 Who must perform the assessment? The assessment must be performed by the department, an area agency on aging, or a federally recognized Indian tribe contracted with the department, as described in chapters 388-106 and 388-828 WAC.

[Statutory Authority: 2022 c 255, RCW 74.09.520, 74.39A.009, 74.39A.090, 74.39A.095, and 74.39A.515. WSR 25-07-060, s 388-106-0060, filed 3/13/25, effective 4/13/25. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 07-24-026, § 388-106-0060, filed 11/28/07, effective 1/1/08; WSR 05-11-082, § 388-106-0060, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0065 What is the process for conducting an assessment? The department:

(1) Will assess you using a department-prescribed assessment tool, titled the comprehensive assessment reporting evaluation (CARE).

(2) May request the assessment be conducted in private. However, you have the right to request that third parties be present.

(3) Has the right to end the assessment if behaviors by any party are impeding the assessment process. If an assessment is terminated, the department will reschedule.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0065, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0065, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0070 Will I be assessed in CARE? You will be assessed in CARE if you are applying for or receiving DDA services, CFC, COPES, MPC, chore, respite, adult day health, medical care services, PACE, private duty nursing, residential support, and new freedom.

If you are under the age of eighteen and within thirty calendar days of your next birthday, CARE determines your assessment age to be that of your next birthday.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0070, filed 1/22/16, effective 2/22/16. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-15-092, § 388-106-0070, filed 7/18/14, effective 8/18/14; WSR

12-16-026, § 388-106-0070, filed 7/25/12, effective 8/25/12; WSR 08-12-023, § 388-106-0070, filed 5/29/08, effective 7/1/08; WSR 07-24-026, § 388-106-0070, filed 11/28/07, effective 1/1/08; WSR 07-10-024, § 388-106-0070, filed 4/23/07, effective 6/1/07; WSR 05-11-082, § 388-106-0070, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0075 How is my need for personal care services assessed in CARE? The department gathers information from you, your caregivers, family members, and other sources to assess your abilities and how you perform personal care tasks. The department will also consider developmental milestones for children as defined in WAC 388-106-0130 when individually assessing your abilities and need for assistance. The department will assess your ability to perform:

(1) Activities of daily living (ADL) using self-performance, support provided, status, and assistance available, as defined in WAC 388-106-0010. Also, the department determines your need for "assistance with body care" and "assistance with medication management," as defined in WAC 388-106-0010; and

(2) Instrumental activities of daily living (IADL) using self-performance, status, and assistance available, as defined in WAC 388-106-0010.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 20-23-124, § 388-106-0075, filed 11/18/20, effective 12/19/20; WSR 12-14-064, § 388-106-0075, filed 6/29/12, effective 7/30/12; WSR 05-11-082, § 388-106-0075, filed 5/17/05, effective 6/17/05.]

CARE CLASSIFICATION

WAC 388-106-0080 How is the amount of long-term care services I can receive in my own home or in a residential facility determined? The amount of long-term care services you can receive in your own home or in a residential facility is determined through a classification system. Seventeen classifications apply to clients served in residential and in-home settings. The department has assigned each classification a residential facility daily rate or a base number of hours you can receive in your own home.

[Statutory Authority: 2008 c 329. WSR 08-19-102, § 388-106-0080, filed 9/17/08, effective 10/18/08. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0080, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0085 What criteria does the CARE tool use to place me in one of the classification groups? The department uses CARE to assess your characteristics. Based on this assessment, the CARE tool uses the following criteria to place you in one of the classification groups:

(1) Cognitive performance.
(2) Clinical complexity.
(3) Mood/behaviors symptoms.
(4) Activities of daily living (ADLs).

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0085, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0090 How does the CARE tool measure cognitive performance? (1) The CARE tool uses the cognitive performance scale (CPS) to evaluate your cognitive impairment. The CPS results in a score that ranges from zero (intact) to six (very severe impairment). Your CPS score is based on information given at your assessment and documented in the CARE tool:

(a) Whether you are comatose.

(b) Your ability to make decisions, as defined in WAC 388-106-0010 "Decisions."

(c) Your ability to make yourself understood, as defined in WAC 388-106-0010 "Ability to make self understood."

(d) Whether you have short-term memory problem (e.g. can you remember recent events?) as determined by the following:

(i) Information given at your assessment and documented in the CARE tool showed there is evidence that you have short-term memory loss; or

(ii) You could not recall at least one of the three words you were asked to recall during the mini mental status exam completed during your assessment using the CARE tool; and

(e) Whether you score as total dependence for self-performance in eating, as defined in WAC 388-106-0010 "Self-performance of ADLs."

(2) You will receive a CPS score of:

(a) **Zero** when you do not have problems with decision-making ability, making yourself understood, or recent memory.

(b) **One** when you meet one of the following:

(i) Decisions are scored as difficulty in new situations or poor decisions/unaware of consequences as defined in WAC 388-106-0010;

(ii) Your ability to make yourself understood is scored as usually, sometimes, or rarely/never understood as defined in WAC 388-106-0010; or

(iii) You have a short-term memory problem.

(c) **Two** when you meet two of the following:

(i) Decisions are scored as difficulty in new situations or poor decisions/unaware of consequences as defined in WAC 388-106-0010;

(ii) Your ability to make yourself understood is scored as usually, sometimes, or rarely/never understood; and/or

(iii) You have a short-term memory problem or delayed recall.

(d) **Three** when you meet at least two of the criteria listed in subsection (2)(b) of this section and one of the following applies:

(i) Decisions are scored as poor decisions/unaware of consequences as defined in WAC 388-106-0010; or

(ii) Your ability to make yourself understood is scored as sometimes or rarely/never understood as defined in WAC 388-106-0010.

(e) **Four** when both of the following criteria applies:

(i) Decisions are scored as poor decisions/unaware of consequences as defined in WAC 388-106-0010; and

(ii) Your ability to make yourself understood is scored as sometimes or rarely/never understood as defined in WAC 388-106-0010.

(f) **Five** Decisions are scored as no/few decisions as defined in WAC 388-106-0010.

(g) **Six** when one of the following applies:

(i) Decisions are scored as no/few decisions and you require total dependence in eating as defined in WAC 388-106-0010; or

(ii) You are comatose.

[Statutory Authority: RCW 49.46.800 and 74.09.520. WSR 25-24-074, s 388-106-0090, filed 12/1/25, effective 1/1/26. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 20-23-124, § 388-106-0090, filed 11/18/20, effective 12/19/20; WSR 05-11-082, § 388-106-0090, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0095 How does the CARE tool measure clinical complexity? The CARE tool places you in the clinically complex classification group only when you have one or more of the following criteria and corresponding ADL scores:

Condition	AND an ADL score of
ALS (Lou Gehrig's Disease)	>14
Aphasia (expressive, receptive, or both)	>=2
Cerebral Palsy	>14
Diabetes Mellitus (insulin dependent)	>14
Diabetes Mellitus (noninsulin dependent)	>14
Emphysema & shortness of breath (at rest or exertion) or dizziness/vertigo	>10
COPD & shortness of breath (at rest or exertion) or dizziness/vertigo	>10
Explicit terminal prognosis	>14
Hemiplegia	>14
Multiple Sclerosis	>14
Parkinson Disease	>14
Pathological bone fracture	>14
Quadriplegia	>14
Rheumatoid Arthritis	>14
You have one or more of the following skin problems: ■ Current pressure injuries, with areas of persistent skin redness; ■ Current pressure injuries with partial loss of skin layers; ■ Current pressure injuries, with a full thickness lost; ■ Skin desensitized to pain/pressure; ■ Open lesions (not cuts, rashes); or ■ Stasis ulcers. AND You received one of the following types of skin care or treatment: ■ Pressure injury care; ■ Pressure relieving device; ■ Turning/repositioning program as defined in WAC 388-106-0010; ■ Application of dressing; or ■ Wound/skin care treatment.	>=2
You have a burn(s) and you received one of the following: ■ Application of dressing; or ■ Wound/skin care	>=2

Condition	AND an ADL score of
You have one or more of the following problems: ■ You are frequently incontinent daily with some control present (bladder); ■ You are incontinent all or most of the time multiple times per day having no control (bladder); ■ You are frequently incontinent two to three times per week (bowel); or ■ You are incontinent all or most of the time (bowel). AND One of the following applies: ■ The status of your individual management of bowel bladder supplies is "Uses, needs assistance, has incontinence"; ■ The status of your individual management of bowel bladder supplies is "Does not use, has leakage onto skin"; or ■ You use "Any scheduled toileting plan."	>10
You have a current swallowing problem, and you are not independent in eating.	>10
You have edema.	>14
You have pain daily.	>14
You need and received a bowel program as defined in WAC 388-106-0010.	>10
You need dialysis.	>10
You require IV nutritional support or tube feedings; and Your total calories received per IV or tube was at least 25%; and Your fluid intake is greater than 2 cups.	>=2
You need hospice care.	>14
You need injections.	>14
You need intravenous medications.	>10
You need management of IV lines.	>10
You need ostomy care.	>=2
You need oxygen therapy.	>10
You need radiation.	>10
You need and received passive range of motion.	>10
You need and received walking training.	>10
You need suction treatment.	>=2
You need tracheostomy care.	>10
You need a ventilator/respirator You are <18 and you have pain related to your disability and you complain of pain or show evidence of pain daily. (If you are under eighteen and do not have pain related to your disability, you may be placed in the clinically complex classification based on other factors above.)	>10 >14
Key: < means less than. > means greater than. >= means greater than or equal to.	

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 20-23-124, § 388-106-0095, filed 11/18/20, effective 12/19/20; WSR 07-10-024, § 388-106-0095, filed 4/23/07, effective 6/1/07; WSR 05-11-082, § 388-106-0095, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0100 How does the CARE tool measure mood and behaviors? (1) When you do not meet the criteria for the clinically complex classification group, or the criteria for exceptional care, or for in-home only have a cognitive performance scale score of five or

six, then the mood and behavior criteria listed in subsections (3) and (4) below determines your classification group. If you are eligible for more than one "B" group classification based on the two methodologies, CARE will place you in the highest group for which you qualify.

(2) For each behavior that was assessed and documented in the CARE tool, the department will determine a status as "current behavior" or "past behavior" as defined in WAC 388-106-0010.

(3) CARE places you in the mood and behavior classification group only if you have one or more of the behavior/moods that also meets the listed status, frequency, and alterability as identified in the following chart:

Behavior/Mood	AND Status, Frequency & Alterability
Assaultive (not during personal care)	Current behavior
Combative during personal care	Current behavior
Combative during personal care	Past behavior, addressed with current interventions
Many incidences of uncontrollable crying tearfulness	Current behavior, frequency 4 or more days per week
Delusions	Past behavior, addressed with current interventions
Depression score of 14 or greater	N/A
Inappropriate nakedness	Current behavior and not easily altered
Easily irritable/ agitated requiring intervention(s)	Current behavior and not easily altered
Eats nonedible substances/objects (Pica)(persistent for at least a month)	Current behavior
Eats nonedible substances/objects (Pica)(persistent for at least a month)	Past behavior, addressed with current interventions
Hallucinations	Current behavior
Hiding items	Past behavior, addressed with current interventions
Hoarding	Past behavior, addressed with current interventions
Mental health therapy/ program	Needs
Nonhealth related repetitive anxious complaints/questions	Current behavior, daily
Nonhealth related repetitive complaints/ questions	Past behavior, addressed with current interventions
Repetitive movement/ pacing, hand wringing, fidgeting	Current behavior, daily
Resistive to care with words/gestures (does not include informed choice)	Current behavior
Resistive to care with words/gestures (does not include informed choice)	Past behavior, addressed with current interventions
Sexual acting out	Current behavior
Sexual acting out	Past behavior, addressed with current interventions
Inappropriate spitting	Current behavior and not easily altered

Behavior/Mood	AND Status, Frequency & Alterability
Inappropriate spitting	Past behavior, addressed with current interventions
Breaks/throws items	Current behavior
Unsafe smoking	Current behavior and not easily altered
Disturbs household at night when others are sleeping and requires intervention	Current behavior
Wanders exit seeking	Current behavior
Wanders exit seeking	Past behavior, addressed with current interventions
Wanders not exit seeking	Current behavior
Wanders not exit seeking	Past behavior, addressed with current interventions
Yelling/screaming	Current behavior, frequency 4 or more days per week

or

(4) CARE places you in the mood and behavior classification group if you have a behavior point score greater than 1, your CPS score (as defined in WAC 388-106-0090) is greater than 2, and your ADL score (as defined in WAC 388-106-0105) is greater than 1.

Status	Intervention	Frequency	Weight
Past	No intervention	N/A	0
Past	With intervention	N/A	0.25
Current	N/A	1-3 days per wk	0.5
Current	N/A	4-6 days per wk	0.75
Current	N/A	Daily	1

Each current behavior (as shown in the table below) has a value from .5 to 6 depending on the severity and alterability. Each status combination (shown in the table above) has a weight from 0 to 1. Behavior points are determined by multiplying the value of each current behavior (from the list below) by the weight of the status combination (above). Behavior points for past behaviors will be determined by multiplying the easily altered value of the behavior from the table below by the appropriate weight from the table above (0 or .25).

The list of behaviors below is divided into categories. Each category has a point limit of how many points can be counted toward the total behavior point score as detailed below. The total behavior point score is determined by totaling the weight-adjusted values for each category below.

Behavior	Value	
	Easily Altered/ Past	Not Easily Altered
1. Many incidences of uncontrollable crying, tearfulness	.5	1
2. Easily irritable/agitated	.5	1
3. Obsessive regarding own health or body functions	.5	1
4. Repetitive physical movement/pacing, hand wringing, fidgeting	.5	1

Behavior	Value	
	Easily Altered/ Past	Not Easily Altered
5. Hiding items	.5	1
6. Hoarding	.5	1
7. Inappropriate verbal noise	.5	1
8. Wanders, not exit seeking	.5	1
Maximum total points after adjusting for status for behaviors 1-8 = 2		
9. Repetitive anxious complaints/questions	1	2
10. Rummages/takes belongings of others	1	2
11. Verbally abusive	1	2
12. Yelling or screaming	1	2
13. Inappropriate spitting	1	2
14. Unrealistic fears and suspicions	1	2
15. Accuses others of stealing	1	2
Maximum total points after adjusting for status for behaviors 9-15 = 3		
16. Resistive to care with words/gestures	2	3
17. Disturbs household at night when others are sleeping, requires intervention	2	3
18. Unsafe cooking	2	3
19. Inappropriate toileting/ menses activity	2	3
20. Unsafe smoking	2	3
21. Left home and gotten lost	2	3
22. Inappropriate nakedness	2	3
Maximum total points after adjusting for status for behaviors 16-22 = 4		
23. Intentional self-injury	4	5
24. Wanders/Exit seeking	4	5
25. Sexual acting out	4	5
26. Intimidating/ threatening (no physical contact)	4	5
27. Assaultive (not during personal care)	4	5
28. Breaks, throws items	4	5
Maximum total points after adjusting for status for behaviors 23-28 = 10		
29. Deliberate fire setting behaviors	5	6
30. Combative during care	5	6
31. Eats nonedible substances/objects (Pica) (persistent for at least a month)	5	6
32. Deliberate sexual violence	5	6

Behavior	Value	
	Easily Altered/ Past	Not Easily Altered
Maximum total points after adjusting for status for behaviors 29-32 = 12		

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 20-23-124, § 388-106-0100, filed 11/18/20, effective 12/19/20. Statutory Authority: RCW 74.08.090, 74.09.520, and 2007 c 522. WSR 08-10-022, § 388-106-0100, filed 4/25/08, effective 5/26/08. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0100, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0105 How does the CARE tool measure activities of daily living (ADLs)? (1) CARE determines an ADL score ranging from zero to twenty-eight for each of the following ADLs.

(a) Personal hygiene;
(b) Bed mobility;
(c) Transfers;
(d) Eating;
(e) Toilet use;
(f) Dressing;
(g) Locomotion in room;
(h) Locomotion outside room; and
(i) Walk in room.

(2) The department through the CARE tool determines the ADL score by using the definitions in WAC 388-106-0010 under "Self-performance for ADLs." The CARE tool assigns the following points to the level of self performance for each of the ADLs listed in subsection (1) of this section. For the locomotion in room, locomotion outside of room and walk in room, the department uses the highest score of the three in determining the total ADL score.

ADL Scoring Chart	
If Self Performance is:	Score Equals
Independent	0
Supervision	1
Limited assistance	2
Extensive assistance	3
Total dependence	4
Did not occur/no provider	4
Did not occur/client not able	4
Did not occur/client declined	0

(3) Although assessed by CARE, the department does not score bathing and medication management to determine classification groups.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0105, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0110 How does the CARE tool evaluate me for the exceptional care classification of the E Group? CARE places you in the

exceptional care E Group classifications when the following criteria are met in either diagram 1 or 2:

Diagram 1
You have an ADL score of greater than or equal to 22.
AND
You need a turning/repositioning program.
AND
You need at least one of the following: ■ External catheter; ■ Intermittent catheter; ■ Indwelling catheter care; ■ Bowel program; ■ Ostomy care; or ■ Total in self performance for toilet use.
AND
You need one of the following services provided by an individual provider, agency provider, a private duty nurse, or through self-directed care when in the in home setting, or provided by AFH/assisted living facility staff, facility RN/LPN, facility staff or private duty nursing when living in a residential setting: ■ Active range of motion (AROM); or ■ Passive range of motion (PROM).

Diagram 2
You have an ADL score of greater than or equal to 22.
AND
You need a turning/repositioning program.
AND
You need one of the following services provided by an individual provider, agency provider, a private duty nurse, or through self-directed care when in the in home setting, or provided by AFH or assisted living facility staff, facility RN/LPN, facility staff or private duty nursing when living in a residential setting: ■ Active range of motion (AROM); or ■ Passive range of motion (PROM).
AND
All of the following apply: ■ You require IV nutrition support or tube feeding; ■ Your total calories received per IV or tube was greater than 50%; and ■ Your fluid intake by IV or tube is greater than 2 cups per day.
AND
You need assistance with one of the following, provided by an individual provider, agency provider, a private duty nurse, or through self-directed care when in the in home setting or provided by AFH or assisted living facility staff, facility RN/LPN, facility staff, a private duty nurse or nurse delegation when living in a residential setting: ■ Dialysis; or ■ Ventilator/respirator.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-15-092, § 388-106-0110, filed 7/18/14, effective 8/18/14. Statutory Authority: 2008 c 329. WSR 08-19-102, § 388-106-0110, filed 9/17/08, effective 10/18/08. Statutory Authority: RCW 74.08.090, 74.09.520, and 2007 c

522. WSR 08-10-022, § 388-106-0110, filed 4/25/08, effective 5/26/08. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0110, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0115 How does CARE use criteria to place me in a classification group for residential facilities? The CARE tool uses the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, ADLs as determined under WAC 388-106-0105 and exceptional care under WAC 388-106-0110 to place you into one of the following seventeen residential classification groups:

CARE classification is determined first by meeting criteria to be placed into a group, then you are further classified based on ADL score or behavior point score into a classification subgroup following a classification path of highest possible group to lowest qualifying group.

(1) If you meet the criteria for exceptional care, then CARE will place you in Group E. CARE then further classifies you into:

(a) Group E High if you have an ADL score of 26-28; or

(b) Group E Medium if you have an ADL score of 22-25.

(2) If you meet the criteria for clinical complexity and have a cognitive performance score of 4-6 then you are classified in Group D regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) Group D High if you have an ADL score of 25-28; or

(b) Group D Medium-High if you have an ADL score of 18-24; or

(c) Group D Medium if you have an ADL score of 13-17; or

(d) Group D Low if you have an ADL score of 2-12.

(3) If you meet the criteria for clinical complexity and have a CPS score of less than 4, then you are classified in Group C regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) Group C High if you have an ADL score of 25-28; or

(b) Group C Medium-High if you have an ADL score of 18-24; or

(c) Group C Medium if you have an ADL score of 9-17; or

(d) Group C Low if you have an ADL score of 2-8.

(4) If you meet the criteria for mood and behavior qualification and do not meet the classification for C, D, or E groups, then you are classified into Group B. CARE further classifies you into:

(a) Group B High if you have an ADL score of 15-28; or

(b) Group B Medium if you have an ADL score of 5-14; or

(c) Group B Low if you have an ADL score of 0-4.

(5) If you meet the criteria for behavior points and have a CPS score of greater than 2 and your ADL score is greater than 1, and do not meet the classification for C, D, or E groups, then you are classified in Group B. CARE further classifies you into:

(a) Group B High if you have a behavior point score 12 or greater; or

(b) Group B Medium-High if you have a behavior point score greater than 6; or

(c) Group B Medium if you have a behavior point score greater than 4; or

(d) Group B Low if you have a behavior point score greater than 1.

(6) If you are not clinically complex and you do not qualify under either mood and behavior criteria, then you are classified in Group A. CARE further classifies you into:

(a) Group A High if you have an ADL score of 10-28; or

(b) Group A Medium if you have an ADL score of 5-9; or

(c) Group A Low if you have an ADL score of 0-4.

[Statutory Authority: 2008 c 329. WSR 08-19-102, § 388-106-0115, filed 9/17/08, effective 10/18/08. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0115, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0120 What is the payment rate that the department will pay the provider if I receive personal care services in a residential facility? The department publishes rates and/or adopts rules to establish how much the department pays toward the cost of your care in a residential facility.

(1) For CFC, COPES, MPC, medical care services, RCL, and new freedom programs, the department assigns payment rates to the CARE classification group. Under these programs, payment for care in a residential facility corresponds to the payment rate assigned to the classification group in which the CARE tool has placed you.

(2) The enhanced services facility rate is determined by legislative action and appropriation.

(3) The rate for adult family homes with a specialized behavior support contract is based on the CARE classification group and an add-on amount, which is negotiated through the collective bargaining process.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0120, filed 1/22/16, effective 2/22/16. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-01-085, § 388-106-0120, filed 12/16/14, effective 1/16/15; WSR 14-15-092, § 388-106-0120, filed 7/18/14, effective 8/18/14; WSR 05-11-082, § 388-106-0120, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0125 How does CARE use criteria to place me in a classification group for in-home care? CARE uses the criteria of cognitive performance score as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behavior and behavior point score as determined under WAC 388-106-0100, ADLs as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110 to place you into one of the following seventeen in-home groups. CARE classification is determined first by meeting criteria to be placed into a group, then you are further classified based on ADL score or behavior point score into a classification sub-group following a classification path of highest possible base hours to lowest qualifying base hours. Each classification group is assigned a number of base hours as described below based upon the level of funding provided by the legislature for personal care services, and based upon the relative level of functional disability of persons in each classification group as compared to persons in other classification groups.

(1) If you meet the criteria for exceptional care, then CARE will place you in **Group E.** CARE then further classifies you into:

(a) **Group E High** with 393 base hours if you have an ADL score of 26-28; or

(b) **Group E Medium** with 327 base hours if you have an ADL score of 22-25.

(2) If you meet the criteria for clinical complexity and have cognitive performance score of 4-6 or you have cognitive performance score of 5-6, then you are classified in **Group D** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group D High** with 260 base hours if you have an ADL score of 25-28; or

(b) **Group D Medium-High** with 215 base hours if you have an ADL score of 18-24; or

(c) **Group D Medium** with 168 base hours if you have an ADL score of 13-17; or

(d) **Group D Low** with 120 base hours if you have an ADL score of 2-12.

(3) If you meet the criteria for clinical complexity and have a CPS score of less than 4, then you are classified in **Group C** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group C High** with 176 base hours if you have an ADL score of 25-28; or

(b) **Group C Medium-High** with 158 base hours if you have an ADL score of 18-24; or

(c) **Group C Medium** with 115 base hours if you have an ADL score of 9-17; or

(d) **Group C Low** with 73 base hours if you have an ADL score of 2-8.

(4) If you meet the criteria for mood and behavior qualification and do not meet the classification for C, D, or E groups, then you are classified into **Group B.** CARE further classifies you into:

(a) **Group B High** with 129 base hours if you have an ADL score of 15-28; or

(b) **Group B Medium** with 69 base hours if you have an ADL score of 5-14; or

(c) **Group B Low** with 39 base hours if you have an ADL score of 0-4; or

(5) If you meet the criteria for behavior points and have a CPS score of greater than 2 and your ADL score is greater than 1, and do not meet the classification for C, D, or E groups, then you are classified in **Group B.** CARE further classifies you into:

(a) **Group B High** with 129 base hours if you have a behavior point score 12 or greater; or

(b) **Group B Medium-High** with 84 base hours if you have a behavior point score greater than 6; or

(c) **Group B Medium** with 69 base hours if you have a behavior point score greater than 4; or

(d) **Group B Low** with 39 base hours if you have a behavior point score greater than 1.

(6) If you are not clinically complex and your CPS score is less than 5 and you do not qualify under either mood and behavior criteria, then you are classified in **Group A.** CARE further classifies you into:

(a) **Group A High** with 59 base hours if you have an ADL score of 10-28; or

(b) **Group A Medium** with 47 base hours if you have an ADL score of 5-9; or

(c) **Group A Low** with 22 base hours if you have an ADL score of 0-4.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 12-13-068, § 388-106-0125, filed 6/18/12, effective 7/19/12. Statutory Authority: RCW 74.08.090, 74.09.520, 2009 c 564 § 206(5). WSR 10-11-050, § 388-106-0125, filed 5/12/10, effective 6/12/10. Statutory Authority: RCW 74.08.090, 74.09.520, and 2007 c 522. WSR 08-10-022, § 388-106-0125, filed 4/25/08, effective 5/26/08. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0125, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0130 How does the department determine the number of hours I may receive for in-home care? (1) The department assigns a base number of hours to each classification group as described in WAC 388-106-0125.

(2) The department will adjust base hours to account for informal supports and age appropriate functioning (as those terms are defined in WAC 388-106-0010), and other paid services that meet some of an individual's need for personal care services:

(a) The CARE tool determines the adjustment for informal supports and age appropriate functioning. A numeric value is assigned to the status and assistance available coding for ADLs and IADLs based on the table below. The base hours assigned to each classification group are adjusted by the numeric value in subsection (b) of this section.

Meds	Status	Assistance Available	Numeric Value
Medication management The rules to the right apply for all self-performance codes except independent which is not counted as a qualifying ADL	Unmet	N/A	1
	Met	N/A	0
	Decline	N/A	0
	Age appropriate functioning	N/A	0
	Partially met	<1/4 time	.9
		1/4 to 1/2 time	.7
		1/2 to 3/4 time	.5
		>3/4 time	.3

Unscheduled ADLs	Status	Assistance Available	Value
Bed mobility, transfer, walk in room, eating, toilet use The rules to the right apply for all self-performance codes except: Did not occur/client not able and Did not occur/no provider = 1; Did not occur/client declined and independent are not counted as qualifying ADLs	Unmet	N/A	1
	Met	N/A	0
	Decline	N/A	0
	Age appropriate functioning	N/A	0
	Partially met	<1/4 time	.9
		1/4 to 1/2 time	.7
		1/2 to 3/4 time	.5
		>3/4 time	.3

Scheduled ADLs	Status	Assistance Available	Value
Dressing, personal hygiene, bathing The rules to the right apply for all self-performance codes except: Did not occur/client not able and Did not occur/no provider = 1; Did not occur/client declined and independent which are not counted as qualifying ADLs	Unmet	N/A	1
	Met	N/A	0
	Decline	N/A	0
	Age appropriate functioning	N/A	0
	Partially met	<1/4 time	.75
		1/4 to 1/2 time	.55
		1/2 to 3/4 time	.35
		>3/4 time	.15

IADLs	Status	Assistance Available	Value
Meal preparation, ordinary housework, essential shopping The rules to the right apply for all self-performance codes except independent is not counted as a qualifying IADL	Unmet	N/A	1
	Met	N/A	0
	Decline	N/A	0
	Child under (age) (see subsection (7))	N/A	0
	Partially met	<1/4 time	.3
		1/4 to 1/2 time	.2
		1/2 to 3/4 time	.1
		>3/4 time	.05

IADLs	Status	Assistance Available	Value
Travel to medical The rules to the right apply for all self-performance codes except independent which is not counted as a qualifying IADL	Unmet	N/A	1
	Met	N/A	0
	Decline	N/A	0
	Child under (age) (see subsection (7))	N/A	0
	Partially met	<1/4 time	.9
		1/4 to 1/2 time	.7
		1/2 to 3/4 time	.5
		>3/4 time	.3

Key: > means greater than; < means less than

(b) To determine the amount adjusted for informal support or age appropriate functioning, the numeric values are totaled and divided by the number of qualifying ADLs and IADLs needs. The result is value A. Value A is then subtracted from one. This is value B. Value B is divided by three. This is value C. Value A and Value C are summed. This is value D. Value D is multiplied by the "base hours" assigned to your classification group and the result is the number of adjusted in-home hours. Values are rounded to the nearest hundredths (for example, .862 is rounded to .86).

(3) Effective July 1, 2012, after adjustments are made to your base hours, as described in subsection (2) of this section, the department may add on hours based on off-site laundry, living more than 45 minutes from essential services, and wood supply, as follows:

Condition	Status	Assistance Available	Add On Hours
Offsite laundry facilities, which means the client does not have facilities in own home and the caregiver is not available to perform any other personal or household tasks while laundry is done. The status used for the rules to the right is for housekeeping.	Unmet	N/A	8
	Met	N/A	0
	Declines	N/A	0
	Child under (age) (see subsection (7))	N/A	0
	Partially met:	<1/4 time	8
		between 1/4 to 1/2 time	6
		between 1/2 to 3/4 time	4
		>3/4 time	2
Client is >45 minutes from essential services (which means the client lives more than 45 minutes one-way from a full-service market). The status used for the rules to the right is essential shopping.	Unmet	N/A	5
	Met	N/A	0
	Declines	N/A	0
	Child under (age) (see subsection (7))	N/A	0
	Partially met	<1/4 time	5
		between 1/4 to 1/2 time	4
		between 1/2 to 3/4 time	3
		>3/4 time	2
Wood supply used as sole source of heat.	Unmet	N/A	8
	Met	N/A	0
	Declines	N/A	0
	Child under (age) (see subsection (7))	N/A	0
	Partially met	<1/4 time	8
		between 1/4 to 1/2 time	6
		between 1/2 to 3/4 time	4
		>3/4 time	2

(4) In the case of New Freedom consumer directed services (NFCDS), the department determines the monthly budget available as described in WAC 388-106-1445.

(5) The result of adjustments under subsections (2) and (3) of this section is the maximum number of hours that can be used to develop your plan of care. The department must take into account cost effectiveness, client health and safety, and program limits in determining how hours can be used to address your identified needs. In the case of New Freedom consumer directed services (NFCDS), a New Freedom spending plan (NFSP) is developed in place of a plan of care.

(6) If you are eligible, your hours may be used to authorize the following services:

(a) Personal care services from a home care agency provider, an individual provider, or both.

(b) Home delivered meals (a half hour from the available hours for each meal authorized) per WAC 388-106-0805.

(c) A private duty nurse (PDN) if you are eligible per WAC 388-106-1010 or 182-551-3000 (one hour from the available hours for each hour of PDN authorized).

(d) The purchase of New Freedom consumer directed services (NFCDS).

(7) If you are a child applying for personal care services:

(a) The department presumes that children have legally responsible parents or other responsible adults who provide informal support for the child's ADLs, IADLs, and other needs. The department will not provide services or supports that are within the range of activities

that a legally responsible parent or other responsible adult would ordinarily perform on behalf of a child of the same age who does not have a disability or chronic illness.

(b) The department will complete a CARE assessment and use the developmental milestones tables in this section when assessing your ability to perform personal care tasks.

(c) Your status will be coded as age appropriate for ADLs when your self-performance is at a level expected for persons in your assessed age range, as indicated by the developmental milestones table in subpart (e) of this section, unless the circumstances in subpart (d) of this section apply.

(d) The department will code status as other than age appropriate for an ADL, despite your self-performance falling within the developmental age range for the ADL on the developmental milestones table in subpart (e) of this section, if the department determines during your assessment that your level of functioning is related to your disability and not primarily due to your age and the frequencyor the duration of assistance required for a personal care task is not typical for a person of your age.

(e)

Developmental Milestones for Activities of Daily Living (ADLs)		
ADL	**Self-Performance**	**Developmental Age Range**
Medication management	Independent Self-directed Assistance required	Child under 18 years of age
	Must Be administered	Child under 12 years of age
Locomotion in room	Independent Supervision Limited Extensive	Child under 4 years of age
	Total	Child under 13 months of age
Locomotion outside room	Independent Supervision	Child under 6 years of age
	Limited Extensive	Child under 4 years of age
	Total	Child under 25 months of age
Walk in room	Independent Supervision Limited Extensive	Child under 4 years of age
	Total	Child under 19 months of age
Bed mobility	Independent Supervision Limited	Child under 37 months of age
	Extensive	Child under 25 months of age
	Total	Child under 19 months of age
Transfers	Independent Supervision Limited Extensive	Child under 3 years of age
	Total	Child under 19 months of age
Toilet use	Independent Supervision Limited Extensive	Child under 7 years of age
	Total	Child under 37 months of age
Eating	Independent Supervision Limited Extensive	Child under 3 years of age
	Total	Child under 13 months of age

Developmental Milestones for Activities of Daily Living (ADLs)		
ADL	**Self-Performance**	**Developmental Age Range**
Bathing	Independent Supervision	Child under 12 years of age
	Physical help/ Transfer only	Child under 5 years of age
	Physical help/part of bathing	Child under 6 years of age
	Total	Child under 37 months of age
Dressing	Independent Supervision	Child under 12 years of age
	Limited	Child under 8 years of age
	Extensive	Child under 7 years of age
	Total	Child under 25 months of age
Personal hygiene	Independent Supervision	Child under 12 years of age
	Limited Extensive	Child under 7 years of age
	Total	Child under 37 months of age

(f) For IADLs, the department presumes that children typically have legally responsible parents or other responsible adults to assist with IADLs. Status will be coded as "child under (age)" the age indicated by the developmental milestones table for IADLs in subpart (h) of this section unless the circumstances in subpart (g) of this section apply. (For example, a 16-year-old child coded as supervision in self-performance for wood supply would be coded "child under 18.")

(g) If the department determines during your assessment that the frequencyor the duration of assistance required is not typical for a person of your age due to your disability or your level of functioning, the department will code status as other than described in subpart (h) of this section for an IADL.

(h)

Developmental Milestones for Instrumental Activities of Daily Living		
IADL	**Self-Performance**	**Developmental Age Range**
Wood supply	Independent Assistance Activity did not occur	Child under 18
Transportation	Independent Assistance Activity did not occur	Child under 18
	Total	Child under 16
Essential shopping, housework, meal preparation	Independent Assistance Activity did not occur	Child under 18
	Total	Child under 12

(i) The department presumes that children have legally responsible parents or other responsible adults who provide support for comprehension, decision-making, memory, and continence issues. These items will be coded as indicated by the additional developmental milestones table in subpart (k) of this section unless the circumstances in subpart (j) of this section apply.

(j) If the department determines during your assessment that due to your disability, the support you are provided for comprehension, decision making, memory, and continence issues is substantially greater than is typical for a person of your age, the department will code status as other than described in subpart (k) of this section.

(k)

Additional Developmental Milestones coding within CARE			
Name of CARE panel	**Question in CARE Panel**	**Developmental Milestone coding selection**	**Developmental Age Range**
Behavioral Health: Cognitive Performance-Comprehension	"By others, client is" / "By client, others are"	Child under 3	Child under 3
Behavioral Health: MMSE	"Can MMSE be administered?"	= No	Child under 18
Behavioral Health: Memory	"Is there evidence of short term memory loss?"	Child under 12	Child under 12
	"Is there evidence of long term memory loss?"	Child under 12	Child under 12
Behavioral Health: Depression	"Interview"	Unable to obtain	Child under 9
Behavioral Health: Cognitive Performance-Decision Making	"Rate how client makes decision"	Child under 12	Child under 12
Bladder/Bowel:	"Bladder/Bowel Control" is which of the following:		
	Continent Usually Continent Occasionally Incontinent	Age appropriate	Child under 12
	Frequently Incontinent	Age appropriate	Child under 9
	Incontinent all or most of the time	Age appropriate	Child under 6
Bladder/Bowel:	"Appliance and programs"	Potty Training	Child under 4

(8) If you are a child applying for personal care services and your status for ADLs and IADLs is not coded per the developmental age range indicated on the milestones tables under subsection (7) of this section, the department will assess for any informal supports available to assist you with each ADL and IADL. The department will presume that children have legally responsible parents or other responsible adults who provide informal support to them.

(a) The department will code status for an ADL or IADL as met if your assessment shows that your need for assistance with a personal care task is fully met by informal supports.

(b) Informal supports for school-age children include supports actually available through a school district, regardless of whether you take advantage of those available supports.

(c) When you are living with your legally responsible parent(s), the department will presume that you have informal supports available to assist you with your ADLs and IADLs over three-fourths but not all the time. Legally responsible parents include natural parents, stepparents, and adoptive parents. Generally, a legally responsible parent will not be considered unavailable to meet your personal care needs simply due to other obligations such as work or additional children because such obligations do not decrease the parent's legal responsibility to care for you regardless of your disabilities. However, the department will consider factors that cannot reasonably be avoided, and which prevent a legally responsible parent from providing for your personal care needs when determining the amount of informal support available to you. You may rebut the department's presumption by pro-

viding specific information during your assessment to indicate why you do not have informal supports available at least three-fourths of time to assist you with a particular ADL or IADL.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 23-16-085, § 388-106-0130, filed 7/28/23, effective 8/28/23; WSR 21-04-037, § 388-106-0130, filed 1/26/21, effective 3/1/21; WSR 15-20-054, § 388-106-0130, filed 9/30/15, effective 10/31/15; WSR 14-04-097, § 388-106-0130, filed 2/4/14, effective 3/7/14. Statutory Authority: RCW 74.08.090, 74.09.520, and 2010 c 37. WSR 11-11-024, § 388-106-0130, filed 5/10/11, effective 6/10/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 08-23-011, § 388-106-0130, filed 11/6/08, effective 12/7/08; WSR 08-03-111, § 388-106-0130, filed 1/22/08, effective 2/22/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-0130, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0130, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0130, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0135 What is the maximum number of hours of personal care services that I can receive for in-home services? (1) If you are age 21 or older, the maximum number of hours that you may receive is the base hours assigned to your classification group and adjusted per WAC 388-106-0130, unless additional hours are authorized through an exception to rule per WAC 388-440-0001. For chore program clients, the maximum personal care hours per month the department will authorize is one hundred sixteen (116).

(2) If you are under age twenty-one:

(a) The maximum number of hours that you may receive will be the base hours assigned to your classification group and adjusted per WAC 388-106-0130, unless additional hours are authorized under parts (2)(b) or (3) below.

(b) Additional hours may be authorized at the department's discretion through an exception to rule per WAC 388-440-0001. You may request additional hours of personal care services through an exception to rule by contacting your case manager and explaining why you do not believe the authorized hours provide adequate assistance with your personal care tasks. The case manager will document your request and forward the request for review per WAC 388-440-0001. You will be notified in writing of the decision.

(3) If you are under age twenty-one, the department will authorize additional hours of personal care services beyond those authorized under section (2) according to the limitation extension process described below. If the evidence shows that additional personal care assistance is necessary to correct, improve, or prevent further deterioration of your condition, the department will authorize additional hours in the amount required to fully complete your ADLs or IADLs.

(a) You may request a limitation extension in writing within 90 days after you have received the department's written decision under subsection (2)(b); or if 30 days have passed since you requested an exception to rule under subsection (2)(b) and you have not yet received a written decision from DSHS.

(b) You may submit any evidence to show that additional hours of personal care are necessary. The following evidence should be provided:

(i) An explanation of the hours necessary to complete your ADLs and IADLs;

(ii) Documentation of the supports available to you over the course of a week; and,

(iii) An explanation of why informal supports are unavailable to provide the additional assistance you are requesting. When you are living with your legally responsible parent, the considerations described in WAC 388-106-0130 (8)(d) apply to the determination of availability of informal supports.

(c) If requested by the department, you must also provide additional documentation of your situation. If requested documents are not reasonably available to you without cost and/or if you need assistance from the department to obtain the requested documents, you must provide written permission to the department to obtain the documents on your behalf. Documents that the department may ask for include the following:

(i) Your most recent individualized educational plan (IEP), if you are still in school.

(ii) Treatment plans for clinically recommended treatments relevant to your personal care services, such as active range of motion, passive range of motion, bowel program, etc.

(iii) Documents indicating residential time with your noncustodial parent or the availability of a noncustodial parent to provide assistance, such as parenting plans or child support orders. If those documents do not accurately reflect the supports currently available to you, you may also submit information or documents describing the support actually provided by your noncustodial parent.

(d) The department may also require a further review of your functional ability to perform specific ADLs and IADLs, to be conducted at the department's expense. The review must be completed under WAC 182-551-2110 by a qualified occupational therapist. If a qualified occupational therapist is not available to complete the review, the department will designate another qualified healthcare professional to complete the review.

(e) Upon receiving your request for a limitation extension and any additional supporting information you choose to submit under subsection (3)(b), the department will make a decision according to the timeline below.

(i) The department will make a decision under subsection (3) within 30 days unless additional information is required under subsections (3)(c) and/or (3)(d).

(ii) If additional information is required under subsections (3)(c) and/or (3)(d), the department will notify you of what additional information is required within 30 days of the date the department received your request and supporting information, if any. The department will then make a determination under subsection (3) within 15 days of either of the following, whichever comes first:

(A) The date that the department receives all of the requested information, including a report of any review of your functional ability conducted under subsection (3)(d); or,

(B) The date that you notify the department that you will not be providing any additional information.

(f) Additional hours will not be approved to substitute for the duties of legally responsible adults, replace child care or school, replace recommended equipment available through medicaid, or provide supervision other than task-specific supervision necessary for you to perform an ADL or IADL.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-10-077, § 388-106-0135, filed 5/6/14, effective 6/26/14; WSR 05-11-082, § 388-106-0135, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0136 What if I disagree with the result of the limitation extension decision regarding personal care? (1) In addition to your right to contest the result of your CARE assessment under WAC 388-106-1305, if you are under the age of twenty-one you have the right to an administrative hearing to contest the number of personal care hours authorized pursuant to WAC 388-106-0135(3).

(2) The department will notify you in writing of your right to an administrative hearing under subsection (1) and will provide you with information about how to request a hearing.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-10-077, § 388-106-0136, filed 5/6/14, effective 6/26/14.]

WAC 388-106-0140 What may change the maximum number of hours that I can receive for in-home personal care services? The maximum number of in-home personal care hours you can receive may change:

(1) When you have a change in any of the criteria listed in WAC 388-106-0125 and/or 388-106-0130; or

(2) Because you meet the criteria in WAC 388-440-0001, an exception to rule is approved by the department for in-home personal care hours in excess of the amount determined to be available to you by the CARE tool.

[Statutory Authority: RCW 74.08.090, 74.09.520, chapters 74.39 and 74.39A RCW. WSR 07-01-046, § 388-106-0140, filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0140, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0145 What may change the maximum payment rate that will be paid for residential personal care services provided to me? The maximum payment rate that will be paid for residential personal care services provided to you may change:

(1) When you have a change in any of the criteria listed in WAC 388-106-0115 and/or 388-106-0120; or

(2) Because you meet the criteria in WAC 388-440-0001, an exception to rule is approved by the department for a payment rate for your residential personal care services in excess of the rate determined to be applicable to you by the CARE tool.

[Statutory Authority: RCW 74.08.090, 74.09.520, chapters 74.39 and 74.39A RCW. WSR 07-01-046, § 388-106-0145, filed 12/14/06, effective 1/14/07.]

MEDICAID PERSONAL CARE (MPC)

WAC 388-106-0200 What services may I receive under medicaid personal care (MPC)? You may be eligible to receive only the following services under medicaid personal care (MPC):

(1) Personal care services, as defined in WAC 388-106-0010, in your own home and, as applicable, assistance with personal care tasks while you are out of the home accessing community resources or working.

(2) Personal care services in one of the following residential care facilities:

(a) Adult family homes; or

(b) A licensed assisted living facility that has contracted with the department to provide adult residential care services.

(3) Nursing services, if you are not already receiving this type of service from another resource. A registered nurse may visit you and perform any of the following activities. The frequency and scope of the nursing services is based on your individual need as determined by your CARE assessment and any additional collateral contact information obtained by your case manager:

(a) Nursing assessment/reassessment;

(b) Instruction to you and your providers;

(c) Care coordination and referral to other health care providers;

(d) Skilled treatment, only in the event of an emergency. A skilled treatment is care that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement. In nonemergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, a home health agency or other appropriate resource;

(e) File review; and/or

(f) Evaluation of health-related care needs affecting service planning and delivery.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-15-092, § 388-106-0200, filed 7/18/14, effective 8/18/14. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0200, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0200, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0210 Am I eligible for medicaid personal care (MPC) funded services? You are eligible for MPC-funded services when the department assesses your functional ability and determines that you meet all of the following criteria:

(1) You are certified as noninstitutional categorically needy, as defined in WAC 182-500-0020, or have been determined eligible for Washington apple health alternative benefit plan coverage, as described in WAC 182-505-0250. Categorically needy medical institutional programs described in chapter 182-513 and 182-515 WAC do not meet the criteria for MPC.

(2) You do not require the level of care furnished in a hospital or nursing facility, as defined in WAC 388-106-0355, an intermediate care facility for intellectual disability, as defined in WAC 388-825-3080 and WAC 388-828-4400, an institution providing psychiatric services for individuals under the age of twenty-one, or an institution for mental disease for individuals age sixty-five or over.

(3) You are functionally eligible which means one of the following applies:

(a) You have an unmet or partially met need for assistance with at least three of the following activities of daily living, as defined in WAC 388-106-0010:

For each Activity of Daily Living, the minimum level of assistance required in:		
	Self-Performance, Status or Treatment Need is:	Support Provided is:
Eating	N/A	Setup
Toileting	Supervision	N/A
Bathing	Supervision	N/A
Dressing	Supervision	N/A
Transfer	Supervision	Setup
Bed Mobility	Supervision	Setup
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Supervision	Setup
Medication Management	Assistance Required	N/A
Personal Hygiene	Supervision	N/A
Body care which includes: ■ Application of ointment or lotions; ■ Toenails trimmed; ■ Dry bandage changes; (■ = if you are over eighteen years of age or older) or Passive range of motion treatment (if you are four years of age or older).	Needs or Received/ Needs Need: Coded as "Yes"	N/A

Your need for assistance in any of the activities listed in subsection (a) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.

; or

(b) You have an unmet or partially met need for assistance or the activity did not occur (because you were unable or no provider was available) with at least one or more of the following:

For each Activity of Daily Living, the minimum level of assistance required in		
	Self-Performance, Status or Treatment Need is:	Support Provided is:
Eating	Supervision	One person physical assist
Toileting	Extensive Assistance	One person physical assist
Bathing	Physical Help/ part of bathing	One person physical assist
Dressing	Extensive Assistance	One person physical assist
Transfer	Extensive Assistance	One person physical assist
Bed Mobility and Turning and repositioning	Limited Assistance and Need	One person physical assist
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Extensive Assistance	One person physical assist
Medication Management	Assistance Required Daily	N/A
Personal Hygiene	Extensive Assistance	One person physical assist
Body care which includes: ■ Application of ointment or lotions; ■ Toenails trimmed; ■ Dry bandage changes; (■ = if you are eighteen years of age or older) or Passive range of motion treatment (if you are four years of age or older).	Needs or Received/ Needs Need: Coded as "Yes"	N/A

Your need for assistance in any of the activities listed in subsection (b) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose determining your functional eligibility.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-11-049, § 388-106-0210, filed 5/15/15, effective 7/1/15; WSR 15-03-038, § 388-106-0210, filed 1/12/15, effective 2/12/15; WSR 12-14-064, § 388-106-0210, filed 6/29/12, effective 7/30/12; WSR 05-11-082, § 388-106-0210, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0215 When do MPC services start? Your eligibility for MPC begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0215, filed 2/6/06, effective 3/9/06.]

WAC 388-106-0220 How do I remain eligible for MPC? (1) In order to remain eligible for MPC, you must be in need of services in accordance with WAC 388-106-0210 as determined through a CARE assessment. The assessment in CARE must be at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for MPC change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your MPC services.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0220, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0225 How do I pay for medicaid personal care? You pay for medicaid personal care (MPC) as follows:

(1) If you live in your own home, you do not share in the cost of your personal care services.

(2) If you live in a residential facility, you:

(a) Keep a personal needs allowance as described in WAC 182-513-1105;

(b) Pay for room and board as described in WAC 182-513-1105; and

(c) May be required to share in the cost of your personal care under WAC 182-513-1205.

(3) The department pays the residential care facility from the first day of service through the:

(a) Last day of service when the medicaid resident dies in the facility; or

(b) Day of service before the day the medicaid resident is discharged.

[Statutory Authority: RCW 74.08.090. WSR 18-01-049, § 388-106-0225, filed 12/12/17, effective 1/12/18. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-11-049, § 388-106-0225, filed 5/15/15, effective 7/1/15; WSR 14-15-092, § 388-106-0225, filed 7/18/14, effective 8/18/14. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530 and Washington state 2007-09 operating budget (SHB 1128). WSR 08-22-052, § 388-106-0225, filed 11/3/08, effective 12/4/08. Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. WSR 08-11-047, § 388-106-0225, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.08.090, 74.09.520 and 2007-09 operating budget (SHB 1128). WSR 07-21-020, § 388-106-0225, filed 10/8/07, effective 11/8/07. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0225, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0230 Can I be employed and receive MPC? You can be employed and receive MPC services if you remain medicaid eligible under the noninstitutional categorically needy program.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0230, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0235 Are there waiting lists for MPC? There are no waiting lists for MPC. Instead of waiting lists, the department may revise rules to reduce caseload size, hours, rates, or payments in order to stay within the legislative appropriation.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0235, filed 5/17/05, effective 6/17/05.]

ROADS TO COMMUNITY LIVING

WAC 388-106-0250 What is the roads to community living (RCL) demonstration project and who is eligible? (1) Roads to community living (RCL) is a demonstration project, funded by a "money follows the person" grant originally authorized under section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171) and extended through the Patient Affordable Care Act (P.L. 111-148). It is designed to test services and supports which help customers move from institutional settings into the community if they wish to.

(2) To be eligible, the department must assess your needs in CARE per chapter 388-106 or 388-845 WAC and you must:

(a) Have a continuous stay of at least sixty days in a qualified institutional setting (hospital, nursing home, residential habilitation center);

(i) Any days you were solely receiving medicare-paid, short term rehabilitation services are excluded from the sixty days.

(ii) If you are discharging from a state psychiatric hospital and meet the length of stay criteria, you must be under age twenty-two, or age sixty-five and older.

(b) Have received at least one day of medicaid-paid inpatient services immediately prior to discharge from the institutional setting;

(c) Intend to move to a home and community based setting (home, apartment, licensed residential setting); and

(d) On the day of discharge, you must be functionally and financially eligible for, but are not required to receive, medicaid waiver or state plan services.

[Statutory Authority: RCW 74.08.090, 74.09.520; Affordable Care Act (ACA), Deficit Reduction Act of 2005 (P.L. 209-171), and Consolidate[d] Appropriations Act of 2021 (Section 204) and 2018 c 278. WSR 21-19-013, § 388-106-0250, filed 9/3/21, effective 10/4/21. Statutory Authority: RCW 74.08.090, 74.09.520, and Affordable Care Act (ACA). WSR 14-01-112, § 388-106-0250, filed 12/18/13, effective 1/18/14. Statutory Authority: RCW 74.08.090, 74.09.520, and Deficit Reduction Act of 2005 (P.L. 109-171). WSR 08-18-046, § 388-106-0250, filed 8/29/08, effective 9/29/08.]

WAC 388-106-0255 What services may I receive under RCL? Following eligibility and case management criteria outlined in chapters 388-106 or 388-845 WAC:

(1) The state plan or medicaid waiver services for which you would otherwise be eligible;

(2) You may receive additional RCL demonstration services; and

(3) When you are discharged to a qualified community setting, you are eligible for continuous medicaid coverage until your RCL services end.

[Statutory Authority: RCW 74.08.090, 74.09.520, and Affordable Care Act (ACA). WSR 14-01-112, § 388-106-0255, filed 12/18/13, effective 1/18/14. Statutory Authority: RCW 74.08.090, 74.09.520, and Deficit Reduction Act of 2005 (P.L. 109-171). WSR 08-18-046, § 388-106-0255, filed 8/29/08, effective 9/29/08.]

WAC 388-106-0256 When do RCL services start? (1) RCL services to prepare for your discharge may begin while you are in the institution.

(2) After discharge, roads to community living (RCL) can be authorized for no longer than three hundred sixty-five days in a qualified community setting. Day one of the demonstration year is the day you move from the institutional setting into the qualified community setting. Day three hundred sixty-five is the last day you can receive demonstration services.

[Statutory Authority: RCW 74.08.090, 74.09.520, and Affordable Care Act (ACA). WSR 14-01-112, § 388-106-0256, filed 12/18/13, effective 1/18/14.]

WAC 388-106-0257 How do I remain eligible for RCL? You remain eligible for RCL until any of the following occur:

(1) Reach the end of your demonstration year;

(2) Return to an institution for longer than 30 days (you can re-enroll later);

(3) Move out of state; or

(4) No longer want the service.

[Statutory Authority: RCW 74.08.090, 74.09.520, and Affordable Care Act (ACA). WSR 14-01-112, § 388-106-0257, filed 12/18/13, effective 1/18/14.]

WAC 388-106-0260 How do I pay for RCL services? Depending on your income and resources, you may be required to participate toward the cost of the services you receive under RCL, including personal care and demonstration services, as outlined in chapters 388-515 or 388-106 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.520, and Affordable Care Act (ACA). WSR 14-01-112, § 388-106-0260, filed 12/18/13, effective 1/18/14. Statutory Authority: RCW 74.08.090, 74.09.520, and Deficit Reduction Act of 2005 (P.L. 109-171). WSR 08-18-046, § 388-106-0260, filed 8/29/08, effective 9/29/08.]

WAC 388-106-0261 How does the department determine the number of hours or the payment rate for my personal care in RCL? (1) The number of personal care hours you receive is determined by the CARE assessment as outlined in chapter 388-106 WAC.

(2) The payment rate structure for residential personal care received in a residential facility is outlined in chapter 388-106 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.520, and Affordable Care Act (ACA). WSR 14-01-112, § 388-106-0261, filed 12/18/13, effective 1/18/14.]

WAC 388-106-0262 What may change the number of hours or payment rate for my personal care in RCL? The maximum number of in-home personal care hours or payment rate you can receive may change:

(1) When you have a change in any of the criteria listed in WAC 388-106-0125, 388-106-0115, 388-106-0120 and/or 388-106-0130; or

(2) Because you meet the criteria in WAC 388-440-0001, an exception to rule is approved by the department.

[Statutory Authority: RCW 74.08.090, 74.09.520, and Affordable Care Act (ACA). WSR 14-01-112, § 388-106-0262, filed 12/18/13, effective 1/18/14.]

WAC 388-106-0265 Do I have the right to an administrative hearing while receiving RCL services? Yes, you may request an administrative hearing based on the rules outlined in WAC 388-106-1305 to contest eligibility decisions made by the department. Once your three hundred sixty-five days of roads to community living (RCL) eligibility end, per WAC 388-106-0256, you may not request an administrative hearing to contest the conclusion of RCL services or to request an extension.

[Statutory Authority: RCW 74.08.090, 74.09.520, and Affordable Care Act (ACA). WSR 14-01-112, § 388-106-0265, filed 12/18/13, effective 1/18/14. Statutory Authority: RCW 74.08.090, 74.09.520, and Deficit Reduction Act of 2005 (P.L. 109-171). WSR 08-18-046, § 388-106-0265, filed 8/29/08, effective 9/29/08.]

COMMUNITY FIRST CHOICE

WAC 388-106-0270 What services are available under community first choice (CFC)? The services you may receive under the community first choice program include:

(1) Personal care services as defined in WAC 388-106-0010.

(2) Relief care, which is personal care services by a second individual or agency provider as a back-up to your primary paid personal care provider.

(3) Skills acquisition training, which is training that allows you to acquire, maintain, and enhance skills necessary to accomplish ADLs, IADLs, or health related tasks more independently. 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.

(4) Personal emergency response systems (PERS), which are basic electronic devices that enable you to secure help in an emergency when:

(a) You live alone in your own home;

(b) You are alone in your own home for significant parts of the day and have no provider for extended periods of time; or

(c) No one in your home, including you, is able to secure help in an emergency.

(5) Assistive technology, including assistive equipment, which are adaptive and assistive items that increase your independence or substitute for human assistance specifically with ADLs, IADLs, or health related tasks, including but not limited to:

(a) PERS add-on services, such as fall detection, GPS, or medication reminder systems;

(b) Department approved devices that are not excluded by WAC 388-106-0274, including but not limited to:

(i) Adaptive utensils to assist with activities such as eating, dressing, and writing;

(ii) Communication applications/software or devices;

(iii) Visual alert systems;

(iv) Voice activated systems;

(v) Switches and eyegazes; and

(vi) Timers or electronic devices that monitor or sense movement and react in a prescribed manner such as turning on or off an appliance;

(c) Repair or replacing items as limited by WAC 388-106-0274; and

(d) Training of participants and caregivers on the maintenance or upkeep of equipment purchased under assistive technology.

(6) Nurse delegation services as defined in WAC 246-840-910 through 246-840-970.

(7) Nursing services when you are not already receiving nursing services from another source. A registered nurse may visit you and perform any of the following activities:

(a) Nursing assessment/reassessment;

(b) Instruction to you and your providers;

(c) Care coordination and referral to other health care providers;

(d) Skilled treatment, which is care that requires authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, including but not limited to medication administration or wound care such as debridement; nursing services will only provide skilled treatment in the event of an emergency and in nonemergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, home health agency, or other appropriate resource;

(e) File review; and

(f) Evaluation of health-related care needs that affect service plan and delivery.

(8) Community transition services, which are nonrecurring, setup items or services to assist you with discharge from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with intellectual disabilities, when these items or services are necessary for you to set up your own home, including but not limited to:

(a) Security deposits that are required to lease an apartment or home, including first month's rent;

(b) Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bath and linen supplies;

(c) Setup fees or deposits for utilities, 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; and

(f) Activities to assess need, arrange for, and procure necessary resources.

(9) Caregiver management training on how to select, manage, and dismiss personal care providers.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400, and 42 C.F.R. 441.500-590. WSR 23-12-082, § 388-106-0270, filed 6/6/23, effective 7/7/23. Statutory Authority: RCW 74.08.090. WSR 17-03-127, § 388-106-0270, filed 1/18/17, effective 2/18/17. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0270, filed 1/22/16, effective 2/22/16.]

WAC 388-106-0271 Are there limits to the skills acquisition training I may receive? Skills acquisition training:

(1) Shall not replace any training or therapy otherwise provided under medicaid, medicare, or any private insurance;

(2) Does not include therapy or nursing services that must be performed by a licensed therapist or nurse, but may be used to complement therapy or nursing goals coordinated through the care plan;

(3) For children, must be related to the child's disability and will not be provided for tasks that are determined to be age appropriate as described in WAC 388-106-0130(7); and

(4) In combination with assistive technology purchases, is limited to a yearly amount determined by the department per fiscal year.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0271, filed 1/22/16, effective 2/22/16.]

WAC 388-106-0272 Who are qualified providers for skills acquisition training? (1) Long term care workers, who must only provide skills acquisition training on IADLs and the following ADL tasks: dressing, application of deodorant, washing hands and face, hair washing, hair combing and styling, application of make-up, menses care, shaving with an electric razor, tooth brushing or denture care, and bathing tasks excluding any transfers in or out of the bathing area; and

(2) Contracted home health agencies, which may provide skills acquisition training on ADLs, IADLs or health related tasks that are within the profession's scope of practice.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0272, filed 1/22/16, effective 2/22/16.]

WAC 388-106-0273 May I receive additional personal emergency response services? Under the assistive technology benefit, you may be eligible to receive:

(1) A fall detection system, if:

(a) You are eligible for a standard PERS unit; and

(b) You have a recent documented history of falls.

(2) A global positioning system (GPS) tracking device with locator capabilities if:

(a) You have a recent documented history of short-term memory loss; and a recent documented history of wandering with exit seeking behavior; or

(b) A recent documented history of getting lost in a familiar surrounding and being unaware of the need or unable to ask for assistance; and

(c) In addition, if you are under the age of 12, there must be information presented at your assessment that due to your disability the support you are provided for memory or decision making is greater than is typical for a person of your age.

(3) A medication reminder if:

(a) You are eligible for a standard PERS unit;

(b) You do not have a caregiver available to provide the service; and

(c) You are able to use the reminder to take your medications.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0273, filed 1/22/16, effective 2/22/16.]

WAC 388-106-0274 Are there limits to the assistive technology I may receive? (1) There are limits to the assistive technology you may receive. Assistive technology excludes:

(a) Any purchase solely for recreational purposes;

(b) Items of general utility, meaning they are used by people in the absence of illness, injury, or disability, such as a wood splitter, facial wipes, menstrual supplies, or a slow cooker;

(c) Subscriptions and data plan charges;

(d) Educational software, game applications, or gift cards for educational/game applications;

(e) Medical supplies and medical equipment, items available as specialized equipment and supplies, or durable medical equipment;

(f) Specialized clothing or slip-on shoes that are for convenience and not adaptive in nature;

(g) Exercise equipment;

(h) Home/environmental modifications;

(i) Medically necessary items, including but not limited to compression socks/stockings, orthotics, hearing aids, and eyeglasses; and

(j) Any item that would otherwise be covered under any other payment source, including but not limited to medicare, medicaid, private insurance, or another resource.

(2) In combination with skills acquisition training, assistive technology purchases are limited to a yearly amount determined by the department per fiscal year.

(3) To help decide whether to authorize assistive technology the department may require a treating professional's written recommendation regarding the need for an assistive technology evaluation. The treating professional who makes this recommendation must:

(a) Have personal knowledge of and experience with the requested assistive technology that is in alignment with their profession; and

(b) Have evaluated you, reviewed your medical records, have knowledge of your level of functioning, and your ability to use the requested assistive technology or device.

(4) Your choice of assistive technology is limited to the most cost effective option that meets your health and welfare needs.

(5) Replacement of an assistive technology item or piece of equipment is limited to once every two years.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400, and 42 C.F.R. 441.500-590. WSR 25-21-065, s 388-106-0274, filed 10/13/25, effective 11/13/25. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400, and 42 C.F.R. 441.500-590. WSR 23-12-082, § 388-106-0274, filed 6/6/23, effective 7/7/23. Statutory Authority: RCW 74.08.090. WSR 17-03-127, § 388-106-0274, filed 1/18/17, effective 2/18/17. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0274, filed 1/22/16, effective 2/22/16.]

WAC 388-106-0275 Are there limits to the community transition services I may receive? Community transition services:

(1) Do not include recreational or diverting items, such as a television, cable or VCR;

(2) Do not include room and board;

(3) Do not include residential unit furnishings, as outlined in WAC 388-78A-3011 for assisted living facilities and WAC 388-76-10685 for adult family homes;

(4) Do not include items that would otherwise be covered under other payment sources, including but not limited to, medicare, medicaid, and private insurance; and

(5) May not exceed twenty-five hundred dollars per discharge for items and services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400; and 42 C.F.R. § 441.500-590. WSR 21-20-036, § 388-106-0275, filed 9/27/21, effective 10/28/21; WSR 16-04-020, § 388-106-0275, filed 1/22/16, effective 2/22/16.]

WAC 388-106-0276 Where can I receive CFC services? You may receive CFC services;

(1) In your own home; or

(2) In a residential facility, which include licensed and contracted:

(a) Adult family homes, as defined in RCW 70.128.010; or

(b) Assisted living facilities as defined in RCW 18.20.020.

(3) As applicable, while you are out of the home accessing the community or working.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0276, filed 1/22/16, effective 2/22/16.]

WAC 388-106-0277 Am I eligible for CFC services? You are eligible for CFC services if you meet the following criteria:

(1) Your CARE assessment shows you need the level of care provided in a hospital, nursing facility, intermediate care facility for the intellectually disabled (ICF/ID), institution providing psychiatric services for individuals under age twenty-one, or an institution for mental diseases for individuals age sixty-five or over (or will likely need the level of care within thirty days unless CFC services are provided); and

(2) You are eligible for a categorically needy (CN) or the alternative benefit plan (ABP) Washington apple health program. Financial eligibility rules for CFC are described in WAC 182-513-1210 through WAC 182-513-1220; or

(3) If you are not financially eligible for a non-institutional CN or ABP program, but are financially eligible for a home and community based waiver, you are eligible for CFC as long as you continue to receive at least one monthly waiver service.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0277, filed 1/22/16, effective 2/22/16.]

WAC 388-106-0280 When do CFC services begin? Your services begin on the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0280, filed 1/22/16, effective 2/22/16.]

WAC 388-106-0283 How do I remain eligible for CFC services? (1) In order to remain eligible for CFC, you must remain financially eligible and be in need of services in accordance with WAC 388-106-0310 as determined through a CARE assessment. The assessment in CARE must be completed at least annually or more often when there are significant changes in your functional or financial circumstances; or

(2) If you receive services through DDA, you must remain financially eligible and eligible for ICF/ID or nursing facility level of care as described in WAC 388-828-4400, 388-828-3080 and 388-106-0355.

(3) When your eligibility is dependent on your eligibility for a home and community based waiver, you must receive at least one waiver service every month. If you do not receive a waiver service for more than thirty calendar days, you will no longer be eligible for CFC and the department will terminate your CFC services.

(4) If eligibility laws, regulations, or rules for CFC change, and if you do not meet the changed eligibility requirements, the department will terminate your CFC services, even if your functional or financial circumstances have not changed.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0283, filed 1/22/16, effective 2/22/16.]

WAC 388-106-0285 What do I pay for if I receive CFC services? (1) If you are receiving services through CFC only, you may be re-

quired to pay toward the cost of your care as outlined in WAC 182-513-1215. If you are receiving services in:

(a) Your own home, you will not have to pay toward the cost of your care.

(b) A residential facility, you must pay for your room and board. You are allowed to keep some of your income for personal needs allowance (PNA). Depending on your financial eligibility group and income, you may also be responsible to pay an additional amount towards the cost of your care.

(2) If you are receiving services through CFC and a home and community based waiver, you may be required to pay toward the cost of your care as outlined in WAC 182-515-1509. If you are receiving services in:

(a) Your own home, you are allowed to keep some of your income for a maintenance allowance.

(b) If you are living in a residential facility, you must pay for your room and board and may have to pay an additional amount towards the cost of services. You are allowed to keep some of your income for PNA.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0285, filed 1/22/16, effective 2/22/16.]

WAC 388-106-0290 What does the department pay towards the cost of care when you are receiving CFC services and live in a residential facility? When you receive CFC services and live in a residential facility, the department pays the facility the difference between what you are required to pay the facility and the department-set rate for the facility. The department pays the residential facility from the first day of service through the:

(1) The day before your discharge date; or

(2) The last day of service if you die while living at the facility.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0290, filed 1/22/16, effective 2/22/16.]

WAC 388-106-0295 May I be employed and receive CFC services? You may be employed and continue to receive CFC services as long as you remain medicaid eligible under the categorically needy (CN) or alternative benefit plan (ABP) program.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.400 and 42 C.F.R. § 441.500-590. WSR 16-04-020, § 388-106-0295, filed 1/22/16, effective 2/22/16.]

COMMUNITY OPTIONS PROGRAM ENTRY SYSTEM (COPES)

WAC 388-106-0300 What services may I receive under community options program entry system (COPES) when I live in my own home? When

you live in your own home, you may be eligible to receive the following services under COPES:

(1) Adult day care if you meet the eligibility requirements under WAC 388-106-0805;

(2) Environmental modifications, if the minor physical adaptations to your home:

(a) Are necessary to ensure your health, welfare, and safety;

(b) Enable you to function with greater independence in the home;

(c) Directly benefit you medically or remedially;

(d) Meet applicable state or local codes; and

(e) Are not adaptations or improvements, which are of general utility or add to the total square footage;

(3) Home delivered meals which provide one nutritionally balanced meal per day if:

(a) You are homebound and live in your own home;

(b) You are unable to prepare the meal;

(c) You don't have a caregiver (paid or unpaid) available to prepare this meal; and

(d) Receiving this meal is more cost-effective than having a paid caregiver;

(4) Community choice guiding are services to help you establish or stabilize your living arrangement in your own home if:

(a) You have frequent institutional contacts;

(b) You have frequent turn-over of caregivers; or

(c) You are in imminent jeopardy of eviction or loss of your current community setting;

(5) Skilled nursing, if the service is:

(a) Provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse; and

(b) Beyond the amount, duration, or scope of medicaid-reimbursed home health services as provided under WAC 182-551-2100;

(6) Specialized medical equipment and supplies under WAC 182-543-1000, if the items:

(a) Are necessary for:

(i) Life support;

(ii) To increase your ability to perform activities of daily living; or

(iii) To perceive, control, or communicate with the environment in which you live; or

(b) Are directly remedially beneficial to you; and

(c) Do not replace any medical equipment or supplies otherwise provided under either medicaid or medicare;

(7) Training needs identified in the CARE assessment which meet a therapeutic goal such as:

(a) Adjusting to a serious impairment;

(b) Managing personal care needs; or

(c) Developing necessary skills to deal with care providers;

(8) Transportation services, when the service:

(a) Provides access to community services and resources to meet a therapeutic goal;

(b) Is not diverting in nature; and

(c) Does not replace the medicaid-brokered transportation or transportation services available in the community;

(9) Nursing services from a registered nurse based on your individual need as determined by your CARE assessment, when you are not already receiving this type of service from another resource, which may include any of the following activities:

(a) Nursing assessment/reassessment;

(b) Instruction to you and your providers;

(c) Care coordination and referral to other health care providers;

(d) Skilled treatment, in the event of an emergency, which requires authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement;

(e) File review; or

(f) Evaluation of health-related care needs affecting service plan and delivery;

(10) Adult day health services as described in WAC 388-71-0706 when you are:

(a) Assessed as having an unmet need for skilled nursing under WAC 388-71-0712 or skilled rehabilitative therapy under WAC 388-71-0714 and:

(i) There is a reasonable expectation that these services will improve, restore, or maintain your health status, or in the case of a progressive disabling condition, will either restore or slow the decline of your health and functional status or ease related pain or suffering;

(ii) You are at risk for deteriorating health, deteriorating functional ability, or institutionalization; and

(iii) You have a chronic or acute health condition that you are not able to safely manage due to a cognitive, physical, or other functional impairment;

(b) Assessed as having needs for personal care or other core services, whether or not those needs are otherwise met; however

(c) You are not eligible for adult day health if you:

(i) Can independently perform or obtain the services provided at an adult day health center; or

(ii) Have referred care needs that:

(A) Exceed the scope of authorized services that the adult day health center is able to provide;

(B) Do not need to be provided or supervised by a licensed nurse or therapist;

(C) Can be met in a less structured care setting;

(D) In the case of skilled care needs, are being met by paid or unpaid caregivers;

(E) Live in a nursing home or other institutional facility; or

(F) Are not capable of participating safely in a group care setting;

(11) Wellness education, as identified in your person centered service plan to address an assessed need or condition; and

(12) Community support: Goods and services are nonrecurring set-up items and services to assist with expenses if you choose to move from a residential setting 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; and

(f) Necessary home accessibility adaptations.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 19-15-029, § 388-106-0300, filed 7/10/19, effective 8/10/19; WSR 15-11-049, § 388-106-0300, filed 5/15/15, effective 7/1/15; WSR 15-03-038, § 388-106-0300, filed 1/12/15, effective 2/12/15. Statutory Authority: RCW 74.08.090, 74.09.520, and 2012 2nd sp.s. c 7. WSR 12-15-087, § 388-106-0300, filed 7/18/12, effective 8/18/12. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 07-24-026, § 388-106-0300, filed 11/28/07, effective 1/1/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0300, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0300, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0305 What services may I receive under COPES if I live in a residential facility? If you live in one of the following residential facilities: A licensed assisted living facility contracted with the department to provide assisted living, enhanced adult residential care, enhanced adult residential care-specialized dementia care, or an adult family home, you may be eligible to receive only the following services under COPES:

(1) Specialized medical equipment and supplies under WAC 182-543-1000, when the items:

(a) Are necessary for:

(i) Life support;

(ii) To increase your ability to perform activities of daily living; or

(iii) To perceive, control, or communicate with the environment in which you live; or

(b) Are directly remedially beneficial to you;

(c) Do not replace any medical equipment or supplies otherwise provided under either medicaid or medicare; and

(d) Do not replace the services required by the department's contract with a residential facility;

(2) Training needs identified in the CARE assessment that are in addition to and do not replace the services required by the department's contract with the residential facility and that meet a therapeutic goal such as:

(a) Adjusting to a serious impairment;

(b) Managing personal care needs; or

(c) Developing necessary skills to deal with care providers;

(3) Transportation services, when the service:

(a) Provides access to community services and resources to meet a therapeutic goal;

(b) Is not diverting in nature;

(c) Does not replace the medicaid-brokered transportation or transportation services available in the community; and

(d) Does not replace the services required by DSHS contract in residential facilities;

(4) Skilled nursing, when the service is:

(a) Provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse;

(b) Beyond the amount, duration or scope of medicaid-reimbursed home health services as provided under WAC 182-551-2100; and

(c) In addition to and does not replace the services required by the department's contract with the residential facility (e.g. intermittent nursing services as described in WAC 388-78A-2310);

(5) Nursing services from a registered nurse based on your individual need as determined by your CARE assessment, when you are not already receiving this type of service from another resource, which may include any of the following activities:

(a) Nursing assessment/reassessment;

(b) Instruction to you and your providers;

(c) Care coordination and referral to other health care providers;

(d) Skilled treatment in the event of an emergency, which requires authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement;

(e) File review; or

(f) Evaluation of health-related care needs affecting service plan and delivery.

(6) Adult day health services as described in WAC 388-71-0706 when you are:

(a) Assessed as having an unmet need for skilled nursing under WAC 388-71-0712 or skilled rehabilitative therapy under WAC 388-71-0714, and:

(i) There is a reasonable expectation that these services will improve, restore or maintain your health status, or in the case of a progressive disabling condition, will either restore or slow the decline of your health and functional status or ease related pain or suffering;

(ii) You are at risk for deteriorating health, deteriorating functional ability, or institutionalization; and

(iii) You have a chronic or acute health condition that you are not able to safely manage due to a cognitive, physical, or other functional impairment;

(b) Assessed as having needs for personal care or other core services, whether or not those needs are otherwise met; however

(c) You are not eligible for adult day health if you:

(i) Can independently perform or obtain the services provided at an adult day health center;

(ii) Have referred care needs that:

(A) Exceed the scope of authorized services that the adult day health center is able to provide;

(B) Do not need to be provided or supervised by a licensed nurse or therapist;

(C) Can be met in a less structured care setting;

(D) In the case of skilled care needs, are being met by paid or unpaid caregivers;

(E) Live in a nursing home or other institutional facility; or

(F) Are not capable of participating safely in a group care setting;

(7) Wellness education, as identified in your person centered service plan to address an assessed need or condition;

(8) Community choice guiding are services to help you establish or stabilize your living arrangement in your own home or a residential setting if:

(a) You have frequent institutional contacts;

(b) You have frequent turn-over of caregivers; or

(c) You are in imminent jeopardy of eviction or loss of your current community setting; and

(9) Community support: Goods and services are nonrecurring set-up items and services to assist with expenses if you choose to move from a residential setting 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; and

(f) Necessary home accessibility adaptations.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 19-15-029, § 388-106-0305, filed 7/10/19, effective 8/10/19; WSR 15-11-049, § 388-106-0305, filed 5/15/15, effective 7/1/15; WSR 14-15-092, § 388-106-0305, filed 7/18/14, effective 8/18/14. Statutory Authority: RCW 74.08.090, 74.09.520, and 2012 2nd sp.s. c 7. WSR 12-15-087, § 388-106-0305, filed 7/18/12, effective 8/18/12. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0305, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0305, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0310 Am I eligible for COPES-funded services? You are eligible for COPES-funded services if you meet all of the following criteria. The department must assess your needs in CARE and determine that:

(1) You are age:

(a) Eighteen or older and blind or have a disability, as defined in WAC 182-512-0050; or

(b) Sixty-five or older.

(2) You meet financial eligibility requirements. This means the department will assess your finances and determine if your income and resources fall within the limits set in WAC 182-515-1505, community options program entry system (COPES).

(3) Your CARE assessment shows you need and are eligible for:

(a) The level of care provided in a nursing facility (or will likely need the level of care within thirty days unless COPES services are provided) which is defined in WAC 388-106-0355(1); and

(b) A COPES waiver service.

(5) You continue to receive at least one monthly waiver service.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-11-049, § 388-106-0310, filed 5/15/15, effective 7/1/15; WSR 12-16-026, § 388-106-0310, filed 7/25/12, effective 8/25/12. Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. WSR 08-11-047, § 388-106-0310, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0310, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0315 When do COPES services start? Your eligibility for COPES begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0315, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0320 How do I remain eligible for COPES? (1) In order to remain eligible for COPES, you must be in need of services in accordance with WAC 388-106-0310 as determined through a CARE assessment. The assessment in CARE must be at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for COPES change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your COPES services.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0320, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0325 How do I pay for COPES services? Depending on your income and resources, you may be required to pay participation toward the cost of your care, as outlined in WAC 182-515-1505. If you have nonexempt income that exceeds the cost of COPES services, you may retain the difference. If you are receiving services in:

(1) Your own home, you are allowed to keep some of your income for a maintenance allowance.

(2) In a residential facility, you must use your income to pay for your room and board and services. You are allowed to keep some of your income for personal needs allowance (PNA). The department determines the amount of PNA that you may keep. The department pays the facility for the difference between what you pay and the department-set rate for the facility. The department pays the residential care facility from the first day of service through the:

(a) Last day of service when the medicaid resident dies in the facility; or

(b) Day of service before the day the medicaid resident is discharged.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-0325, filed 1/12/15, effective 2/12/15; WSR 05-11-082, § 388-106-0325, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0330 Can I be employed and receive COPES? You can be employed and receive COPES, per WAC 182-515-1505.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-0330, filed 1/12/15, effective 2/12/15; WSR 05-11-082, § 388-106-0330, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0335 Are there waiting lists for COPES? The department will create a waiting list in accordance with caseload limits de-

termined by legislative funding. Wait listed clients will gain access in the following manner:

(1) Nursing home residents wanting COPES waiver services will be ranked first on the waitlist by date of application for services;

(2) Then clients living in the community with a higher level of need, as determined by the CARE assessment, will be ranked higher on the waitlist over clients with a lower level of need; and

(3) When two or more clients in the community have equal need levels, the client with the earlier application for services will have priority over later applications for services.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0335, filed 5/17/05, effective 6/17/05.]

RESIDENTIAL SUPPORT

WAC 388-106-0336 What services may I receive under the residential support waiver? You may receive the following services under the residential support waiver:

(1) Adult family homes and assisted living facilities with an expanded community services contract that will provide:

(a) Personal care;

(b) 24-hour on-site support and response staff;

(c) The development and implementation of an individualized behavior support plan to prevent and respond to crises;

(d) Medication management; and

(e) Coordination and collaboration with a contracted behavior support provider;

(2) Adult family homes with a specialized behavior support contract that will provide:

(a) Personal care;

(b) 24-hour on-site support and response staff;

(c) The development and implementation of an individualized behavior support plan to prevent and respond to crises;

(d) Medication management;

(e) Coordination and collaboration with a contracted behavior support provider; and

(f) Specialized behavior support that provides you with six to eight hours a day of individualized staff time;

(3) Assisted living facilities with a community stability support contract that will provide:

(a) Personal care;

(b) 24-hour on-site support and response staff;

(c) The development and implementation of an individualized behavior support plan to prevent and respond to crises;

(d) Medication management; and

(e) On-site staffing ratios and professional staffing as described in the contract;

(4) Enhanced services facilities that will provide:

(a) Personal care;

(b) 24-hour on-site support and response staff;

(c) The development and implementation of an individualized behavior support plan to prevent and respond to crises;

(d) Medication management; and

(e) On-site staffing ratios and professional staffing as described in WAC 388-107-0230 through 388-107-0270;

(5) Specialized durable and nondurable medical equipment and supplies under WAC 182-543-1000 when:

(a) Medically necessary under WAC 182-500-0005;

(b) Necessary:

(i) For life support;

(ii) To increase your ability to perform activities of daily living; or

(iii) To perceive, control, or communicate with the environment in which you live;

(c) Directly medically or remedially beneficial to you;

(d) They are additional and do not replace any medical equipment or supplies otherwise provided under either medicaid, medicare, or both; and

(e) In addition to and do not replace the services required by the department's contract with a residential facility;

(6) Client support training to address your needs identified in your CARE assessment or other professional evaluation that are additional and do not replace the services required by the department's contract with the residential facility and meet a therapeutic goal, such as:

(a) Adjusting to a serious impairment;

(b) Managing personal care needs; or

(c) Developing necessary skills to deal with care providers;

(7) Nurse delegation under RCW 18.79.260 when:

(a) You receive personal care from a registered or certified nursing assistant who has completed nurse delegation core training;

(b) The delegating nurse considers your medical condition stable and predictable;

(c) The services comply with WAC 246-840-930; and

(d) The services are additional and do not replace the services required by the department's contract with the residential facility;

(8) Skilled nursing when:

(a) Provided by a registered nurse or licensed practical nurse under a registered nurse's supervision;

(b) Beyond the amount, duration, or scope of medicaid-reimbursed home health services as provided under WAC 182-551-2100; and

(c) Additional and do not replace the services required by the department's contract with the residential facility;

(9) Nursing services not already received from another resource, based on your individual need as determined by your CARE assessment and any additional collateral contact information obtained by your case manager, including any one or more of the following activities performed by a registered nurse:

(a) Nursing assessment/reassessment;

(b) Instruction to you, your providers, and your caregivers;

(c) Care coordination and referral to other health care providers;

(d) Skilled treatment, only in the event of an emergency as in nonemergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider or other appropriate resource;

(e) File review; or

(f) Evaluation of health-related care needs affecting service plan and delivery;

(10) Adult day health services as described in WAC 388-71-0706 when:

(a) Your CARE assessment shows an unmet need for personal care or other core services, whether or not those needs are otherwise met; and

(b) Your CARE assessment shows an unmet need for skilled nursing under WAC 388-71-0712 or skilled rehabilitative therapy under 388-71-0714 and:

(i) There is a reasonable expectation that the services will improve, restore, or maintain your health status, or in the case of a progressive disabling condition, will either restore or slow the decline of your health and functional status or ease related pain and suffering;

(ii) You are at risk for deteriorating health, deteriorating functional ability, or institutionalization; or

(iii) You have a chronic acute health condition that you are not able to safely manage due to a cognitive, physical, or other functional impairment.

(11) For care plans resulting from an eligibility assessment on or after July 1, 2025, to be eligible to receive the following waiver services you must first be found to not be eligible to receive services through the community behavioral health supports 1915(i) state plan option under chapter 182-561 WAC:

(a) Services provided under a specialized behavior support contract in an adult family home as described in subsection (2) of this section; or

(b) On-site staffing ratios as described in subsections (3)(e) and (4)(e) of this section.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030, and 74.39A.400. WSR 25-15-100, s 388-106-0336, filed 7/16/25, effective 8/16/25. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030, 74.39A.400, 42 C.F.R. § 441.300-310, and 42 C.F.R. § 441.500-590. WSR 24-09-037, § 388-106-0336, filed 4/11/24, effective 5/12/24. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 16-19-055, § 388-106-0336, filed 9/16/16, effective 10/17/16; WSR 15-01-085, § 388-106-0336, filed 12/16/14, effective 1/16/15; WSR 14-15-092, § 388-106-0336, filed 7/18/14, effective 8/18/14.]

WAC 388-106-0337 When are you not eligible for adult day health services? You are not eligible for adult day health if you:

(1) Can independently perform or obtain the services provided in an adult day health center; or

(2) Have referred care needs that:

(a) Exceed the scope of authorized services that the adult day health center is able to provide;

(b) Do not need to be provided or supervised by a licensed nurse or therapist;

(c) Can be met in a less structured care setting;

(d) In the case of skilled care needs, are being met by paid or unpaid providers;

(e) Live in a nursing home or other institutional facility; or

(f) Are not capable of participating safely in a group care setting.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 16-19-055, § 388-106-0337, filed 9/16/16, effective 10/17/16.]

WAC 388-106-0338 Am I eligible for services funded by the residential support waiver? (1) You are eligible for services funded by the residential support waiver if the department, based on its assessment of your needs in CARE, determines you meet all of the following criteria:

(a) You are at least 18 years old and blind or have a disability as defined in WAC 182-512-0050, or are age 65 or older;

(b) Your income and resources fall within the limits set in WAC 182-515-1505 and meet the income and resource criteria for home and community based waiver programs and hospice clients;

(c) Your CARE assessment shows you need the level of care provided in a nursing facility or that you will likely need this level of care within 30 days unless you receive residential support waiver services as defined in WAC 388-106-0355(1);

(d) You have been assessed as medically and psychiatrically stable and one or more of the following applies:

(i) You currently reside at a state mental hospital or the psychiatric unit of a hospital and the hospital has found you are ready for discharge to the community;

(ii) You have a history of frequent or protracted psychiatric hospitalizations; or

(iii) You have a history of an inability to remain medically or behaviorally stable for more than six months and you;

(A) Have exhibited serious challenging behaviors within the last year; or

(B) Have had problems managing your medication which has affected your ability to live in the community;

(e) Because of the protracted nature of your behavior and clinical complexity, you have no other placement options and have found no community placement with a qualified community provider;

(f) You have behavioral or clinical complexity that requires staffing supports available only in the qualified community settings provided through the residential support waiver; and

(g) You require caregiving staff with specific training in providing personal care, supervision, and behavioral supports to adults with challenging behaviors.

(2) You are not eligible to receive a service under the waiver that is similar in scope and nature and available to you through the Washington medicaid state plan, including, but not limited to, services and supports offered under the community behavioral health supports 1915(i) state plan option under chapter 182-561 WAC.

(3) Under this section, "challenging behaviors" means a persistent pattern of behaviors or uncontrolled symptoms of a cognitive or mental condition that inhibit the individual's functioning in public places, the facility, or integration within the community that have been present for long periods of time or have manifested as an acute onset.

(4) Subsection (2) of this section applies to eligibility assessments for care plans starting on or after July 1, 2025.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030, and 74.39A.400. WSR 25-15-100, s 388-106-0338, filed 7/16/25, effective 8/16/25. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 16-19-055, § 388-106-0338, filed 9/16/16, effective 10/17/16; WSR 14-15-092, § 388-106-0338, filed 7/18/14, effective 8/18/14.]

WAC 388-106-0340 When do services from the residential support waiver start? Your eligibility for Residential Support begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-15-092, § 388-106-0340, filed 7/18/14, effective 8/18/14.]

WAC 388-106-0342 How do I remain eligible for residential support waiver services? (1) In order to remain eligible for residential support waiver services, you must be in need of services as determined through a CARE assessment and as determined by the department. Your CARE assessment must show your need for the level of care provided in a nursing facility, as defined in WAC 388-106-0355(1). The assessment in CARE must be completed at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations and/or rules for the residential support waiver change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your Residential Support services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-15-092, § 388-106-0342, filed 7/18/14, effective 8/18/14.]

WAC 388-106-0344 How do I pay for residential support waiver services? Depending on your income and resources, you may be required to pay participation toward the cost of your care, as outlined in WAC 182-515-1505. If you have nonexempt income that exceeds the cost of residential support services, you may retain the difference. If you are receiving services under the residential support waiver you must use your income to pay for your room and board and services. You are allowed to keep some of your income for personal needs allowance (PNA). The department determines the amount of PNA that you may keep. The department pays the facility for the difference between what you pay and the department-set rate for the facility. The department pays the residential care facility from the first day of service through the:

(1) Last day of service when the medicaid resident dies in the facility; or

(2) Day of service before the day the medicaid resident is discharged.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-01-085, § 388-106-0344, filed 12/16/14, effective 1/16/15; WSR 14-15-092, § 388-106-0344, filed 7/18/14, effective 8/18/14.]

WAC 388-106-0346 Can I be employed and receive residential support waiver services? You can be employed and receive residential support services, per WAC 182-515-1505.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-15-092, § 388-106-0346, filed 7/18/14, effective 8/18/14.]

WAC 388-106-0348 Are there waiting lists for the residential support waiver services? The department will create a waiting list in accordance with caseload limits determined by legislative funding. Wait listed clients will gain access in the following manner:

(1) Length of time since the participant requested placement;
(2) Continued functional and financial eligibility;
(3) Geographical preferences; and
(4) Choice of provider, setting, and roommate.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-15-092, § 388-106-0348, filed 7/18/14, effective 8/18/14.]

NURSING FACILITY CARE SERVICES

WAC 388-106-0350 What are nursing facility care services? You may receive care in a nursing facility, as outlined in chapter 388-97 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0350, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0355 Am I eligible for nursing facility care services? You are eligible for nursing facility care if the department:

(1) Assesses you in CARE and determines that you meet the functional criteria for nursing facility level of care which means one of the following applies:

(a) You require care provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis;

(b) You have an unmet or partially met need with at least three of the following activities of daily living, as defined in WAC 388-106-0010:

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	N/A	Setup
Toileting	Supervision	N/A
Bathing	Supervision	N/A
Transfer	Supervision	Setup
Bed Mobility	Supervision	Setup
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Supervision	Setup
Medication Management	Assistance Required	N/A

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Your need for assistance in any activities listed in subsection (b) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose in determining your functional eligibility.		

(c) You have an unmet or partially met need with at least two of the following activities of daily living, as defined in WAC 388-106-0010:

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	Supervision	One person physical assist
Toileting	Extensive Assistance	One person physical assist
Bathing	Limited Assistance	One person physical assist
Transfer	Extensive Assistance	One person physical assist
Bed Mobility and Turning and repositioning	Limited Assistance and Need	One person physical assist
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Extensive Assistance	One person physical assist
Medication Management	Assistance Required Daily	N/A
Your need for assistance in any of the activities listed in subsection (c) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

or:

(d) You have a cognitive impairment and require supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and have an unmet or partially met need with at least one or more of the following:

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	Supervision	One person physical assist

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Toileting	Extensive Assistance	One person physical assist
Bathing	Limited Assistance	One person physical assist
Transfer	Extensive Assistance	One person physical assist
Bed Mobility and Turning and repositioning	Limited Assistance and Need	One person physical assist
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Extensive Assistance	One person physical assist
Medication Management	Assistance Required Daily	N/A
Your need for assistance in any of the activities listed in subsection (d) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

(2) Determines that you meet the financial eligibility requirements set through WAC 182-513-1315.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-0355, filed 1/12/15, effective 2/12/15; WSR 05-11-082, § 388-106-0355, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0360 How do I pay for nursing facility care services? (1) If you are medicaid eligible and the nursing facility admits you without a request for assessment from the department, the nursing facility will not:

(a) Be reimbursed by the department; or

(b) Be allowed to collect payment, including a deposit or minimum stay fee, from you or your family/representative for any care provided before the date of request for assessment.

(2) If you are eligible for medicaid-funding nursing facility care, the department pays for your services beginning on the date:

(a) Of the request for a department assessment; or

(b) Nursing facility care actually begins, whichever is later.

(3) If you become financially eligible for medicaid after you have been admitted, the department pays for your nursing facility care beginning on the date of:

(a) Request for assessment or financial application, whichever is earlier;

(b) Nursing facility placement; or

(c) When you are determined financially eligible, whichever is later.

(4) Exception: Payment back to the request date is limited to three months prior to the month that the financial application is received.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0360, filed 5/17/05, effective 6/17/05.]

CHORE

WAC 388-106-0600 What services may I receive under chore? You may receive personal care services in your own home and, as applicable, assistance with personal care tasks while you are out of the home accessing community resources or working.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0600, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0610 Am I eligible for chore-funded services? To be eligible for chore-funded services you must meet all of the following criteria:

(1) Be grandfathered on the chore program before August 1, 2001 and have continued to receive chore without a break in service.

(2) Not be eligible for MPC or COPES.

(3) Be eighteen years of age or older.

(4) Have an unmet or partially met need with at least one of the following activities of daily living, as defined in WAC 388-106-0010.

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	N/A	Setup
Toileting	Supervision	N/A
Bathing	Supervision	N/A
Dressing	Supervision	N/A
Transfer	Supervision	Setup
Bed Mobility	Supervision	Setup
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Supervision	Setup
Medication Management	Assistance Required	N/A
Personal Hygiene	Supervision	N/A

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Body care which includes: Application of ointment or lotions; Toenails trimmed; Dry bandage changes; or Passive range of motion treatment.	Need	N/A
Your need for assistance in any of the activities listed in this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

(5) Have net household income (as described in WAC 388-450-0005 and 388-450-0040) not exceeding:

(a) The sum of the cost of your chore services; and

(b) One-hundred percent of the federal poverty level (FPL) adjusted for family size.

(6) Have resources, as described in chapter 388-470 WAC, which do not exceed ten thousand dollars for a one-person family or fifteen thousand dollars for a two-person family. (Note: One thousand dollars for each additional family member may be added to these limits.); and

(7) Not transfer assets on or after November 1, 1995 for less than fair market value, as described in WAC 182-513-1365.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-0610, filed 1/12/15, effective 2/12/15; WSR 05-11-082, § 388-106-0610, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0615 When do chore services start? Your eligibility for chore services begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0615, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0620 How do I remain eligible for chore? (1) In order to remain eligible for chore, you must be in need of services in accordance with WAC 388-106-0610 as determined through a CARE assessment. The assessment in CARE must be at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for chore change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your chore services.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0620, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0625 How do I pay for chore? You may retain an amount equal to one hundred percent of the federal poverty level, adjusted for family size, as the home maintenance allowance and pay the difference between the FPL and your nonexempt income. Exempt income includes:

(1) Income listed in WAC 182-513-1340;

(2) Spousal income allocated and actually paid as participation in the cost of the spouse's community options program entry system (COPES) services;

(3) Amounts paid for medical expenses not subject to third party payment;

(4) Health insurance premiums, coinsurance or deductible charges; and

(5) If applicable, those work expense deductions listed in WAC 388-106-0630(2).

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-0625, filed 1/12/15, effective 2/12/15; WSR 05-11-082, § 388-106-0625, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0630 Can I be employed and receive chore? If you are not medicaid eligible due to your earned income and resources and are receiving chore personal care services:

(1) You may be required to pay participation, per WAC 388-106-0625, for any earned income above one hundred percent of the federal poverty level.

(2) The department will exempt fifty percent of your earned income after work expense deductions. Work expense deductions are:

(a) Personal work expenses in the form of self-employment taxes (FICA); and income taxes when paid;

(b) Payroll deductions required by law or as a condition of employment in the amounts actually withheld;

(c) The necessary cost of transportation to and from the place of employment by the most economical means, except rental cars;

(d) Expenses necessary for continued employment such as tools, materials, union dues, transportation to service customers not furnished by the employer; and

(e) Uniforms needed on the job and not suitable for wear away from the job.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0630, filed 5/17/05, effective 6/17/05.]

VOLUNTEER CHORE

WAC 388-106-0650 What is the volunteer services program? The volunteer services program is a state-funded program that provides volunteer assistance to eligible persons who need help to live safely in the community. The availability of services under this program is subject to available funding and volunteer resources. Further, when allocating volunteer services, the needs of persons who have traditionally been served through long-term care services and supports, including older adults, individuals with disabilities or their unpaid caregivers, will be given priority.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-07-074, § 388-106-0650, filed 3/17/15, effective 4/17/15; WSR 05-11-082, § 388-106-0650, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0655 Am I eligible to receive assistance through volunteer services? You may be eligible to receive volunteer services if you are:

(1) An older adult age sixty or older or a person with a disability eighteen years of age or older; or

(2) Living at home, unless you are moving from a residential facility to home and need assistance moving; or

(3) Unable to perform certain independent living tasks due to a functional, mental or cognitive disability;

(4) Financially unable to purchase services privately; or

(5) Not receiving medicaid paid long-term care services under the medicaid state plan or medicaid waiver program unless the volunteer service is not available through the state plan waiver program; or

(6) An unpaid caregiver who provides ongoing care for an older adult or person with a disability, including minors, who meets any of the criteria in WAC 388-106-0655 (2) through (5) above.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-07-074, § 388-106-0655, filed 3/17/15, effective 4/17/15; WSR 15-03-038, § 388-106-0655, filed 1/12/15, effective 2/12/15; WSR 05-11-082, § 388-106-0655, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0660 What types of services may be offered through volunteer services? The types of services an individual may be offered include, but are not limited to:

(1) Housework and laundry;
(2) Shopping and errands;
(3) Meal preparation;
(4) Minor home repair;
(5) Yard work;
(6) Provision of wood for heating;
(7) Pet care;
(8) Auto maintenance;
(9) Moving;
(10) Limited personal care;
(11) Socialization activities to improve quality of life;
(12) Electronic device/computer use;
(13) Clerical and budgeting tasks;
(14) Transportation
(15) Emergency preparation;
(16) Companionship or supervision;
(17) Access to benefits;
(18) Access to employment opportunities; and
(19) Health and nutrition enhancement.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-07-074, § 388-106-0660, filed 3/17/15, effective 4/17/15.]

WAC 388-106-0665 How are volunteers qualified to provide volunteer services? Volunteers are qualified to provide volunteer services through the following mechanisms:

(1) Volunteers who will have unsupervised access to vulnerable adults cannot have any convictions, pending crimes or findings that are listed in WAC 388-103-0001 or provide contracted services per RCW 43.20A.0710 (1)(c) prior to working alone with them.

(2) The volunteer services contractor(s) will provide orientation and ongoing training as needed to volunteers.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 21-11-072, § 388-106-0665, filed 5/17/21, effective 6/17/21; WSR 15-07-074, § 388-106-0665, filed 3/17/15, effective 4/17/15.]

WAC 388-106-0670 When may volunteer services not be available or offered? Volunteer services may not be available or offered when:

(1) Available funding has been exhausted; or

(2) The regional area does not have qualified volunteers available; or

(3) Existing volunteers do not have the skill set needed to perform the task/service desired; or

(4) A volunteer stops providing services at their discretion; or

(5) Providing the service would cause a health or safety risk to the volunteer or staff.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-07-074, § 388-106-0670, filed 3/17/15, effective 4/17/15.]

WAC 388-106-0675 What if I disagree with a decision made by the contracted volunteer services provider(s) related to volunteer services? If you do not agree with a decision made by the volunteer services contractor, you may make a written complaint with the volunteer services program manager at the aging and long term support administration, P.O. Box 45600, Olympia, WA 98504-5600. You are not entitled to a hearing under chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-07-074, § 388-106-0675, filed 3/17/15, effective 4/17/15.]

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

WAC 388-106-0700 What services may I receive under PACE? Under their contract with the department, the PACE provider develops an individualized plan of care, as defined in 42 C.F.R. 460.106, that integrates necessary long-term care, medical services, mental health services, and alcohol and substance abuse treatment services.

(1) The care plan includes, but is not limited to any of the following long-term care services:

(a) Care coordination;

(b) Home and community-based services:

(i) Personal (in-home) care;

(ii) Residential care.

(c) And, if necessary, nursing facility care.

(2) The care plan may also include, but is not limited to, the following medical services:

(a) Primary medical care;

(b) Vision care;

(c) End of life care;

(d) Restorative therapies, including speech, occupational, and physical therapy;

(e) Oxygen therapy;

(f) Audiology (including hearing aids);

(g) Transportation;

(h) Podiatry;

(i) Durable medical equipment (e.g., wheelchair);

(j) Dental care;

(k) Pharmaceutical products;

(l) Immunizations and vaccinations;

(m) Emergency room visits and inpatient hospital stays.

(3) The care plan may also include any other services determined necessary by the interdisciplinary team to improve and maintain your overall health status.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0700, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0705 Am I eligible for PACE services? To qualify for medicaid-funded PACE services, you must apply for an assessment by contacting your local home and community services office. The department will assess and determine whether you:

(1) Are age:

(a) Fifty-five or older, and blind or have a disability, as defined in WAC 182-512-0050, SSI-related eligibility requirements; or

(b) Sixty-five or older.

(2) Need nursing facility level of care as defined in WAC 388-106-0355;

(3) Live within the designated service area of the PACE provider;

(4) Meet financial eligibility requirements. This means the department will assess your finances, determine if your income and resources fall within the limits, and determine the amount you may be required to contribute, if any, toward the cost of your care as described in WAC 182-515-1505;

(5) Not be enrolled in any other medicare or medicaid prepayment plan or optional benefit; and

(6) Agree to receive services exclusively through the PACE provider and the PACE provider's network of contracted providers.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-0705, filed 1/12/15, effective 2/12/15. Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. WSR 08-11-047, § 388-106-0705, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-0705, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0705, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0710 How do I pay for PACE services? Depending on your income and resources, you may be required to pay for part of the

PACE services. The department's financial worker will determine what amount, if any, you must contribute if you decide to enroll. The department pays the PACE provider the remaining amount.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0710, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0715 How do I end my enrollment in the PACE program? (1) You may choose to voluntarily end your enrollment in the PACE program without cause at any time. To do so, you must give the PACE provider written notice. A PACE participant's voluntary disenrollment is effective on the first day of the month following the date the PACE organization receives the participant's notice of voluntary disenrollment.

(2) Your enrollment may also end involuntarily if you:

(a) Move out of the designated service area or are out of the service area for more than thirty consecutive days, unless the PACE provider agrees to a longer absence due to extenuating circumstances;

(b) Engage in disruptive or threatening behavior such that the behavior jeopardizes your health or safety, or the safety of others;

(c) Fail to comply with your plan of care or the terms of the PACE enrollment agreement;

(d) Fail to pay or make arrangements to pay your part of the costs after the thirty-day grace period;

(e) Become financially ineligible for medicaid services, unless you choose to pay privately;

(f) Are enrolled with a provider that loses its license or contract, or both; or

(g) No longer meet the nursing facility level of care requirement as defined in WAC 388-106-0205.

(3) For any of the above reasons, the PACE provider must give you written notice, including your appeal rights, explaining that they are terminating benefits. A PACE participant's involuntary disenrollment is effective on the first day of the next month that begins thirty days after the day the PACE organization sends notice of the disenrollment to the participant.

(4) Before the PACE provider can involuntarily end your enrollment in the PACE program, the department must review and approve it.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010, and 74.39A.020. WSR 20-13-027, § 388-106-0715, filed 6/9/20, effective 7/10/20; WSR 06-05-022, § 388-106-0715, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0715, filed 5/17/05, effective 6/17/05.]

ADULT DAY SERVICES

WAC 388-106-0800 What adult day care services may I receive? You may receive the following services in an adult day care:

(1) Core services, which include assistance with:

(a) Locomotion outside of room, locomotion in room, walk in room;

(b) Body care;

(c) Eating;

(d) Repositioning;

(e) Medication management that does not require a licensed nurse;
(f) Transfer;
(g) Toileting;
(h) Personal hygiene at a level that ensures your safety and comfort while in attendance at the program; and
(i) Bathing at a level that ensures your safety and comfort while in attendance at the program.
(2) Social services on a consultation basis, which may include:
(a) Referrals to other providers for services not within the scope of medicaid reimbursed adult day care services;
(b) Caregiver support and education; or
(c) Assistance with coping skills.
(3) Routine health monitoring with consultation from a registered nurse that a consulting nurse acting within the scope of practice can provide with or without a physician's order. Examples include:
(a) Obtaining baseline and routine monitoring information on your health status, such as vital signs, weight, and dietary needs;
(b) General health education such as providing information about nutrition, illnesses, and preventative care;
(c) Communicating changes in your health status to your caregiver;
(d) Annual and as needed updating of your medical record; or
(e) Assistance as needed with coordination of health services provided outside of the adult day care program.
(4) General therapeutic activities that an unlicensed person can provide or that a licensed person can provide with or without a physician's order. These services are planned for and provided based on your abilities, interests, and goals. Examples include:
(a) Recreational activities;
(b) Diversionary activities;
(c) Relaxation therapy;
(d) Cognitive stimulation; or
(e) Group range of motion or conditioning exercises.
(5) General health education that an unlicensed person can provide or that a licensed person can provide with or without a physician's order, including but not limited to topics such as:
(a) Nutrition;
(b) Stress management;
(c) Disease management skills; or
(d) Preventative care.
(6) A nutritional meal and snacks are provided every four hours, including a modified diet if needed and within the scope of the program, as provided under WAC 388-71-0768;
(7) Supervision and/or protection if needed for your safety;
(8) Assistance with arranging transportation to and from the program; and
(9) First aid and provisions for obtaining or providing care in an emergency. NOTE: If you require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of your physician, consider adult day health services.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0800, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0805 Am I eligible for adult day care? (1) If you receive COPES, you may be eligible for adult day care as a waiver

service if you are assessed as having an unmet need for one or more of the following core services:

(a) Personal care services;

(b) Routine health monitoring with consultation from a registered nurse;

(c) General therapeutic activities; or

(d) Supervision and/or protection if required for your safety.

(2) You are not eligible for adult day care if you receive COPES and you:

(a) Can independently perform or obtain the services provided at an adult day care center;

(b) Have unmet needs that can be met through the COPES program more cost effectively without authorizing day care services;

(c) Have referred care needs that:

(i) Exceed the scope of authorized services that the adult day care center is able to provide;

(ii) Can be met in a less structured care setting; or

(iii) Are being met by paid or unpaid caregivers.

(d) Live in a nursing home, assisted living facility, adult family home, or other licensed institutional or residential facility; or

(e) Are not capable of participating safely in a group care setting.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-15-092, § 388-106-0805, filed 7/18/14, effective 8/18/14; WSR 05-11-082, § 388-106-0805, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0810 What adult day health services may I receive? You may receive the following adult day health services:

(1) All core services under WAC 388-106-0800;

(2) Skilled nursing services other than routine health monitoring with nurse consultation;

(3) At least one of the following skilled therapy services: physical therapy, occupational therapy, or speech-language pathology or audiology, as defined under chapters 18.74, 18.59, and 18.35 RCW, and

(4) Psychological or counseling services, including assessing for psycho-social therapy need, dementia, abuse or neglect, and alcohol or drug abuse; making appropriate referrals; and providing brief, intermittent supportive counseling.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0810, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0815 Am I eligible for adult day health? You are eligible for adult day health if you meet the conditions described in WAC 388-106-0300 or 388-106-0305.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 2012 2nd sp.s. c 7. WSR 12-15-087, § 388-106-0815, filed 7/18/12, effective 8/18/12. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0815, filed 5/17/05, effective 6/17/05.]

GAU-FUNDED RESIDENTIAL CARE

WAC 388-106-0900 What services may I receive under medical care services? You may receive personal care services in an adult family home or a licensed assisted living facility contracted with the department to provide adult residential care services. You may also receive nurse delegation services under this program.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-15-092, § 388-106-0900, filed 7/18/14, effective 8/18/14; WSR 05-11-082, § 388-106-0900, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0905 Am I eligible to receive medical care services (MCS) residential care services? You are eligible to receive MCS-funded residential care services if:

(1) You meet financial eligibility requirements for medical care services (MCS), described in WAC 182-508-0005;

(2) You are not eligible for services under COPES, or MPC; and

(3) You are assessed in CARE and meet the functional criteria outlined in WAC 388-106-0210(3) or 388-106-0355(1).

[Statutory Authority: RCW 74.08.090. WSR 18-22-066, § 388-106-0905, filed 11/1/18, effective 12/2/18. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-0905, filed 1/12/15, effective 2/12/15; WSR 05-11-082, § 388-106-0905, filed 5/17/05, effective 6/17/05.]

COMMUNITY TRANSITION OR SUSTAINABILITY SERVICES

WAC 388-106-0950 What services may I receive under community transition or sustainability services? Community transition or sustainability services are nonrecurring setup items or services necessary to assist you to establish, resume, or stabilize your home or community-based residential setting. Community transition or sustainability 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.

(5) Moving expenses.

[Statutory Authority: RCW 74.08.090. WSR 18-12-100, § 388-106-0950, filed 6/5/18, effective 7/6/18. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-0950, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0955 Am I eligible for community transition or sustainability services? You may be eligible for community transition or sustainability services if you:

(1) Meet eligibility criteria to receive long-term services and supports from home and community services;

(2) Are transitioning to the community from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family 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 you with these costs; and

(a) Have needs beyond what is covered under community transition services (under community first choice); or

(b) Are not eligible for community transition services (under community first choice).

[Statutory Authority: RCW 74.08.090. WSR 18-12-100, § 388-106-0955, filed 6/5/18, effective 7/6/18. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-0955, filed 1/12/15, effective 2/12/15; WSR 14-15-092, § 388-106-0955, filed 7/18/14, effective 8/18/14; WSR 05-11-082, § 388-106-0955, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0960 Are there limits to the community transition or sustainability services I may receive? Community transition or sustainability services:

(1) Do not include recreational or entertainment items, such as a television, cable, or a DVD player;

(2) Do not include room and board; and

(3) May not exceed eight hundred fifty dollars per transition or occurrence of instability that threatens the loss of your home in the community.

[Statutory Authority: RCW 74.08.090. WSR 18-12-100, § 388-106-0960, filed 6/5/18, effective 7/6/18.]

WAC 388-106-0965 Are there waiting lists for community transition or sustainability services? There are no waiting lists for community transition or sustainability services. Instead of waiting lists, the department may revise rules to reduce the type of available services, the number of individuals served, or maximum rate, in order to stay within the legislative appropriation.

[Statutory Authority: RCW 74.08.090. WSR 18-12-100, § 388-106-0965, filed 6/5/18, effective 7/6/18.]

PRIVATE DUTY NURSING

WAC 388-106-1000 What is the intent of WAC 388-106-1000 through 388-106-1055? The intent of WAC 388-106-1000 through 388-106-1055 is to:

(1) Describe the eligibility requirements under which an adult age eighteen or older may receive private duty nursing (PDN) services

through the department's aging and disability services administration (ADSA);

(2) Provide assistance to clients and enable families to support clients in their own homes; and

(3) Describe the requirements clients and their families, home health agencies, and privately contracted registered nurses (RNs) and licensed practical nurses (LPNs) must meet in order for services to be authorized for PDN.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. WSR 05-24-091, § 388-106-1000, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1005 What services may I receive under private duty nursing (PDN)? PDN is a program that provides skilled nursing care if you have complex medical needs that cannot be met through other services. PDN is an alternative to institutional care and is the program of last resort.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. WSR 05-24-091, § 388-106-1005, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1010 Am I eligible for medicaid-funded private duty nursing services? In order to be eligible for medicaid-funded private duty nursing (PDN):

(1) You must be eighteen years of age or older and financially eligible, which means you:

(a) Meet medicaid requirements under the categorically needy program or the medically needy program; and

(b) Use private insurance as first payer, as required by medicaid rules. Private insurance benefits, which cover hospitalization and in-home services, must be ruled out as the first payment source to PDN.

(2) You must be medically eligible, which means:

(a) The department has received the skilled nursing task log or ADSA-approved equivalent completed by a nurse licensed under chapter 18.79 RCW.

(b) You have been assessed by an ADSA community nurse consultant (CNC) or nursing care consultant (NCC) and determined medically eligible for PDN.

(3) The department must assess you using the CARE assessment tool, as provided in chapter 388-106 WAC to determine that you:

(a) Require care in a hospital or meet nursing facility level of care, as defined in WAC 388-106-0310; and

(b) Have unmet skilled nursing needs that cannot be met in a less costly program or less restrictive environment; and

(c) Are not able to have your care tasks provided through nurse delegation, WAC 246-840-910 through 246-840-970; COPES skilled nursing, WAC [388] [182]-515-1505; DDD waiver skilled nursing, WAC 388-845-0215 or self-directed care RCW 74.39.050; and

(d) Have a complex medical need that requires four or more hours every day of continuous skilled nursing care that can be safely provided outside a hospital or nursing facility; and

(e) Require skilled nursing care that is medically necessary, per WAC 182-500-0070; and

(f) Are able to supervise your care or have a guardian who is authorized and able to supervise your care; and

(g) Have a family member or other appropriate informal support who is responsible for assuming a portion of your care; and

(h) Are medically stable and appropriate for PDN services, as reflected by your primary care provider's:

(i) Orders for medical services; and

(ii) Documentation of approval for the service provider's PDN care plan.

(i) Do not have any other resources or means to obtain PDN services; and

(j) Are dependent upon technology every day with at least one of the following skilled care needs:

(i) Mechanical ventilation which takes over active breathing due to your inability to breathe on your own due to injury or illness. A tracheal tube is in place and is hooked up to a ventilator that pumps air into the lungs; or

(ii) Complex respiratory support, which means that you require two of the following treatment needs:

(A) Postural drainage and chest percussion;

(B) Application of respiratory vests;

(C) Nebulizer treatments with or without medications;

(D) Intermittent positive pressure breathing;

(E) O2 saturation measurement with treatment decisions dependent on the results; or

(F) Tracheal suctioning.

(iii) Intravenous/parenteral administration of multiple medications, and care is occurring on a continuing or frequent basis; or

(iv) Intravenous administration of nutritional substances, and care is occurring on a continuing or frequent basis.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-1010, filed 1/12/15, effective 2/12/15; WSR 11-05-079, § 388-106-1010, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. WSR 05-24-091, § 388-106-1010, filed 12/6/05, effective 1/6/06.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-106-1020 How do I pay for my PDN services? You are not required to pay participation for PDN services, but the cost of services is subject to estate recovery, under chapter 182-527 WAC. If you are also receiving other services (e.g. COPES), you may be responsible for paying participation as required under WAC 182-515-1505. Your financial worker will inform you about your participation requirements for those services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-1020, filed 1/12/15, effective 2/12/15. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. WSR 05-24-091, § 388-106-1020, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1021 What days are considered holidays for private duty nursing providers? The following dates are holidays solely for the purpose of contracted services rates for private duty nursing providers:

(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 19th day of June (Juneteenth);
(6) The fourth day of July (Independence Day);
(7) The first Monday in September (Labor Day);
(8) The 11th day of November (Veteran's 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 25th day of December (Christmas Day).

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 25-02-051, s 388-106-1021, filed 12/20/24, effective 1/20/25.]

WAC 388-106-1025 Who can provide my PDN services? PDN services can be provided by:
(1) A home health agency licensed by the Washington state department of health chapter 246-335 WAC that has a contract with the medicaid agency to provide PDN services; or
(2) A Washington state licensed RN, or LPN under the direction of an RN who has a contract with the medicaid agency to provide PDN services and meets the requirements set forth in WAC 388-106-1040.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 11-05-079, § 388-106-1025, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. WSR 05-24-091, § 388-106-1025, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1030 Are there limitations or other requirements for PDN? Limitations and other requirements to PDN services are as follows:
(1) You may be authorized to receive PDN services for between four to sixteen hours per day, except as noted in WAC 388-106-1045(4).
(2) PDN hours will be deducted from the personal care hours generated by CARE to account for services that meet your need for personal care services (i.e., one hour from the available hours for each hour of PDN authorized). WAC 388-106-0130 (9)(e).
(3) Trained family members must provide for any hours above your assessment determination, or you or your family must pay for these additional hours.
(4) In instances where your family is temporarily absent due to vacations, additional PDN hours must be:
(a) Paid for by you or your family; or
(b) Provided by other trained family members. If this is not possible, you may require placement in a long-term care facility during their absence.
(5) You may use respite care if you and your unpaid family caregiver meet the eligibility criteria defined in WAC 388-106-1210 (for LTC clients) or WAC 388-832-0145 (for DDD individual and family services clients) or WAC 388-845-1605 (for DDD waiver clients).
(6) There may be a one time approval for additional hours for a period not to exceed thirty days when:

(a) Your family is being trained in care and procedures;

(b) You have an acute episode that would otherwise require hospitalization;

(c) Your caregiver is ill or temporarily unable to provide care; or

(d) There is a family emergency.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 11-05-079, § 388-106-1030, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. WSR 05-24-091, § 388-106-1030, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1035 What requirements must a home health agency meet in order to provide and be paid for my PDN? In order for a home health agency to provide and be paid for your PDN, the home health agency must:

(1) Be licensed by the Washington state department of health pursuant to chapter 246-335 WAC and have a contract with the medicaid agency to provide PDN services;

(2) Operate under primary care provider orders;

(3) Develop and follow a detailed service plan that is reviewed and signed at least every six months by the client's primary care provider and submitted to CNC or NCC for review;

(4) Initiate and complete the PDN skilled nursing task log or an approved equivalent for seven days and submit it to the CNC or NCC for review for an initial eligibility determination and for ongoing eligibility every six months thereafter;

(5) Meet all documentation required by DOH for in-home licensing, WAC 246-335-055, 246-335-080, and 246-335-110; and

(6) Submit timely and accurate invoices for payments.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 11-05-079, § 388-106-1035, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. WSR 05-24-091, § 388-106-1035, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1040 What requirements must an RN, or LPN under the supervision of an RN, meet in order to provide and get paid for my PDN services? In order to be paid by the department, a private RN under the supervision of a primary care provider or an LPN under the supervision of an RN, must:

(1) Be licensed and in good standing, as provided in RCW 18.79.030 (1)(3);

(2) Have a contract with the medicaid agency to provide PDN services;

(3) Complete a background check which requires fingerprinting if the RN or LPN has lived in Washington state less than three years;

(4) Have no conviction for a disqualifying crime, as provided in RCW 43.43.830 and 43.43.842 and WAC 388-71-0500 through 388-71-05640 series;

(5) Have no finding of fact and conclusion of law (stipulated or otherwise), agreed order, or final order issued by a disciplining authority, a court of law, or entered into a state registry with a finding of abuse, neglect, abandonment or exploitation of a minor or vulnerable adult;

(6) Provide services according to the care plan under the supervision/direction of the primary care provider;

(7) Document all PDN services provided by the care plan as required by WAC 182-502-0020 and 246-840-700;

(8) Meet provider requirements under WAC 388-71-0510, 388-71-0515, 388-71-0540, 388-71-0551, and 388-71-0556;

(9) Complete time sheets on a monthly basis;

(10) Complete the PDN seven-day look back skilled nursing task log and submit it to the CNC or NCC for review for initial eligibility determination, and for ongoing eligibility every six months; and

(11) Submit timely and accurate invoices for payment.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-1040, filed 1/12/15, effective 2/12/15; WSR 11-05-079, § 388-106-1040, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. WSR 05-24-091, § 388-106-1040, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1045 When may I receive private duty nursing (PDN) services in a contracted PDN adult family home (AFH)? You may receive private duty nursing (PDN) services in an adult family home (AFH) when:

(1) You are assessed;

(a) Using the comprehensive assessment reporting evaluation (CARE) assessment tool as provided in WAC 388-106-0500; and

(b) By an aging and long-term support administration (ALTSA) community nurse consultant (CNC) or developmental disabilities administration (DDA) nurse care consultant (NCC) who, using their professional judgment, determines that you require a minimum of eight hours of PDN services per day.

(2) You reside in an AFH that:

(a) Meets all AFH licensing requirements under chapter 388-76 WAC; and

(b) Has a PDN contract with ALTSA; and

(c) Meets all other requirements in WAC 388-106-1046.

(3) Your detailed service plan is reviewed and signed by your primary care provider at your initial assessment and at least every six months thereafter, and your detailed service plan is submitted to an ALTSA CNC or DDA NCC for review along with the following documents:

(a) Physical exam findings completed by your physician;

(b) Current Physician's orders;

(c) Current nursing assessment;

(d) Current plan of care;

(e) The nursing progress notes for the seven days prior to assessment, if applicable; and

(f) The PDN skilled nursing task log for dates corresponding with the nursing progress notes, if applicable.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 18-08-084, § 388-106-1045, filed 4/4/18, effective 5/5/18; WSR 11-05-079, § 388-106-1045, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. WSR 05-24-091, § 388-106-1045, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1046 When may an adult family home (AFH) be paid an all-inclusive daily rate for private duty nursing (PDN) services? An adult family home (AFH) may be paid for private duty nursing (PDN) services when:

(1) The AFH provider, as defined in WAC 388-76-10000, ensures that personal care and nursing services are available in the home 24 hours per day.

(2) The AFH provider is either:

(a) A registered nurse (RN) licensed in Washington state in good standing under RCW 18.79.030(1); or

(b) Operates an in-home services agency licensed through the Washington state department of health (DOH) to provide home health services under chapter 246-335 WAC; and

(i) Employs a resident manager or entity representative, who is a registered nurse licensed in Washington state in good standing under RCW 18.79.030(1); and

(ii) The PDN program manager has approved a plan submitted by the AFH provider to replace the resident manager or entity representative in the event the resident manager or entity representative is no longer employed by the AFH; and

(iii) Ensures that a sufficient number of capable, qualified, and trained staff are available to provide necessary care and services consistent with each client's negotiated service agreement at all times, including but not limited to routine conditions, emergencies, fires, and disaster situations; and

(iv) May use nurses employed by their own in-home services agency to provide PDN for clients in the AFH.

(3) The RN resident manager or RN entity representative employed by the AFH provider, as required under subsection (2):

(a) Manages the daily operations of the AFH and oversees the care provided to the client; and

(b) Must notify the local fire agency, gas, phone, and electric companies at the time of each PDN client's admission to the AFH.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 18-08-084, § 388-106-1046, filed 4/4/18, effective 5/5/18.]

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? Department of social and health services (DSHS) will pay the adult family home (AFH) an all-inclusive daily rate for a private duty nursing (PDN) client, which includes payment for PDN services, all skilled nursing tasks, and all personal care services. DSHS will not authorize payment for nurse delegation services or hours provided by the in-home services agency nurses in addition to the PDN all-inclusive daily rate.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 18-08-084, § 388-106-1047, filed 4/4/18, effective 5/5/18.]

WAC 388-106-1050 May I receive other long-term care services in addition to PDN? (1) In addition to PDN services, you may be eligible to receive care through community options program entry system (COPES), or medicaid personal care (MPC), for unmet personal needs not performed by informal supports.

(2) PDN hours will be deducted from the personal care hours generated by CARE to account for services that meet some of your need for personal care services (i.e., one hour from the available hours for each hour of PDN authorized per WAC 388-106-1030).

(3) Services may not be duplicated. PDN hours may not be scheduled during the same time that personal care hours are being provided by an individual provider or home care agency provider.

(4) The PDN provider is responsible for providing assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) unless there is an informal support that is providing or assisting at the same time.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-1050, filed 1/12/15, effective 2/12/15; WSR 11-05-079, § 388-106-1050, filed 2/15/11, effective 3/18/11. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. WSR 05-24-091, § 388-106-1050, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1055 Can I choose to self-direct my care if I receive PDN services? You may choose to self-direct part of your health-related tasks to an individual provider, as outlined in RCW 74.39.050. You may also still receive PDN services, if you meet the PDN eligibility requirements.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. WSR 05-24-091, § 388-106-1055, filed 12/6/05, effective 1/6/06.]

SENIOR CITIZENS' SERVICES

WAC 388-106-1100 What services can I receive under the Senior Citizens' Services Act (SCSA) fund? You may receive community-based services, described in RCW 74.38.040.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-1100, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1105 How do I apply for SCSA-funded services? To receive SCSA-funded services, you or your representative must:

(1) Complete and submit a department application form, providing complete and accurate information; and

(2) Promptly submit a written report of any changes in income or resources. For the definition of income and resources, refer to chapter 182-509 WAC.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 15-03-038, § 388-106-1105, filed 1/12/15, effective 2/12/15; WSR 05-11-082, § 388-106-1105, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1110 Am I eligible for SCSA-funded services at no cost? To be eligible for SCSA-funded services at no cost, you must:

(1) Be age:

(a) Sixty-five or older; or

(b) Sixty or older, and:
(i) Either unemployed, or
(ii) Working twenty hours a week or less;
(2) Have a physical, mental, or other type of impairment, which without services would prevent you from remaining in your home;
(3) Have income at or below forty percent of the state median income (SMI), based on family size; and
(4) Have nonexempt resources (including cash, marketable securities, and real or personal property) not exceeding ten thousand dollars for a single person or fifteen thousand for a family of two, increased by one thousand dollars for each additional family member of the household. Household means a person living alone or a group of people living together.
(5) If you have income over forty percent of SMI, you may be eligible for services on a sliding fee basis.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-1110, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1115 What income and resources are exempt when determining eligibility? The following income and resources, regardless of value, are exempt when determining whether you are eligible for SCSA-funded services:
(1) Your home, and the lot it is upon;
(2) Garden produce, livestock, and poultry used for home consumption;
(3) Program benefits which are exempt from consideration in determining eligibility for needs based programs (e.g., uniform relocation assistance, Older Americans Act funds, foster grandparents' stipends or similar moneys);
(4) Used and useful household furnishings, personal clothing, and automobiles;
(5) Personal property of great sentimental value;
(6) Personal property used by the individual to earn income or for rehabilitation;
(7) One cemetery plot for each member of the family unit;
(8) Cash surrender value of life insurance;
(9) Real property held in trust for an individual Indian or Indian tribe; and
(10) Any payment received from a foster care agency for children in the home.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-1115, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1120 What if I am not eligible to receive SCSA-funded services at no cost? (1) Even if your income is above the forty percent SMI limit to receive SCSA-funded services at no cost, you may receive SCSA-subsidized services. The department uses a sliding fee schedule to determine what percentage the department pays for the cost of your services. You pay the remaining amount, but not more than the usual rate paid for services, as negotiated by the AAA or the department. The formula for determining the department's share of the cost of the services is:

100% State Median Income (SMI) - Household Income x 100

100% - 40% SMI

(2) Service providers must be responsible for collecting fees owed by eligible persons and reporting to area agencies all fees paid or owed by eligible persons.

(3) Some services are provided at no charge regardless of income or need requirements. These services include, but are not limited to, nutritional services, health screening, services under the long-term care ombudsman program, and access services. Note: Well adult clinic services may be provided in lieu of health screening services if such clinics use the fee schedule established by this section.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-1120, filed 5/17/05, effective 6/17/05.]

RESPITE CARE SERVICES

WAC 388-106-1200 What definitions apply to respite care services through the family caregiver support program? The following definitions apply to respite care services:

"Caregivers" means a spouse, relative, or friend who has primary responsibility for the care or supervision of an adult with a functional disability without receiving direct, public or private payment for the caregiver services they provide.

"Continuous care or supervision" means daily assistance or oversight of an adult with a functional disability.

"Family caregiver support program or FCSP" means a statewide program offered by area agencies on aging to provide support for unpaid caregivers who provide care to an adult with a functional disability.

"Functional disability" means a physical, mental or cognitive condition requiring continuous care or supervision in completing activities of daily living or instrumental activities for daily living.

"Care receiver" means an adult (age eighteen and over) with a functional disability who needs daily continuous care or supervision.

"Service provider" means an agency, or organization under contract to the area agency on aging (AAA) or its subcontractor.

"Supervision" means providing oversight of an individual to assure his/her safety and well-being.

"TCARE®, tailored caregiver assessment and referral system" means the process (screening, assessment and care planning) to establish eligibility for respite care and other caregiver support services for unpaid family caregivers.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 12-13-040, § 388-106-1200, filed 6/13/12, effective 7/14/12; WSR 05-11-082, § 388-106-1200, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1205 What are respite care services? Respite services relieve unpaid caregivers by providing temporary care or supervision to adults with a functional disability.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-1205, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1210 Who is eligible to receive respite care services through the family caregiver support program? (1) To be eligible to receive respite care services, the caregivers must:

(a) Have primary responsibility for the care or supervision of an adult with a functional disability who is not receiving a state or medicaid funded, long-term care service (e.g., COPES, personal care services, DD waiver); and

(b) Provide a minimum of an average of forty hours per week of care, and/or supervision, or live with an adult who needs continuous care or supervision; and

(c) Not receive financial payment for the care; and

(d) Be assessed in the TCARE®, tailored caregiver assessment and referral system and determined to meet the eligibility threshold levels determined by state level policy and have TCARE® recommend the strategy to introduce alternate sources for care to provide respite.

(2) An eligible participant is an adult who:

(a) Has a functional disability;

(b) Has a caregiver who is assessed in the TCARE® system and meets the criteria in WAC 388-106-1210(1); and

(c) Is not receiving a state or medicaid funded, long-term care service (e.g., COPES, personal care services, DD waiver).

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 12-13-040, § 388-106-1210, filed 6/13/12, effective 7/14/12; WSR 05-11-082, § 388-106-1210, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1215 Who may provide respite care services through the family caregiver support program? Respite care providers include, but are not limited to the following:

(1) Nursing homes (chapter 388-97 WAC).

(2) Adult day service providers, whose services includes adult day care, dementia day services and adult day health.

(3) Home care and/or home health agencies licensed through the department of health for in-home services.

(4) Hospitals.

(5) Licensed residential care facilities such as boarding homes, adult family homes, and assisted living facilities.

(6) Providers such as volunteer services, and senior companions.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 12-13-040, § 388-106-1215, filed 6/13/12, effective 7/14/12; WSR 05-11-082, § 388-106-1215, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1220 How are respite care providers reimbursed for their services through the family caregiver support program? The department reimburses:

(1) Respite care providers for the number of hours or days of services authorized and provided. If the provider already has a medicaid rate established for providing a similar service, that rate is to be reimbursed by the local area agency on aging. If there is no estab-

lished rate for the service, one can be negotiated between the local area agency on aging and the respite care service provider.

(2) Medicaid-certified licensed residential facilities providing respite services at the medicaid rate approved for that facility. Medicaid contracted providers must not charge more than the medicaid rate for any services covered from the date of eligibility, unless authorized by the department (see RCW 18.51.070). Participants must pay for services not included in the medicaid rate.

(3) Private nursing homes at their published daily rate.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 12-13-040, § 388-106-1220, filed 6/13/12, effective 7/14/12; WSR 05-11-082, § 388-106-1220, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1225 Are participants required to pay for the cost of their respite care services through the family caregiver support program? (1) There is no charge to the care receiver whose income is at or below forty percent of the state median income, based on family size.

(2) If the care receiver's gross income is above forty percent of the state median income, he or she is required to pay for part or all of the cost of the respite care services. The department will determine what amount the participant must contribute based on the state median income and family size.

(3) If the care receiver's gross income is one hundred percent or more of the state median income, 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 area agency on aging may grant an exception to policy and then must document this in the client's records.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 12-13-040, § 388-106-1225, filed 6/13/12, effective 7/14/12; WSR 05-11-082, § 388-106-1225, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1230 What determines emergent and nonemergent respite care services through the family caregiver support program? (1) The department and the area agency on aging (AAA) must first consider requests for emergency respite care. An example of an emergency is when the caregiver becomes ill or injured to the extent that the caregiver's ability to care for the care receiver is impaired. AAA policies will determine how best to serve caregivers in crisis depending on available local FCSP funding. A caregiver must be screened in TCARE® within thirty days following the crisis if ongoing services exceeding five hundred dollars are requested.

(2) In nonemergency situations, respite care is allocated based upon the results of the TCARE® assessment and available local FCSP funds. If sufficient funds are not available when an eligible caregiver requests services, AAA may establish wait lists to prioritize clients receiving services as funding becomes available.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 12-13-040, § 388-106-1230, filed 6/13/12, effective 7/14/12; WSR 05-11-082, § 388-106-1230, filed 5/17/05, effective 6/17/05.]

CLIENT RIGHTS

WAC 388-106-1300 What rights do I have as a client of the department? As a client of the department, you have a right to:

(1) Be treated with dignity, respect and without discrimination;

(2) Not be abused, neglected, financially exploited, abandoned;

(3) Have your property treated with respect;

(4) Not answer questions, turn down services, and not accept case management services you do not want to receive. However, it may not be possible for the department to offer some services if you do not give enough information;

(5) Be told about all services you can receive and make choices about services you want or don't want;

(6) Have information about you kept private within the limits of the laws and DSHS regulations;

(7) Be told in writing of agency decisions and receive a copy of your care plan;

(8) Make a complaint without fear of harm;

(9) Not be forced to answer questions or do something you don't want to;

(10) Talk with your social service worker's supervisor if you and your social service worker do not agree;

(11) Request a fair hearing;

(12) Have interpreter services provided to you free of charge if you cannot speak or understand English well;

(13) Take part in and have your wishes included in planning your care;

(14) Choose, fire, or change a qualified provider you want; and

(15) Receive results of the background check for any individual provider you choose.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-1300, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1303 What responsibilities do I have as a client of the department? As a client of the department, you have a responsibility to:

(1) Give us enough information to assess your needs;

(2) Let the social services worker into your home so that your needs can be assessed;

(3) Follow your care plan;

(4) Not act in a way that puts anyone in danger;

(5) Provide a safe work place;

(6) Tell your social services worker if there is a change in:

(a) Your medical condition;

(b) The help you get from family or other agencies;

(c) Where you live; or

(d) Your financial situation.

(7) Tell your social services worker if someone else makes medical or financial decision for you;

(8) Choose a qualified provider;

(9) Inform the department and your home care agency if an employee assigned by the home care agency is related to you by blood, marriage, adoption, or registered domestic partnership.

(10) Keep provider background checks private;

(11) Tell your social services worker if you are having problems with your provider; and

(12) Choose your own health care. Tell your social services worker when you do not do what your doctor says.

[Statutory Authority: RCW 74.08.090, 74.09.520, 2009 c 571, and Washington state 2009-11 budget, section 206(17). WSR 10-06-112, § 388-106-1303, filed 3/3/10, effective 4/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. WSR 06-05-022, § 388-106-1303, filed 2/6/06, effective 3/9/06.]

WAC 388-106-1305 What if I disagree with the result of the CARE assessment and/or other eligibility decisions made by the department? (1) You have a right to contest the result of your CARE assessment and/or other eligibility decisions made by the department. The department will notify you in writing of the right to contest a decision and provide you with information on how to request a hearing.

(2) Additionally, if you believe that you need more in-home personal care services than the CARE assessment has authorized for you, and you believe that your situation meets the criteria in WAC 388-440-0001(1) for an exception to rule (ETR), you may request additional personal care services.

(a) Requests may be made to your case manager or local HCS, AAA or DDA field office, either verbally or in writing.

(b) Requests that are approved at the field level will be forwarded to the ETR committee located in Olympia for a final decision.

(c) If your request is denied at the field level:

(i) You will receive a written notification.

(ii) You may request a headquarters review of your request by contacting your case manager or local HCS, AAA or DDA field office or by contacting the headquarters committee directly.

(d) You will be notified in writing whether additional ETR hours are approved or if your request was denied.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-09-015, § 388-106-1305, filed 4/4/14, effective 5/5/14; WSR 05-11-082, § 388-106-1305, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1310 When I request a fair hearing on my CARE assessment and another CARE assessment(s) is done between my fair hearing request and the fair hearing, which CARE assessment must the administrative law judge review? When you request a fair hearing on your CARE assessment and another CARE assessment(s) is done between your fair hearing request and the fair hearing, the administrative law judge must review the most recent CARE assessment.

[Statutory Authority: RCW 74.08.090, 74.09.520. WSR 05-11-082, § 388-106-1310, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1315 Do I have a right to an administrative hearing if my total in-home personal care hours or New Freedom budget approved as an exception to rule are reduced or terminated or if my increased residential payment rate approved as an exception to rule is reduced or terminated? Notwithstanding WAC 388-440-0001(3), you have a right to an administrative hearing regarding the department's exception to rule decision if:

(1) You receive services in your own home, and:

(a) The total number of in-home personal care hours you are currently receiving includes in-home personal care hours approved as an exception to rule in addition to the number of in-home care hours determined to be available to you by CARE; and

(b) The total number of in-home personal care hours or New Freedom budget you are currently receiving is reduced because of a reduction or termination in the number of in-home personal care hours approved as an exception to rule.

(2) You receive services in a residential facility, and:

(a) You currently have an increased residential payment rate approved as an exception to rule; and

(b) Your increased residential payment rate that was approved as an exception to rule is reduced or terminated.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 13-18-039 and 13-17-125, § 388-106-1315, filed 8/29/13 and 8/21/13, effective 10/1/13. Statutory Authority: RCW 74.08.090, 74.09.520, chapters 74.39 and 74.39A RCW. WSR 07-01-046, § 388-106-1315, filed 12/14/06, effective 1/14/07.]

NEW FREEDOM CONSUMER DIRECTED SERVICES (NFCDS)

WAC 388-106-1400 What services may I receive under New Freedom consumer directed services (NFCDS)? (1) In order for services, supports, or items to be purchased under New Freedom, they must:

(a) Be for your sole benefit;

(b) Be at a reasonable cost;

(c) Meet your identified needs and outcomes in the CARE assessment and address your health, safety, and welfare; and

(d) Be documented on your New Freedom spending plan defined in WAC 388-106-0010. The spending plan, which is established with the Care Consultant, documents how you will spend your service budget dollars.

(2) Your consultant 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 needed to ensure the service, support, or item will increase, maintain, or delay decline of functional abilities, and to ensure the purchase supports your health and welfare.

(3) Medicare or medicaid state plan benefits or other insurance must be used prior to using New Freedom funds if the goods or services are covered under these programs.

(4) You may use your individual budget to purchase services, supports, or items that fall into the following service categories:

(a) **Personal assistance services**, defined as supports involving the labor of another person to assist you to carry out activities you

are unable to perform independently. Services may be provided in your home or in the community and may include:

(i) Direct personal care services defined as assistance with activities of daily living, as defined in WAC 388-106-0010. These must be provided by a qualified individual provider or AAA-contracted home-care agency as described in WAC 388-106-0040 (1) and (2);

(ii) Delegated nursing tasks, per WAC 246-841-405 and 388-71-05830. Providers of direct personal care services may be delegated by a registered nurse to provide nurse delegated tasks according to RCW 18.79.260 and WAC 246-840-910 through 246-840-970;

(iii) Other tasks or assistance with activities that support independent functioning, and are necessary due to your functional disability;

(iv) Personal assistance with transportation or assistance with instrumental activities of daily living (essential shopping, housework, and meal preparation).

(b) **Treatment and health maintenance**, defined as treatments or activities that are beyond the scope of the medicaid state plan that are necessary to promote your health and ability to live independently in the community and:

(i) Are provided for the purpose of preventing further deterioration of your level of functioning, or improving or maintaining your current level of functioning; and

(ii) Are performed or provided by people with specialized skill, registration, certification, or licenses as required by state law.

(c) **Individual directed goods, services and supports**, defined as services, equipment or supplies not otherwise provided through this waiver or through the medicaid state plan; and

(i) Will allow you to function more independently; or

(ii) Increase your safety and welfare; or

(iii) Allow you to perceive, control, or communicate with your environment; or

(iv) Assist you to transition from an institutional setting to your home. Transition services may include safety deposits, utility set-up fees or deposits, health and safety assurances such as pest eradication, allergen control or one-time cleaning prior to occupancy, moving fees, furniture, essential furnishings and basic items essential for basic living outside the institution. Transition services do not include rent, recreational or diverting items such as TV, cable or VCR/DVDs.

(d) **Environmental or vehicle modifications**, defined as alterations to your residence or vehicle that are necessary to accommodate your disability and promote your functional independence, health, safety, and welfare.

(i) Environmental modifications cannot be adaptations or improvements that are of general utility or merely add to the total square footage of the home.

(ii) Vehicles subject to modification must be owned by you or a member of your family who resides with you; must be in good working condition, licensed, and insured according to Washington state law; and be cost effective when compared to available alternative transportation.

(e) **Training and educational supports**, defined as supports beyond the scope of medicaid state plan services that are necessary to promote your health and ability to live and participate in the community and maintains, slows decline, or improves functioning and adaptive skills. Examples include:

(i) Training or education on your health issues, or personal skill development;

(ii) Training or education to paid or unpaid caregivers related to your needs.

(5) You may receive comprehensive adult dental services as defined in WAC 388-106-0300(15) through December 31, 2013. The cost of the dental services will not be deducted from your individual budget.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 22-18-047, § 388-106-1400, filed 8/30/22, effective 9/30/22; WSR 13-18-039 and 13-17-125, § 388-106-1400, filed 8/29/13 and 8/21/13, effective 10/1/13; WSR 10-08-074, § 388-106-1400, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1400, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1405 What services are not covered under New Freedom consumer directed services (NFCDS)? (1) Goods, services, and supports that are not consistent with the description in WAC 388-106-1400.

(2) Services, supports or items covered by the state plan, medicare, or other programs or services.

(3) Any fees related to health or long-term care incurred by you, including co-pays, waiver cost of care (participation), or insurance.

(4) Home modifications that merely add square footage to your home.

(5) Vacation or travel expenses other than the direct cost of provision of personal care services while on vacation (and you may not use New Freedom funds to pay travel expenses for your provider).

(6) Rent or room and board.

(7) Tobacco or alcohol products.

(8) Lottery tickets.

(9) Entertainment-related items such as televisions, cable, DVD players, stereos, radios, and other electronics, that are nonadaptive in nature.

(10) Vehicle purchases, maintenance, or upgrades that do not include maintenance to modifications related to disability.

(11) Tickets and related costs to attend sporting or other recreational events.

(12) Pets, therapy animals and their related costs (including food and veterinary services).

(13) Postage outside of shipping costs related to approved spending plan items.

(14) Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 182-500-0070.

(15) Monthly service fees for utilities.

(16) Warranties (for equipment, furnishings, or installations).

(17) Cosmetic services and treatments (i.e. manicures, pedicures, face lifts, etc).

(18) Basic groceries, clothing, and footwear.

(19) Any item previously purchased through medicaid funding that is within the health care authority replacement period.

(20) Any goods, services, or supports that are considered of general utility, meaning the service/good/support is not specific to the individuals' needs based on their disabilities or health conditions.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 22-18-047, § 388-106-1405, filed 8/30/22, effective 9/30/22; WSR 13-18-039 and 13-17-125, § 388-106-1405, filed 8/29/13 and 8/21/13, effective 10/1/13; WSR 10-08-074, § 388-106-1405, filed 4/6/10, effective 5/7/10.]

WAC 388-106-1410 Am I eligible for New Freedom consumer directed services (NFCDS)-funded services? You are eligible for NFCDS-funded services if you reside in your own home and meet all of the following criteria. The department must assess your needs using CARE and determine that:

(1) You are in NFCDS HCBS waiver specified target groups of:

(a) Eighteen or older and blind or have a physical disability; or

(b) Sixty-five or older; and

(C) You reside in a county where New Freedom is offered.

(2) You meet financial eligibility requirements described in WAC 182-513-1315. This means the department will assess your finances, determine if your income and resources fall within the limits, and determine the amount you may be required to contribute, if any, toward the cost of your care as described in WAC 182-515-1505; and

(3) You:

(a) Are not eligible for medicaid personal care services (MPC); or

(b) Are eligible for MPC services, but the department determines that the amount, duration, or scope of your needs is beyond what MPC can provide; and

(4) Your CARE assessment shows you need the level of care provided in a nursing facility as defined in WAC 388-106-0355; and

(5) You live in your own home, or will be living in your own home by the time NFCDS start.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 13-18-039 and 13-17-125, § 388-106-1410, filed 8/29/13 and 8/21/13, effective 10/1/13. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1410, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1415 When do New Freedom consumer directed services (NFCDS) start? Your New Freedom services begin the date personal care provider(s) are authorized to begin providing services or the spending plan is approved.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 13-18-039 and 13-17-125, § 388-106-1415, filed 8/29/13 and 8/21/13, effective 10/1/13. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1415, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1420 How do I remain eligible for New Freedom consumer directed services (NFCDS)? (1) In order to remain eligible for NFCDS, you must be in need of services in accordance with WAC 388-106-1410, as determined through a CARE assessment, and continue to meet the financial eligibility requirements in WAC 182-513-1315.

(a) The CARE assessment must be performed at least annually or more often when there are significant changes in your functional or financial circumstances.

(b) Your continued financial eligibility is reviewed annually.

(2) When eligibility statutes, regulations, and/or rules for NFCDS change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your NFCDS services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 13-18-039 and 13-17-125, § 388-106-1420, filed 8/29/13 and 8/21/13, effective 10/1/13. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1420, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1422 What happens to my New Freedom service dollar budget if I am temporarily hospitalized, placed in a nursing facility, or intermediate care facilities for intellectual disability (ICF/ID)? If you are admitted to a hospital, nursing home, or ICF/ID, you cannot access or accumulate funds to your New Freedom service budget during your stay.

If you are institutionalized for 30 days or less and you intend to return to New Freedom when discharged, your service budget will be temporarily suspended while you are temporarily hospitalized for up to 30 days. Upon discharge home, if within 30 days, your service budget will be reinstated if you are still eligible for New Freedom services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 22-18-047, § 388-106-1422, filed 8/30/22, effective 9/30/22; WSR 13-18-039 and 13-17-125, § 388-106-1422, filed 8/29/13 and 8/21/13, effective 10/1/13; WSR 10-08-074, § 388-106-1422, filed 4/6/10, effective 5/7/10.]

WAC 388-106-1425 How do I pay for New Freedom consumer directed services (NFCDS)? (1) Depending on your income, you may be required to pay participation toward the cost of your care, as described in WAC 182-515-1505. If you have nonexempt income that exceeds the cost of NFCDS services, you may keep the difference. Since you are receiving services in your own home, you are allowed to keep some of your income for a maintenance allowance.

(2) You are responsible to pay for your goods and services received up to your participation amount determined by the department. Any approved budget expenditures for goods and services you receive, which exceed your participation amount, will be paid by the department once your participation, if any, is accounted for.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 13-18-039 and 13-17-125, § 388-106-1425, filed 8/29/13 and 8/21/13, effective 10/1/13. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1425, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1430 Can I be employed and receive New Freedom consumer directed services (NFCDS)? You can be employed and receive NFCDS, if eligible, per WAC 182-515-1505.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 13-18-039 and 13-17-125, § 388-106-1430, filed 8/29/13 and 8/21/13, effective 10/1/13. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1430, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1435 Who can direct New Freedom consumer directed services (NFCDS)? You, as an NFCDS participant, direct your services. You may also designate, or a court may appoint, a representative to assist you in directing your services, or to direct your services on your behalf. A New Freedom designated representative cannot also be your paid provider.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 10-08-074, § 388-106-1435, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1435, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1440 What is an individual budget? An individual budget means the maximum amount of funding authorized by the department and allocated to the participant for the purchase of New Freedom consumer directed services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1440, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1445 How is the amount of the individual budget determined? The department will calculate your individual budget amount after you are assigned a number of monthly hours resulting from completion of the comprehensive assessment reporting and evaluation tool, CARE. The calculation will be based on the average wage, including a mileage allowance, as determined by the collective bargaining agreement for individual provider personal care multiplied by the number of units generated by the assessment, multiplied by a factor of .93, plus an amount equal to the average per participant expenditures for non-personal care supports purchased in the COPES waiver.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.832, 74.39A.270, 74.39A.056, 74.39A.074, 43.20A.710, 74.39A.525, 43.43.842, 74.39A.326, 74.39A.515, 74.39A.505, 18.88B.021, 43.43.837 and 2018 c 278. WSR 21-18-081, § 388-106-1445, filed 8/30/21, effective 10/1/21. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 13-18-039 and 13-17-125, § 388-106-1445, filed 8/29/13 and 8/21/13, effective 10/1/13; WSR 10-08-074, § 388-106-1445, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1445, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1450 Is the individual budget intended to fully meet all of my needs? The program provides funds in an amount proportionate to the amount of resources you would receive through COPES, and gives you flexibility to self-direct the purchase of goods and services to address your long-term care needs. The degree to which the budget meets your needs depends on the supports you identify and pri-

oritize in your spending plan. Depending on your decisions, after your budget is exhausted, some of your needs may be unmet, or you may find other resources to address them.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 13-18-039 and 13-17-125, § 388-106-1450, filed 8/29/13 and 8/21/13, effective 10/1/13. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1450, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1455 What happens to individual budget funds when I don't use them? (1) The balance of individual budget funds that were not allocated for purchase of personal care may be used to purchase other goods and services in accordance with the approved New Freedom spending plan or saved for future purchase as described in (2) below.

(2) Up to $3,500 may be held in savings for future purchases documented in the New Freedom spending plan.

(3) Reserves in excess of $3,500 may only be maintained for exceptional, planned purchases with preapproval from the department.

(4) Unused funds will revert back to the department under the following circumstances:

(a) You have savings funds in excess of $3,500 that are not identified for exceptional, pre-approved purchases in your spending plan;

(b) You disenroll from New Freedom;

(c) You lose eligibility for New Freedom;

(d) You are hospitalized, in a nursing home, or ICF/ID for over 30 days; or

(e) You have personal care funds not used in the month for which you allocated them.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 22-18-047, § 388-106-1455, filed 8/30/22, effective 9/30/22; WSR 13-18-039 and 13-17-125, § 388-106-1455, filed 8/29/13 and 8/21/13, effective 10/1/13; WSR 10-08-074, § 388-106-1455, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1455, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1458 How do I create and use my spending plan? (1) You create your spending plan in collaboration with your care consultant using the CARE tool.

(2) The spending plan must be approved by both you and the care consultant.

(3) You, as the participant, must identify how many personal care service units you intend to purchase prior to the month you plan to use them (service month).

(4) The value of those units is deducted from your new freedom budget.

(5) The rest of the funds can be used for other covered goods and services or saved.

(6) Once a service month begins, the number of personal care units may not be altered during that month.

(7) The maximum number of personal care units that can be purchased from the monthly budget is calculated from the individual budget as described in WAC 388-106-1445, divided by the individual provider average wage including mileage.

(8) Prior to the service month, you may elect to use savings funds to buy additional personal care.

(9) You may choose to have your personal care provided by an individual provider (IP) or a home care agency.

(10) Each unit will be deducted from your new freedom budget at the average IP wage rate including mileage.

(11) The balance of your individual new freedom budget will be available in your NFSP to save or purchase other goods and services up to the limit described in WAC 388-106-1455(2).

(12) If you have a change of condition or situation and your new freedom budget increases due to a new assessment or exception to rule, you may purchase additional personal care from an IP or home care agency mid-month at the average IP rate, including mileage during the month your budget changed.

(13) You may assign your predetermined personal care units to a different provider during the month of service.

(14) Under chapter 388-114 WAC, individual providers for one or more department clients who work more than 40 hours in a work week, are entitled to overtime and the responsibility for paying the extra cost as follows:

(a) If the individual provider is contracted with the department and approved to work more than 40 hours per week as described in WAC 388-114-0080, the department will pay the extra cost for overtime up to the number of service hours the individual provider is approved to work and the payment for these extra costs will not be charged to your budget; and

(b) If you assign more overtime hours to your individual provider than the department approved, you must pay the extra costs for the unapproved overtime hours and the additional cost will impact your monthly budget and may reduce the number of service hours you are able to purchase from it.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 22-18-047, § 388-106-1458, filed 8/30/22, effective 9/30/22. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.832, 74.39A.270, 74.39A.056, 74.39A.074, 43.20A.710, 74.39A.525, 43.43.842, 74.39A.326, 74.39A.515, 74.39A.505, 18.88B.021, 43.43.837 and 2018 c 278. WSR 21-18-081, § 388-106-1458, filed 8/30/21, effective 10/1/21. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.270, and 2016 1st sp.s. c 30. WSR 17-08-065, § 388-106-1458, filed 3/31/17, effective 5/1/17. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 13-18-039 and 13-17-125, § 388-106-1458, filed 8/29/13 and 8/21/13, effective 10/1/13.]

WAC 388-106-1460 When can my New Freedom spending plan (NFSP) be denied? Your NFSP may be denied when the plan you develop includes noncovered items from WAC 388-106-1405 and/or does not:

(a) Include only services in the New Freedom service definition found in WAC 388-106-1400;

(b) Address your needs as it relates to performance of activities of daily living and instrumental activities of daily living;

(c) Include strategies and steps to address known critical risks;

(d) Identify a reasonable payment rate; or

(e) Adequately describe the service.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 13-18-039 and 13-17-125, § 388-106-1460, filed 8/29/13 and 8/21/13, effective

10/1/13. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1460, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1465 Who can deny my New Freedom spending plan (NFSP)? Your plan can be denied by your New Freedom consultant, who assists NFCDS participants to develop and use a New Freedom spending plan to:

(a) Address identified personal care, health and safety needs;
(b) Develop options to meet those needs;
(c) Make informed decisions about their individual budget; and
(d) Obtain identified supports and services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 13-18-039 and 13-17-125, § 388-106-1465, filed 8/29/13 and 8/21/13, effective 10/1/13. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1465, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1470 Are there waiting lists for New Freedom consumer directed services (NFCDS)? The department will create a waiting list for NFCDS in accordance with caseload limits determined by legislative funding. Participants on the waiting list will gain access in the following order:

(1) Nursing home residents who are returning home and are assessed for NFCDS waiver services will be ranked first on the waiting list by date of application for services;

(2) Individuals living in the community with a higher level of need, as determined by the CARE assessment, will be ranked higher on the waitlist over participants with a lower level of need; and

(3) When two or more individuals on the waiting list have equal need levels, the individual with the earlier application for NFCDS will have priority over later applications for services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1470, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1475 How do I end enrollment in New Freedom consumer directed services (NFCDS)? (1) You may choose to voluntarily end your enrollment from NFCDS without cause at any time. To do so, you must give notice to the department. If you give notice:

(a) Before the 15th of the month, the department will end your enrollment at the end of the month; or

(b) After the 15th, the department will end your enrollment the end of the following month.

(2) Your enrollment may also end involuntarily if you:

(a) Move out of the designated service area or are out of the service area for more than 30 consecutive days, unless you have documented the purpose of the longer absence in the NFSP; or

(b) Do not meet the terms for consumer direction of services outlined in the New Freedom Participant Responsibility Agreement when:

(i) Even with coaching and collaboration, you are unable to develop a NFSP or self-direct services or manage your individual budget or NFSP;

(ii) Any one factor or several factors of such a magnitude jeopardize the health, welfare, and safety of you and others, requiring termination of services under WAC 388-106-0047;

(iii) You become financially ineligible for medicaid services;

(iv) You no longer meet the nursing facility level of care requirement as defined in WAC 388-106-0355;

(v) You misuse program funds and services as determined by the department; or

(vi) You are unable to follow the responsibilities of a participant on the New Freedom program as determined by the department.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 22-18-047, § 388-106-1475, filed 8/30/22, effective 9/30/22; WSR 13-18-039 and 13-17-125, § 388-106-1475, filed 8/29/13 and 8/21/13, effective 10/1/13. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1475, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1480 What are my hearing rights to appeal New Freedom consumer directed services (NFCDS) assessment and eligibility actions? You have a right to a hearing under WAC 388-106-1300 through 388-106-1315, and under chapter 182-526 WAC.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 13-18-039 and 13-17-125, § 388-106-1480, filed 8/29/13 and 8/21/13, effective 10/1/13. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. WSR 06-16-035, § 388-106-1480, filed 7/25/06, effective 8/25/06.]

NURSING FACILITY CERTIFICATE OF NEED

WAC 388-106-1600 What definitions apply to the nursing facility certificate of need? "Activities of daily living", as defined in WAC 388-106-0010, includes tasks such as walking, eating, taking medications, maintaining personal hygiene, moving in bed and toileting.

"Care assessment" is an assessment tool used to determine eligibility for services and level of service need, and identify strengths, preferences and potential referrals to develop an individualized care plan.

"Certificate of need program" is a regulatory process under chapter 70.38 RCW that requires certain health care providers, including nursing homes, to receive approval from the department of health before building certain types of facilities or offering new or expanded services.

"Community residential" refers to licensed community settings such as assisted living facilities and adult family homes where long-term care services are provided to residents.

"Department" means the department of social and health services.

"Department of health" is the state agency that operates the certificate of need review program and determines the need for specific facilities and services, including nursing homes, in a manner that is consistent with the statewide health resources strategy developed under RCW 43.370.030 and chapter 70.38.

"In-home personal care" is care provided by an agency or individual provider to clients living in their own home.

"Minimum data set" or **"MDS"** is a tool that is used to perform the comprehensive assessment of each resident's functional capabilities, which is required for all residents in medicare or medicaid certified nursing homes.

"RUG-III score" is the classification of each nursing facility resident into a specific group based on the individual's medical condition and level of care required.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-05-061, § 388-106-1600, filed 2/18/14, effective 3/21/14.]

WAC 388-106-1610 What is the purpose of determining nursing facility comparable home and community-based long-term capacity? The department of health's certificate of need program is required to determine the need for nursing homes under WAC 246-310-210 (6)(b)(ii). The determination of need is based in part upon the availability of home and community-based long-term services in the planning area of the proposed nursing facility. When evaluating the need for additional nursing home beds, the data considered by the department of health must include data provided by the department.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-05-061, § 388-106-1610, filed 2/18/14, effective 3/21/14.]

WAC 388-106-1620 What methodology does the department use to determine statewide or county specific nursing home comparable home and community-based long-term services availability? The department uses the following methodology to determine the statewide or county specific nursing home comparable home and community-based long-term services availability.

(1) The department selects a recent, one-year time period from which to use MDS assessment data.

(2) The "typical RUG-III ADL score" is determined as follows. From the MDS data, two activity of daily living (ADL) RUG-III score values are calculated: (1) the mean RUG-III ADL score, rounded to the nearest whole number, and (2) the modal RUG-III ADL score that occurs most commonly in the nursing home population in the selected time period. The "typical RUG-III ADL score" is the lower of the mean and modal values.

(3) Using the most recent month that both payment and assessment data are considered to be complete, persons receiving medicaid paid in-home personal care or community residential services are identified, and the MDS-equivalent ADL score from each home and community-based client's current CARE assessment is constructed.

(4) Using data from the month selected in subsection (3), count the number of in-home personal care clients being served by either the aging and long-term support or developmental disabilities administrations who have an MDS-equivalent score at or above the typical RUG-III ADL nursing home score that was calculated in subsection (2).

(5) Using data from the month selected in subsection (3), calculate the proportion of medicaid-paid community residential clients with an MDS-equivalent score that is at or above the typical RUG-III ADL nursing home score calculated in subsection (2).

(a) When determining county level measures of nursing home comparable home and community based capacity, the statewide average for medicaid paid community residential clients is used.

(6) Calculate the overall statewide licensed capacity of community residential facilities.

(7) The proportion calculated in subsection (5) and the community residential capacity determined in subsection (6) are multiplied to estimate the community residential capacity that is nursing home comparable.

(8) Add the numbers calculated in subsections (4) and (7) to determine the total countable nursing-home-comparable home and community-based long-term capacity to be used in reporting to the department of health the availability of other services in the community as required in RCW 70.38.115.

[Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 14-05-061, § 000-106-1620 (codified as WAC 388-106-1620), filed 2/18/14, effective 3/21/14.]

SUPPORTIVE HOUSING

WAC 388-106-1700 What definitions apply to supportive housing? The following definitions apply to WAC 388-106-1700 through 388-106-1765:

"Supportive housing tenant" is a person utilizing voluntary supportive services who is:

(1) Living in a stable community setting of their choosing including hotels/motels; or

(2) Entitled to occupy a dwelling unit primarily for living or dwelling purposes under a rental agreement pursuant to chapter 59.18 RCW.

[Statutory Authority: RCW 74.08.090, 74.08.283, and 74.08.390. WSR 25-20-014, s 388-106-1700, filed 9/19/25, effective 10/20/25; WSR 17-11-016, § 388-106-1700, filed 5/9/17, effective 6/9/17.]

WAC 388-106-1705 What services may I receive under supportive housing? (1) The services you may receive under supportive housing include, but are not limited to, activities that assist you to:

(a) Identify appropriate housing;

(b) Prepare for and transition to housing;

(c) Connect with direct and collateral services;

(d) Maintain your housing;

(e) Develop and maintain a positive relationship with your landlord and other tenants; and

(f) Integrate into your community and support social inclusion.

(2) The services you receive will be identified in your assessment as defined in WAC 388-106-0010.

[Statutory Authority: RCW 74.08.090, 74.08.283, and 74.08.390. WSR 25-20-014, s 388-106-1705, filed 9/19/25, effective 10/20/25; WSR 17-11-016, § 388-106-1705, filed 5/9/17, effective 6/9/17.]

WAC 388-106-1710 Where may I receive supportive housing services? (1) You may receive supportive housing services in:

(a) Your place of residence; or

(b) The community setting where the authorized service occurs.

(2) Supportive housing services must be provided in:

(a) Washington state or a recognized out-of-state bordering city as defined in WAC 182-501-0175;

(b) An integrated setting of your choice; and

(c) A manner that ensures your individual right of privacy, dignity, respect, and freedom from coercion and restraint.

(3) Once you are a supportive housing tenant, your supportive housing services must be provided in a setting as defined in 42 C.F.R. Sec. 441.530, such as those that:

(a) Do not have the qualities of an institution;

(b) Are not located in a building that is also a publicly or privately operated facility providing inpatient institutional treatment;

(c) Are not on the grounds of, or immediately adjacent to a public institution;

(d) Do not have the effect of isolating you from community members who are not receiving medicaid services; and

(e) Are not a licensed residential care facility such as an adult family or assisted living facility.

[Statutory Authority: RCW 74.08.090, 74.08.283 and 74.08.390. WSR 17-11-016, § 388-106-1710, filed 5/9/17, effective 6/9/17.]

WAC 388-106-1715 Who may provide supportive housing services? To provide supportive housing services, supportive housing providers must meet minimum qualifications as established by DSHS supportive housing contract language and pass a DSHS criminal history background check.

[Statutory Authority: RCW 74.08.090, 74.08.283 and 74.08.390. WSR 17-11-016, § 388-106-1715, filed 5/9/17, effective 6/9/17.]

WAC 388-106-1720 Am I eligible for supportive housing funded services? You are eligible for supportive housing services if you meet the following criteria:

(1) Meet functional eligibility as defined in WAC 388-106-0210, 388-106-0277, 388-106-0310, 388-106-0338, or 388-106-1410;

(2) Meet financial eligibility as defined in chapters 182-513 and 182-515 WAC;

(3) Have a planned discharge or diversion from Eastern or Western State Hospital; or

(4) Meet foundational community supports program (FCS) supportive housing eligibility as defined by chapter 182-559 WAC.

[Statutory Authority: RCW 74.08.090, 74.08.283, and 74.08.390. WSR 25-20-014, s 388-106-1720, filed 9/19/25, effective 10/20/25. Statutory Authority: RCW 74.08.090. WSR 18-08-002, § 388-106-1720, filed 3/21/18, effective 4/21/18. Statutory Authority: RCW 74.08.090, 74.08.283 and 74.08.390. WSR 17-11-016, § 388-106-1720, filed 5/9/17, effective 6/9/17.]

WAC 388-106-1725 When do supportive housing services begin? Your supportive housing services begin on the date the department authorizes your supportive housing services.

[Statutory Authority: RCW 74.08.090, 74.08.283 and 74.08.390. WSR 17-11-016, § 388-106-1725, filed 5/9/17, effective 6/9/17.]

WAC 388-106-1730 How do I remain eligible for supportive housing? (1) To remain eligible for supportive housing you must remain functionally eligible as defined in WAC 388-106-0210, 388-106-0277, 388-106-0310, 388-106-0338, or 388-106-1410 and financially eligible as defined in chapters 182-513 and 182-515 WAC.

(2) If eligibility laws, regulations, or rules for supportive housing change, and if you do not meet the changed eligibility requirements, the department will terminate your services, even if your functional or financial circumstances have not changed.

[Statutory Authority: RCW 74.08.090, 74.08.283 and 74.08.390. WSR 17-11-016, § 388-106-1730, filed 5/9/17, effective 6/9/17.]

WAC 388-106-1735 Do I have to pay for my supportive housing services? The department will not require you to pay toward the cost of your supportive housing services.

[Statutory Authority: RCW 74.08.090, 74.08.283 and 74.08.390. WSR 17-11-016, § 388-106-1735, filed 5/9/17, effective 6/9/17.]

WAC 388-106-1745 May I be employed and receive supportive housing services? You may be employed and receive supportive housing services as long as you remain medicaid eligible under the categorically needy (CN) program or alternative benefit plan (ABP) program.

[Statutory Authority: RCW 74.08.090, 74.08.283 and 74.08.390. WSR 17-11-016, § 388-106-1745, filed 5/9/17, effective 6/9/17.]

WAC 388-106-1750 Are there limits to the supportive housing services I receive? There are limits to the supportive housing services you receive. Supportive housing services must not:

(1) Exceed the amount authorized by the department;

(2) Replace or duplicate existing services already available to you such as foundational community supports as defined in WAC 182-559-100.

[Statutory Authority: RCW 74.08.090, 74.08.283, and 74.08.390. WSR 25-20-014, s 388-106-1750, filed 9/19/25, effective 10/20/25; WSR 17-11-016, § 388-106-1750, filed 5/9/17, effective 6/9/17.]

WAC 388-106-1755 Are there waiting lists for supportive housing? The department may create a waiting list for supportive housing services in accordance with funding appropriation.

[Statutory Authority: RCW 74.08.090, 74.08.283 and 74.08.390. WSR 17-11-016, § 388-106-1755, filed 5/9/17, effective 6/9/17.]

WAC 388-106-1765 When may the department terminate or deny supportive housing services? The department may deny or terminate supportive housing services if you are not eligible for long-term care services pursuant to WAC 388-106-0047, 388-106-0210, 388-106-0277, 388-106-0310, 388-106-0338, or 388-106-1410.

[Statutory Authority: RCW 74.08.090, 74.08.283 and 74.08.390. WSR 17-11-016, § 388-106-1765, filed 5/9/17, effective 6/9/17.]

LONG-TERM SERVICES AND SUPPORTS (LTSS) PRESUMPTIVE ELIGIBILITY (PE)

WAC 388-106-1800 What definitions apply to LTSS PE? "Abbreviated care plan" means the document generated using the presumptive eligibility screening tool in CARE that identifies the long-term services and supports you are eligible to receive during the presumptive eligibility period under step 1.

"Acute care hospital" as defined in chapter 182-550 WAC, may offer inpatient services, outpatient services, continuous nursing services, pharmacy services, food services, and necessary ancillary services. These hospitals may offer specialized patient care services including alcoholism and chemical dependency units or services.

"Comprehensive assessment reporting evaluation tool" or "CARE" means the department prescribed assessment tool.

"Care plan" means the document generated using the presumptive eligibility assessment tool in CARE that identifies the long-term services and supports you are eligible to receive during the presumptive eligibility period under step 2.

"Community psychiatric hospital" means a specialized psychiatric hospital or psychiatric unit within a community hospital that is certified to provide involuntary evaluation and treatment services.

"Diversion" means you have discharged from a local community psychiatric facility onto HCS LTSS and have a 90- or 180-day commitment order for further involuntary treatment; or you are detained through the Involuntary Treatment Act and are stabilized and discharged onto LTSS prior to the need to petition for a 90- or 180- day commitment order.

"Home and community services" or "HCS" means a division within the DSHS home and community living administration (HCLA).

"LTSS" means long-term services and supports as defined in WAC 182-513-1100.

"MPC" means medicaid personal care which is defined as personal care services in WAC 388-106-0010.

"NFLOC" means nursing facility level of care as defined in WAC 388-106-0355.

"PE assessment" means the questions asked, using the presumptive eligibility assessment tool within CARE, to determine the level of care that is needed and opens step 1 and 2 services.

"PE screening" means the minimum functional and financial abbreviated questionnaire to obtain the minimum information necessary, completed using the presumptive eligibility screening tool within CARE,

to determine presumptive eligibility for LTSS NFLOC PE services or LTSS MPC PE services.

"Presumptive eligibility" means a determination made using a screening process completed by the department to gather preliminary information to determine if you meet the eligibility criteria described in WAC 388-106-1805 and 388-106-1815 of this section to receive services while the final eligibility determination is being completed. This is also known as PE.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 26-07-011, s 388-106-1800, filed 3/6/26, effective 4/6/26; WSR 23-21-012, § 388-106-1800, filed 10/5/23, effective 11/6/23.]

WAC 388-106-1805 Am I eligible for LTSS NFLOC PE services? You are eligible to receive LTSS NFLOC PE services if you meet the following criteria based upon the attested information in your PE screening:

(1) Meet functional eligibility requirements as defined in WAC 388-106-0355 (1)(a), (b), (c), or (d); and

(2) Meet financial eligibility requirements as defined in WAC 182-513-1315; and

(3) Live in your own home as defined in WAC 388-106-0010; and

(4) Are not receiving any other medicaid funded long-term services and supports.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 26-07-011, s 388-106-1805, filed 3/6/26, effective 4/6/26; WSR 23-21-012, § 388-106-1805, filed 10/5/23, effective 11/6/23.]

WAC 388-106-1810 What services may I receive under LTSS NFLOC PE? You may receive LTSS NFLOC PE services under either of the two steps depending on your needs and requests identified in the LTSS PE screening for step 1 or the LTSS PE assessment for step 2. Steps do not need to be used in order. For example, you may begin services at step 1 or 2. In general, step 1 services are used by clients requesting lesser supports than those using step 2 services.

(1) Step 1: After completing an LTSS PE screening and abbreviated care plan, you may receive any of the following services:

(a) Personal emergency response system (PERS), as defined in WAC 388-106-0270;

(b) Home delivered meals, as defined in WAC 388-106-0300;

(c) Assistive/adaptive technology and equipment, as defined in WAC 388-106-0270;

(2) Step 2: After completing an LTSS PE assessment and care plan, you may receive any of the services under step 1 or one or more of the following services:

(a) Nurse delegation, as defined in WAC 388-106-0270;

(b) Specialized medical equipment and supplies, as defined in WAC 388-106-0300;

(c) Community transition or sustainability services as defined in WAC 388-106-0270, 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:

(i) Security deposits that are required to lease an apartment or home;

(ii) Activities to assess need, arrange for, and obtain needed resources, including essential household furnishings;

(iii) Set-up fees or deposits for utility or services access, including telephone, electricity, heating, water, and garbage;

(iv) Services necessary for your health and safety such as pest eradication and one-time cleaning prior to occupancy;

(v) Moving expenses; and

(vi) Minor home accessibility modifications necessary for hospital discharge.

(d) Community choice guide: Specialty services providing assistance and support to ensure an individual's successful transition to the community, or maintenance of independent living, as defined in WAC 388-106-0300; and

(e) Supportive housing as defined in chapter 388-106 WAC.

(f) Up to a maximum of 103 hours a month of personal care services, as defined in WAC 388-106-0010;

(i) The number of hours of personal care services you can receive in your own home is determined by five-tier classifications using the CARE tool to assess your characteristics.

(ii) The number of hours of personal care services you may receive for the five tier classifications are:

(A) Tier 1 is a maximum of 34 hours.

(B) Tier 2 is a maximum of 47 hours.

(C) Tier 3 is a maximum of 59 hours.

(D) Tier 4 is a maximum of 69 hours.

(E) Tier 5 is a maximum of 103 hours.

(iii) The CARE tool uses the following criteria to place you in a tier classification group:

(A) To be eligible for tier 1 classification, you have:

(I) An unmet or partially met need with at least three of the following activities of daily living, as defined in WAC 388-106-0010: or

For each activity of daily living, the minimum level of assistance required in each of the following categories:		
	Self-performance is:	**Support provided is:**
Eating	n/a	Setup
Toileting	Supervision	n/a
Bathing	Supervision	n/a
Transfer	Supervision	Setup
Bed mobility	Supervision	Setup
Walk in room, or locomotion in room, or locomotion outside immediate living environment	Supervision	Setup
Medication management	Assistance required	n/a
Your need for assistance in any activities listed in this chart did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

(II) A cognitive impairment and require supervision due to one or more of the following: disorientation, memory impairment, impaired decision making, or wandering; and

(III) An unmet or partially met need with at least one or more of the following:

For each activity of daily living, the minimum level of assistance required in each of the following categories:		
	Self-performance is:	**Support provided is:**
Eating	Supervision	One-person physical assist

For each activity of daily living, the minimum level of assistance required in each of the following categories:		
	Self-performance is:	**Support provided is:**
Toileting	Extensive assistance	One-person physical assist
Bathing	Physical help with bathing	One-person physical assist
Transfer	Extensive assistance	One-person physical assist
Bed mobility and turning and repositioning	Limited assistance and need	One-person physical assist
Walk in room, or locomotion in room, or locomotion outside immediate living environment	Extensive assistance	One-person physical assist
Medication management	Assistance required daily	n/a
Your need for assistance in any activities listed in this chart did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

(B) To be eligible for tier 2 classification, you:

(I) Require care provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis; or

(II) Have an unmet or partially met need with at least two of the following activities of daily living, as defined in WAC 388-106-0010:

For each activity of daily living, the minimum level of assistance required in each of the following categories:		
	Self-performance is:	**Support provided is:**
Eating	Supervision	One-person physical assist
Toileting	Extensive assistance	One-person physical assist
Bathing	Physical help with bathing	One-person physical assist
Transfer	Extensive assistance	One-person physical assist
Bed mobility and turning and repositioning	Limited assistance and need	One-person physical assist
Walk in room, or locomotion in room, or locomotion outside immediate living environment	Extensive assistance	One-person physical assist
Medication management	Assistance required daily	n/a
Your need for assistance in any activities listed in this chart did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

(C) To be eligible for tier 3 classification, you have an unmet or partially met need with at least three of the following activities of daily living, as defined in WAC 388-106-0010:

For each activity of daily living, the minimum level of assistance required in each of the following categories:		
	Self-performance is:	**Support provided is:**
Eating	Supervision	One-person physical assist
Toileting	Extensive assistance	One-person physical assist
Bathing	Physical help with bathing	One-person physical assist
Transfer	Extensive assistance	One-person physical assist
Bed mobility and turning and repositioning	Limited assistance and need	One-person physical assist
Walk in room, or locomotion in room, or locomotion outside immediate living environment	Extensive assistance	One-person physical assist
Medication management	Assistance required daily	n/a
Your need for assistance in any activities listed in this chart did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

(D) To be eligible for tier 4 classification, you:

(I) Require care provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis; and

(II) Have an unmet or partially met need with at least three of the following activities of daily living, as defined in WAC 388-106-0010:

For each activity of daily living, the minimum level of assistance required in each of the following categories:		
	Self-performance is:	**Support provided is:**
Eating	Supervision	One-person physical assist
Toileting	Extensive assistance	One-person physical assist
Bathing	Physical help with bathing	One-person physical assist
Transfer	Extensive assistance	One-person physical assist
Bed mobility and turning and repositioning	Limited assistance and need	One-person physical assist
Walk in room, or locomotion in room, or locomotion outside immediate living environment	Extensive assistance	One-person physical assist
Medication management	Assistance required daily	n/a
Your need for assistance in any activities listed in this chart did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

(E) To be eligible for tier 5 classification, you:

(I) Are bedfast/chairfast, as defined by you are confined primarily to a bed or recliner, or if you are wheelchair dependent when not in a bed or recliner; and

(II) Require care provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis; and

(III) Have an unmet or partially met need with at least three of the following activities of daily living, as defined in WAC 388-106-0010:

For each activity of daily living, the minimum level of assistance required in each of the following categories:		
	Self-performance is:	**Support provided is:**
Eating	Supervision	One-person physical assist
Toileting	Extensive assistance	One-person physical assist
Bathing	Physical help with bathing	One-person physical assist
Transfer	Extensive assistance	One-person physical assist
Bed mobility and turning and repositioning	Limited assistance and need	One-person physical assist
Walk in room, or locomotion in room, or locomotion outside immediate living environment	Extensive assistance	One-person physical assist
Medication management	Assistance required daily	n/a
Your need for assistance in any activities listed in this chart did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 26-07-011, s 388-106-1810, filed 3/6/26, effective 4/6/26; WSR 23-21-012, § 388-106-1810, filed 10/5/23, effective 11/6/23.]

WAC 388-106-1815 Am I eligible for LTSS MPC PE services? You are eligible to receive LTSS MPC PE services if you meet the following criteria based upon the attested information in your PE screening:

(1) Meet functional eligibility requirements as defined in WAC 388-106-0210; and

(2) Meet financial eligibility requirements as defined in WAC 182-513-1225; and

(3) Live in your own home as defined in WAC 388-106-0010; and

(4) Are not receiving any other medicaid funded long-term services and supports.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 26-07-011, s 388-106-1815, filed 3/6/26, effective 4/6/26; WSR 23-21-012, § 388-106-1815, filed 10/5/23, effective 11/6/23.]

WAC 388-106-1820 What services may I receive under LTSS MPC PE? Under LTSS MPC PE you may receive up to 34 hours per month of personal care services as defined in WAC 388-106-0010.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 23-21-012, § 388-106-1820, filed 10/5/23, effective 11/6/23.]

WAC 388-106-1825 Who can provide long-term care services when I am eligible for LTSS NFLOC or LTSS MPC PE services? The following types of providers can provide long-term care services:

(1) Individual providers (IPs) as defined in WAC 388-115-0503, who provide services to clients in the client's own home.

(2) Home care agencies that provide services to clients in the client's own home. Home care agencies must be licensed under chapter 70.127 RCW and chapter 246-335 WAC and contracted with the department.

(3) Providers who have contracted with the department to perform other services.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 23-21-012, § 388-106-1825, filed 10/5/23, effective 11/6/23.]

WAC 388-106-1830 When will the department authorize my LTSS NFLOC or LTSS MPC PE services? The department will authorize LTSS NFLOC PE or LTSS MPC PE services when you:

(1) Are found both financially and functionally eligible for PE services by completing your PE screening which includes the amount of participation toward the cost of your care that you must pay (if any);

(2) Have given consent for services and approved your care plan; and

(3) Have chosen a DSHS qualified provider(s), per WAC 388-71-0510.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 23-21-012, § 388-106-1830, filed 10/5/23, effective 11/6/23.]

WAC 388-106-1835 When do LTSS NFLOC PE or LTSS MPC PE services end? (1) Your LTSS NFLOC PE or LTSS MPC PE services end with the earlier date of:

(a) The date the decision was made on your application as defined in WAC 388-106-0010;

(b) The date you were confirmed by a CARE assessment to not meet functional eligibility criteria as defined in WAC 388-106-0355 or 388-106-0210; or

(c) The last day of the month following the month in which your presumptive eligibility services were authorized if you did not submit your application.

(2) You may only receive LTSS NFLOC PE or LTSS MPC PE services once within a 24-month period.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 23-21-012, § 388-106-1835, filed 10/5/23, effective 11/6/23.]

WAC 388-106-1840 Where can I receive LTSS NFLOC PE or LTSS MPC PE services? You can receive LTSS NFLOC PE or LTSS MPC PE services:

(1) In your own home as defined in WAC 388-106-0010;

(2) While you are out of your home accessing the community or working while:

(a) within the state of Washington; or

(b) in a recognized out-of-state bordering city as defined in WAC 182-501-0175.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 23-21-012, § 388-106-1840, filed 10/5/23, effective 11/6/23.]

WAC 388-106-1845 What do I pay for if I receive LTSS NFLOC PE or LTSS MPC PE services? (1) If you receive LTSS MPC PE services you are not required to pay toward the cost of care for those services.

(2) If you receive LTSS NFLOC PE, you may be required to pay toward the cost of your care as outlined in WAC 182-515-1509. You are allowed to keep some of your income for a maintenance allowance.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 23-21-012, § 388-106-1845, filed 10/5/23, effective 11/6/23.]

WAC 388-106-1850 Do I have a right to an administrative hearing on LTSS NFLOC PE or LTSS MPC PE determinations? Applicants do not have an administrative hearing right as defined in chapter 388-02 WAC on LTSS NFLOC PE or LTSS MPC PE eligibility determinations.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 23-21-012, § 388-106-1850, filed 10/5/23, effective 11/6/23.]

WAC 388-106-1855 Can an exception to rule (ETR) be granted for eligibility or service determinations? ETRs will not be granted for LTSS NFLOC PE or LTSS MPC PE eligibility determinations or service determinations.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 23-21-012, § 388-106-1855, filed 10/5/23, effective 11/6/23.]

MAC AND TSOA SERVICES

WAC 388-106-1900 What definitions apply to MAC and TSOA services? The following definitions apply to MAC and TSOA services:

"Care plan" means the plan developed by the department in GetCare that summarizes the services described in WAC 388-106-1915 that you chose to receive.

"Care receiver" means an adult age 55 and over who has been authorized for MAC or TSOA services.

"Caregiver" means a spouse, relative, or friend (age 18 and over) who has primary responsibility for the care or supervision of an adult who meets eligibility criteria and does not receive direct, public, or private payment such as a wage for the caregiving services they provide.

"Caregiver assistance services" are services that take the place of those typically performed by an unpaid caregiver in support of the care receiver's unmet needs for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

"Caregiver phases" means the phases a caregiver experiences as the needs of the care receiver change, which in turn changes the responsibilities and tasks of caregiving. The change in responsibilities and tasks impacts the relationship between the caregiver and the care receiver. There are five phases showing the change in relationship roles from primarily family member to primarily caregiver. The five phases are:

(1) Phase one - Acting as a relative/friend almost all of the time;

(2) Phase two - Acting most often as a relative/friend, but sometimes as a caretaker;

(3) Phase three - Acting equally as a relative/friend and as a caregiver;

(4) Phase four - Acting most often as a caregiver, but sometimes you are still a relative/friend; and

(5) Phase five - Acting as a caregiver almost all of the time.

"Family caregiver" means the same as "caregiver."

"GetCare" means a statewide web-based information system that includes a client management component that includes screening and assessment tools for use by area agencies on aging (AAA) and other aging and disability network partners.

"GetCare assessment" is a process during which the department gathers information for an individual without a caregiver in the following areas: Functional needs, diagnoses and conditions, behavior health supports, oral health, and nutritional health to assist the individual with choosing step three services.

"GetCare screening" is a process during which the department gathers information for an individual without a caregiver in order to determine risk scores. The information covers the following areas: Function needs, fall risk, availability of informal help, memory and decision-making issues, and emotional well-being. The risk scores are used to determine if the individual is referred for a full GetCare assessment.

"Health maintenance and therapies" are 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.

"Identity discrepancy" means a negative psychological state that occurs when the activities and responsibilities that a caregiver assumes with regard to the care receiver are inconsistent with the caregiver's expectations or personal norms concerning these activities and responsibilities.

"MAC" means medicaid alternative care, which is a federally funded program authorized under section 1115 of the Social Security Act. It enables an array of person-centered services to be delivered to unpaid caregivers caring for a medicaid eligible person who lives in a private residence (such as their own home or a family member's home) and chooses to receive community-based services.

"Medicaid transformation project" refers to the authority granted to the state by the federal government under section 1115 of the Social Security Act. This is a five year demonstration waiver to support health care systems prepare for and implement health reform and provide new targeted medicaid services to eligible individuals with significant needs. It includes MAC and TSOA programs.

"Personal assistance services" are supports involving the labor of another person to help the care receiver complete activities of daily living and instrumental activities of daily living that they are unable to perform independently. Services may be provided in the care receiver's home or to access community resources.

"RDAD" means reducing disability in Alzheimer's disease. This program is designed to improve the ability of the person with memory problems to complete activities of daily living while also helping caregivers provide assistance to the person.

"Service provider" means an agency or organization contracted with the department.

"Specialized medical equipment and supplies" are goods and supplies needed by the care receiver that are not covered under the medicaid state plan, medicare, or private insurance.

"TCARE" means tailored caregiver assessment and referral, which is an evidence-based caregiver coordination process designed to assist department assessors who work with family caregivers to support adults living with disabilities. TCARE is designed to tailor services to the unique needs of each caregiver to help reduce stress, depression, and burdens associated with caregiving. TCARE was developed by a research team at the University of Wisconsin-Milwaukee led by Dr. Rhonda Montgomery in collaboration with over 30 organizations serving family caregivers. The TCARE process is licensed for use by Tailored Care Enterprises, Inc.

"TCARE assessment" is a part of the TCARE process during which the department assessors gather responses to all of the TCARE screening questions and additional questions focused on both the caregiver's experience and the care receiver's situation, such as memory issues, behavioral needs, assistance needs with activities of daily living and instrumental activities of daily living, and diagnoses/conditions.

"TCARE screening" is a part of the TCARE process during which the department gathers information from the caregiver to determine scores and ranges for the caregiver's identity discrepancy, burdens, uplifts, and depression. The ranges are used to determine if the caregiver is referred for a full TCARE assessment.

"Training and education" are services and supports to help caregivers gain skills and knowledge to implement services and supports

needed by the care receiver to remain at home and skills needed by the caregiver to remain in their role.

"TSOA" means tailored supports for older adults, which is a federally-funded program approved under section 1115 of the Social Security Act. It enables the delivery of person-centered services to:

(1) Caregivers who care for an eligible person as defined in WAC 388-106-1910; and

(2) Eligible persons as defined in WAC 388-106-1910, without a caregiver.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 23-15-060, § 388-106-1900, filed 7/14/23, effective 8/14/23; WSR 22-18-004, § 388-106-1900, filed 8/25/22, effective 9/25/22. Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1900, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1905 Am I eligible for MAC services? (1) You are eligible to receive MAC services if you, as a care receiver, meet the following criteria:

(a) Are age 55 or older;

(b) Meet nursing facility level of care as defined in WAC 388-106-0355;

(c) Meet medicaid financial eligibility requirements as defined in WAC 182-513-1605;

(d) Have an unpaid caregiver who:

(i) Is age 18 or older;

(ii) Has participated in the following:

(A) Care plan for step one services;

(B) TCARE screening and care plan for step two services; or

(C) TCARE assessment and care plan for step three services;

(e) Live in a private residence (such as your own home or a family member's home) and choose to receive community based services; and

(f) Do not receive any other medicaid funded long-term services and supports (LTSS) while receiving MAC services.

(2) The department may use preliminary information you provide through a presumptive eligibility screening to determine if you, as the care receiver, meet the eligibility criteria in subsection (1) of this section in order to receive services while the formal eligibility determination is being completed. This is called presumptive eligibility.

(a) Your presumptive eligibility period ends with the earlier date of:

(i) The date you were confirmed not to meet full functional eligibility criteria; or

(ii) The last day of the month following the month when your MAC services were first authorized.

(b) In the event the department implements a waitlist under WAC 388-106-1970 for MAC services, your presumptive eligibility ends.

(c) You may only receive services under presumptive eligibility once within a 24 month period.

(d) Under presumptive eligibility you may receive services as described in WAC 388-106-1915.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 22-18-004, § 388-106-1905, filed 8/25/22, effective 9/25/22. Statutory Authority:

RCW 74.08.090. WSR 18-08-033, § 388-106-1905, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1910 Am I eligible for TSOA services? (1) You are eligible to receive TSOA services if you, as a care receiver, meet the following criteria:

(a) Are age 55 or older;

(b) Meet nursing facility level of care as defined in WAC 388-106-0355;

(c) Meet financial eligibility requirements defined in WAC 182-513-1615 or 182-513-1620;

(d) Live in a private residence (such as your own home or a family member's home) and choose to receive community-based services; and

(e) Meet the criteria in either (e)(i) or (ii) of this subsection:

(i) Have an unpaid caregiver who is age 18 or older and has participated in the following:

(A) A care plan for step one services;

(B) A TCARE screening and care plan for step two services; or

(C) A TCARE assessment and care plan for step three services; or

(ii) You do not have an available caregiver and have participated in the following:

(A) A care plan for step one services;

(B) A GetCare screening and care plan for step two services; or

(C) A GetCare assessment and care plan for step three services.

(2) The department may use preliminary information you provide through a presumptive eligibility screening to determine if you, as the care receiver, meet the eligibility criteria in subsection (1) of this section in order to receive services while the formal eligibility determination is being completed. This is called presumptive eligibility.

(a) Your presumptive eligibility period ends with the earlier date of:

(i) The day the decision was made on your TSOA application;

(ii) The date you were confirmed not to meet full functional eligibility criteria; or

(iii) The last day of the month following the month in which your presumptive eligibility services were authorized if you did not submit your TSOA application.

(b) In the event the department implements a waitlist under WAC 388-106-1970 for TSOA services, your presumptive eligibility ends.

(c) You may only receive services under presumptive eligibility once within a 24 month period.

(d) Under presumptive eligibility, you may receive services as described in WAC 388-106-1915.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 22-18-004, § 388-106-1910, filed 8/25/22, effective 9/25/22. Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1910, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1915 What services may I receive in MAC and TSOA? MAC and TSOA services include the following three benefit levels referred to as steps in subsections (1) through (3) of this section. You and your family caregiver may receive services under any of the three

steps depending upon your requests and needs identified in the screening process for step two and the assessment process for step three. Steps do not need to be used in order. For example, you may begin services at step two or three. In general, step one services are used by caregivers or care receivers requesting lesser supports than those using step three services.

(1) Step one: After the department obtains your demographics and approves your program eligibility, you may receive the following services:

(a) Information and referrals to family caregiver or community resources;

(b) A selection of the following services up to a one time limit of $250:

(i) Training and education, which includes but is not limited to:

(A) Support groups;

(B) Group training;

(C) Caregiver coping and skill building training;

(D) Consultation on supported decision making;

(E) Caregiver training to meet the needs of the care receiver;

(F) Financial or legal consultation; and

(G) Health and wellness consultation;

(ii) Specialized medical equipment and supplies for the care receiver, which includes but is not limited to:

(A) Supplies;

(B) Specialized medical equipment, which includes durable medical equipment; and

(C) Assistive technology;

(iii) Caregiver assistance services, which includes but is not limited to short term respite to allow the caregiver to attend an educational event or training series; and

(iv) Health maintenance and therapy supports, which may include but are not limited to:

(A) Adult day health;

(B) RDAD and evidence based exercise programs;

(C) Health promotion and wellness services; and

(D) Counseling related to caregiving role.

(2) Step two: After the department obtains your demographics, approves your program eligibility, and completes a GetCare or TCARE screening, you may receive the following:

(a) Information and referrals to family caregiver or community resources;

(b) The following services up to an annual limit of $500 minus any expenditures for step one services:

(i) Training and education, which includes but is not limited to:

(A) Support groups;

(B) Group training;

(C) Caregiver coping and skill building training;

(D) Consultation on supported decision making;

(E) Caregiver training to meet the needs of the care receiver;

(F) Financial or legal consultation; and

(G) Health and wellness consultation;

(ii) Specialized medical equipment and supplies for the care receiver, which includes but is not limited to:

(A) Supplies;

(B) Specialized medical equipment, which includes durable medical equipment;

(C) Assistive technology; and

(D) Personal emergency response system (PERS);

(iii) Caregiver assistance services, which include but are not limited to:

(A) Short-term respite and, if necessary, nurse delegation to allow the caregiver to attend an educational event or training series;

(B) Home delivered meals for the care receiver and caregiver;

(C) Minor home modifications and repairs to the care receiver's home;

(D) Home safety evaluation of the care receiver's home; and

(E) Transportation, in accordance with the assessment to facilitate access to waiver and other community services, activities, and resources as specified by the individualized care plan; and

(F) Bath aide;

(iv) Health maintenance and therapy supports, which include but are not limited to:

(A) Adult day health;

(B) RDAD and evidence based exercise programs;

(C) Health promotion and wellness services such as massage therapy and acupuncture therapy; and

(D) Counseling related to the caregiving role; and

(v) Personal assistance services for the TSOA without an unpaid caregiver, as described in WAC 388-106-1910 (e)(ii), which include but are not limited to:

(A) Adult day care;

(B) Transportation, in accordance with the assessment to facilitate access to waiver and other community services, activities, and resources as specified by the individualized care plan;

(C) Home delivered meals;

(D) Home safety evaluation of the care receiver's home; and

(E) Minor home modifications and repairs to the care receiver's home.

(3) Step three:

(a) For MAC and TSOA care receivers with caregivers:

(i) You may receive information and referrals to family caregiver or community resources.

(ii) After the department has obtained your demographics and approved your program eligibility, your caregiver must complete a TCARE assessment in order to access step three services. In order to qualify for a TCARE assessment, the TCARE screening must result in at least three medium scores or one high score for the TCARE measures described in WAC 388-106-1932. TCARE uses an evidence-based algorithm to identify a primary goal based on your caregiver's answers to the TCARE assessment questions. The department will assist you to develop an individualized care plan containing the services chosen by you and your caregiver up to the limits established in WAC 388-106-1920.

(iii) The table below lists the available step three services. The Xs in the table indicate the services that may be recommended by the TCARE strategies, defined in WAC 388-106-1930, from your caregiver's assessment. You may request services in this step that the TCARE assessment does not list as a recommendation.

Services	**Strategies**				
	A	B	C	D	E
Training and education					
Group training		X			
Caregiver coping and skill building training	X	X	X	X	

Services	Strategies				
Consultation on supported decision making	X	X	X		
Caregiver training to meet needs of care receiver	X	X	X		
Financial or legal consultation		X			
Health and wellness consultation		X			
Support groups	X	X	X		
Specialized medical equipment and supplies					
Supplies		X			
Specialized medical equipment		X			
Assistive technology		X			
Personal emergency response system		X			
Caregiver assistance services					
Home delivered meals		X			
Minor home modifications and repairs		X			
Housework/errands and yard work		X			
In-home respite, including a bath aide		X			
OT/PT evaluation	X	X		X	
Home safety evaluation		X			
Out-of-home respite		X			
Transportation		X			
Pest eradication services		X			
Specialized deep cleaning services		X			
Nurse delegation, in conjunction with respite care		X			
Health maintenance and therapy supports					
Adult day health		X			
RDAD and evidence based exercise programs		X		X	
Health promotion and wellness services such as acupuncture and massage therapy				X	X
Counseling related to the caregiver role	X		X	X	

(b) For TSOA care receivers who do not have an available caregiver:

(i) You may receive information and referrals to community resources.

(ii) After the department has obtained your demographics and approved your program eligibility, you must complete a GetCare assessment in order to access step three services. In order to qualify for a GetCare assessment, the GetCare screening must result in a risk score of moderate or high as described in WAC 388-106-1933. The department will assist you to develop an individualized care plan that includes the services you have chosen up to the limits established in WAC 388-106-1920.

(iii) The services available include any step one and step two services noted in subsections (1) and (2) of this section (except for respite) and the following:

(A) Personal assistance services which include:

(a) Personal care;

(b) Nurse delegation; and

(c) Housework/errands and yard work;

(B) Pest eradication services;

(C) Specialized deep cleaning; and

(D) Community choice guide services.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 23-15-060, § 388-106-1915, filed 7/14/23, effective 8/14/23; WSR 22-18-004, § 388-106-1915, filed 8/25/22, effective 9/25/22. Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1915, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1920 What is the maximum amount of step three services I may receive a month? (1) Unless the department authorizes additional funds through an exception to rule under WAC 388-440-0001, beginning January 1, 2019, the maximum amount of step three services you and your caregiver may receive in MAC and TSOA will be published on the ALTSA/HCS rates website at: https://www.dshs.wa.gov/sites/default/files/ALTSA/msd/documents/All_HCS_Rates.pdf.

(2) If you are a care receiver who does not have an available unpaid caregiver, you are receiving TSOA personal assistance services, and the department has not authorized additional funds through an exception to rule under WAC 388-440-0001, beginning January 1, 2019, the maximum amount of step three services you may receive will be published on the ALTSA/HCS rates website at: https://www.dshs.wa.gov/sites/default/files/ALTSA/msd/documents/All_HCS_Rates.pdf.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 19-09-003, § 388-106-1920, filed 4/4/19, effective 5/5/19. Statutory Authority: RCW 74.08.090. WSR 18-20-001, § 388-106-1920, filed 9/19/18, effective 10/20/18; WSR 18-08-033, § 388-106-1920, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1921 How does the TCARE assessment determine what step three services are recommended to my caregiver? (1) The TCARE assessment process gathers the following information reflecting the current status of both you and your caregiver in order to recommend services for your caregiver:

(a) TCARE screening scores from the five measures described in WAC 388-106-1931;

(b) Caregiver obligations;

(c) Caregiver's phase in the caregiving journey;

(d) Potential risk of out-of-home placement;

(e) Care receiver's need for assistance with activities of daily living and instrumental activities of daily living;

(f) Care receiver's memory status, physical health conditions, and behavioral support needs; and

(g) Caregiver's understanding of the care receiver's level of need and the ability to safely provide care with the assistance of available resources/services.

(2) Based upon the information gathered during the TCARE assessment process described in subsection (1) of this section, one of three primary goals, as defined in WAC 388-106-1925, is established for your caregiver with at least one strategy identified for meeting that goal. One or more of the five strategies described in WAC 388-106-1930, which are linked to recommended services and supports that have the most potential to help your caregiver continue providing care safely while also addressing their needs as a caregiver, may be recommended to reach the established goal.

[Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1921, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1925 What are the goals in TCARE? The three primary goals for caregivers identified in TCARE are:

(1) Maintain current identity: The goal appropriate for caregivers who experience modest levels of identity discrepancy and stress and are willing and able to continue in their current role. Suggested support services will help caregivers make small adjustments in their personal norms and the manner in which they undertake their caregiving responsibilities.

(2) Embrace caregiver identity: The goal appropriate for caregivers who are likely to benefit from embracing a stronger identity as a caregiver and releasing, to some degree, their commitment to a familial identity. Suggested support services will encourage the caregiver to accept a greater identity with the caregiver role.

(3) Reduce caregiver identity: The goal appropriate for caregivers who are engaged in a level of caregiving that requires emotional or physical resources beyond their capability. Suggested support services will encourage caregivers to explore ways to reduce workload and stress related to their caregiving role.

[Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1925, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1930 What is the purpose of the TCARE assessment? The purpose of the TCARE assessment is to gather critical information about the caregiving context, identity, strengths, problems and concerns. These data are used to identify strategies and goals to address your caregiver's needs. Program limits are established in WAC 388-106-1915.

(1) The five strategies in TCARE are:

(a) Strategy A: Change personal rules for care, which entails encouraging and helping your caregiver to change or adjust their personal rules or norms.

(b) Strategy B: Reduce or minimize work load, which focuses on reducing the amount or intensity of your caregiver's work load and therefore aligns your caregiver's behaviors with their expectations.

(c) Strategy C: Support positive self-appraisal, which focuses on offering positive affirmation and assuring your caregiver that the behaviors that they must engage in as a caregiver are consistent with their norms.

(d) Strategy D: Reduce generalized stress, which focuses on giving your caregiver tools and skills to cope with daily stresses of caregiving.

(e) Strategy E: Improve overall health, which encourages your caregiver to seek appropriate health services.

(2) Each service is mapped to a strategy(s) that may support your caregiver's needs. A service may be mapped to more than one strategy.

(3) Assessors assist you and your caregiver to understand the evidence based strategies and recommended services, choose the services to meet the identified goals, and create an individualized care plan.

[Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1930, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1931 What are the TCARE screening measures? The following six TCARE screening measures and response options will be presented to your caregiver in order to receive step two services and to determine whether a TCARE assessment is needed for step three services:

(1) Identity discrepancy: The following are some thoughts and feelings that people sometimes experience when they assist their receiver:

(a) I am not always able to be the person I want to be when I am with my care receiver.

(b) It is difficult for me to accept all the responsibility for my care receiver.

(c) I am not sure that I can accept any more responsibility than I have right now.

(2) Relationship burden: Have your caregiving responsibilities:

(a) Caused conflicts with your care receiver?

(b) Increased the number of unreasonable requests made by your care receiver?

(c) Caused you to feel that your care receiver makes demands over and above what they need?

(3) Objective burden: Have your caregiving responsibilities:

(a) Changed your routine?

(b) Left you with almost no time to relax?

(4) Stress burden: Have your caregiving responsibilities:

(a) Depressed you?

(b) Caused you to worry?

(5) Depression: How many days have you felt this way in the past week?

(a) Had trouble keeping your mind on what you were doing?

(b) Felt depressed?

(c) Felt hopeful about the future?

(d) Had restless sleep?

(6) Uplifts: Have your caregiving responsibilities:

(a) Given your life more meaning?

(b) Made you more satisfied with your relationship?

(c) Given you a sense of fulfillment?

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 22-18-004, § 388-106-1931, filed 8/25/22, effective 9/25/22. Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1931, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1932 How is the TCARE screening scored to determine if my caregiver is eligible for a TCARE assessment and related step three services? (1) The TCARE screening measures are scored with a number value of one through six for the measure on identity discrepancy or one through five for the remaining measures based upon the caregiver's responses. Ranges for each measure determine whether the measure score is high, medium, or low. One high or three medium scores from the table in this subsection, except for the uplifts measure, will make a caregiver eligible for a TCARE assessment and step three

services as described in WAC 388-106-1915 (3)(a)(ii). The following table indicates the score ranges for each measure:

	High	Medium	Low
Identity discrepancy	13-18	8-12	3-7
Relationship burden	10-18	6-9	3-5
Objective burden	9-12	5-8	2-4
Stress burden	9-12	6-8	2-5
Uplifts	10-18	6-9	3-5
Depression-CESD	14-16	7-13	4-6

(2) The scale used to score the responses within the identity discrepancy, relationship, objective, stress, and uplift measures are:

(a) Strongly disagree = one;

(b) Disagree = two;

(c) Disagree a little = three;

(d) Agree a little = four;

(e) Agree = five; and

(f) Strongly agree = six.

(3) The scale used to score the responses within the depression measures in WAC 388-106-1931 (5)(a), (b), (c), and (d) are:

(a) Rarely or none of the time (less than one day in the last week) = one;

(b) Some or a little of the time (one to two days in the last week) = two;

(c) Occasionally or a moderate amount of time (three to four days in the last week) = three; and

(d) All of the time (five to seven days in the last week) = four.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 22-18-004, § 388-106-1932, filed 8/25/22, effective 9/25/22. Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1932, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1933 How is the GetCare screening scored to determine if I am eligible for a GetCare assessment and related step three services? (1) To be eligible for a GetCare assessment, care plan, and associated step three services as described in WAC 388-106-1915 (3)(b)(ii), a TSOA individual without a caregiver must have a moderate or high risk score resulting from the thirteen screening questions listed in the following table:

No.	Question	Scoring							
		Response	Score	Response	Score	Response	Score	Response	Score
1	Do you need help to do the following? Bathing Bed mobility Medication management Transferring Ambulating Eating Toileting Dressing Personal hygiene	Zero to two selected	Zero	Three or more selected	Two				
2	Do you need help turning and repositioning?	No	Zero	Yes	Two				
3	Who helps you with daily activities?	No one	One	Family/ friend/other/ paid help	Zero				

No.	Question	Scoring							
		Response	Score	Response	Score	Response	Score	Response	Score
4	During the last six months, have you had a fall that caused injuries?	No	Zero	Yes	Two				
5	Have you had a hospitalization, or been admitted to a nursing facility, or both, in the past six months?	No	Zero	Yes	Two				
6	Have you received rehabilitation in the past six months?	No	Zero	Yes	Two				
7	Have you been treated in an emergency room, called 911 in the past six months, or both?	No	Zero	Yes, one to two times	One	Yes, three or more times	Two		
8	Do you live alone? If yes, do you feel safe living alone?	No No	Zero One	Yes Yes	Two Zero				
9	Do you plan on moving to other housing in the near future?	No	Zero	Yes	Two				
10	Do you or your family have concerns about your memory, thinking, ability to make decisions, or remembering to pay your bills?	No, not concerned	Zero	Yes, somewhat concerned	One	Yes, very concerned	Two		
11	Are you content with your social life?	No	Two	Somewhat	One	Yes	Zero		
12	Over the last two weeks, have you been bothered by, or have little interest in doing things?	Not at all	Zero	Several days	One	More than half the days	Two	Nearly every day	Three
13	Over the last two weeks, have you been bothered by feeling down, depressed, or hopeless?	Not at all	Zero	Several days	One	More than half the days	Two	Nearly every day	Three

(2) The risk level is calculated by totaling the points assigned to each question as determined by responses to the screening questions in subsection (1) of this section and matching the total points to the risk level in the following table:

Risk level	Point totals
No risk	0
Low risk	1- 8
Moderate risk	9-16
High risk	17 and up

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 19-09-003, § 388-106-1933, filed 4/4/19, effective 5/5/19. Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1933, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1935 Where may I receive MAC and TSOA services? You may receive MAC and TSOA services:

(1) In your own home; and

(2) In the community setting where the authorized service occurs:

(a) Within the state of Washington; or

(b) In a recognized out-of-state bordering city as defined in WAC 182-501-0175.

[Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1935, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1940 When will my MAC or TSOA services be authorized? Your MAC or TSOA services will be authorized when you:

(1) Have completed initial requirements for intake including but not limited to screenings and assessments;

(2) Are found to be at least presumptively eligible, both financially and functionally;

(3) Have chosen a provider(s) qualified for payment; and

(4) Have given consent for services and approved your care plan.

[Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1940, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1945 When do my MAC or TSOA services begin? Your MAC or TSOA services may begin once you have approved your care plan and as early as the date authorized by the department.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 22-18-004, § 388-106-1945, filed 8/25/22, effective 9/25/22. Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1945, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1950 How do I remain eligible for MAC and TSOA services? (1) In order to remain eligible for MAC and TSOA services, you, as the care receiver must:

(a) Remain functionally eligible as defined in WAC 388-106-0355 and financially eligible as defined in WAC 182-513-1605, 182-513-1615, and 182-513-1620;

(b) Have your functional and financial eligibility reviewed at least annually; and

(c) Have participated in the assessment and care plan process at least annually.

(2) If eligibility laws, regulations, or rules change, and if you as the caregiver or the care receiver do not meet the changed eligibility requirements, the department will terminate services, even if your circumstances have not changed. You will receive advance notice of any termination or change in your services and an opportunity to appeal.

[Statutory Authority: RCW 74.08.090 and 74.39A.030. WSR 22-18-004, § 388-106-1950, filed 8/25/22, effective 9/25/22. Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1950, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1955 What do I pay for if I receive MAC or TSOA services? You, as a caregiver or a care receiver, will not be required to pay toward the cost of your MAC or TSOA services. This means that neither estate recovery nor participation towards cost of care are required.

[Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1955, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1960 May I be employed and receive MAC or TSOA services? You, as the care receiver may be employed and receive MAC or

TSOA services. Your caregiver may be employed in roles other than caregiving and receive services under MAC or TSOA.

[Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1960, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1965 Are there limits to the services I may receive? The services you may receive under MAC or TSOA will not include the following:

(1) Rent or mortgage;
(2) Groceries;
(3) Car repairs;
(4) Utility bills;
(5) Household appliances;
(6) Vacation expenses;
(7) Entertainment items such as TVs, radios, computers, cell phones;
(8) Pet care items;
(9) Gift cards;
(10) Any services not defined in WAC 388-106-1915; and
(11) Any services covered under your medicaid state plan coverage, medicare, private insurance, or other federal or state programs.

[Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1965, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1970 Who may provide MAC and TSOA services? The following providers may provide MAC and TSOA services:

(1) Durable medical equipment vendors and adult day health providers that have a core provider agreement with the health care authority; and
(2) Providers who are contracted with the department to provide goods and services.

[Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1970, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1975 Will there be a waitlist for MAC and TSOA? (1) The department will implement a statewide waitlist if program expenditures or enrollment exceeds availability of demonstration funding.

(2) If the department implements a waitlist for new MAC and TSOA applicants:

(a) We will stop conducting presumptive eligibility determinations and financial and functional eligibility assessments.

(b) We may reduce benefit limits for step one, two, and three to maintain department spending within available demonstration funding. If we reduce benefit limits, individuals currently receiving benefits will maintain their current benefit level, including those with approved presumptive eligibility.

(c) If additional funding becomes available, applicants on a waitlist for MAC or TSOA services will be considered on a first come first serve basis based upon their request date for MAC or TSOA services.

[Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1975, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1980 When may the department terminate or deny MAC or TSOA services? (1) The department will deny or terminate MAC or TSOA services if you are not eligible for services pursuant to WAC 388-106-1905, 388-106-1910, and 388-106-1945.

(2) The department may deny or terminate your MAC or TSOA services if, after exhaustion of standard case management activities and the approaches delineated in the department's challenging cases protocol that must include an attempt to reasonably accommodate your disability or disabilities, one or more of the following conditions exist:

(a) Your rights and responsibilities as a client of the department are reviewed with you by a department representative under WAC 388-106-1300 and 388-106-1303, and you refuse to accept those services identified in your care plan that are vital to your health, welfare, or safety.

(b) You choose to receive services in your own home and you or others in your home demonstrate behaviors that are substantially likely to cause serious harm to you or your care provider.

(c) You choose to receive services in your own home and hazardous conditions in or immediately around your home jeopardize the health, safety, or welfare of you or your provider. Hazardous conditions include but are not limited to the following:

(i) Threatening, uncontrolled animals (such as dogs);

(ii) The manufacture, sale, or use of illegal drugs;

(iii) The presence of hazardous materials (such as exposed sewage, evidence of a methamphetamine lab).

(3) The department may terminate services if the department does not receive consent of the care plan within sixty days of the completion of your care plan. Written consent for step one and step two care plans may be provided by secure email or other electronic means.

[Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1980, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1985 Do I have the right to an administrative hearing regarding MAC or TSOA services? Yes, you may request an administrative hearing based on the rules outlined in WAC 388-106-1305 to contest the department's decisions regarding MAC or TSOA services except for presumptive eligibility determinations described in WAC 388-106-1905(2) and 388-106-1910(2).

[Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1985, filed 3/27/18, effective 4/27/18.]

WAC 388-106-1990 May I choose to receive traditional medicaid long-term services and supports instead of services under the MAC program? Yes. You, as the care receiver, may choose to apply for traditional medicaid long term services and supports such as community first choice, community option program entry system (COPES), new freedom, and residential support waiver, instead of services under the MAC program. You must contact your case manager who will assist you with

this process. You may only receive services that you are eligible for under the applicable rules. You may not receive services under MAC and a traditional medicaid long-term services and supports program at the same time.

[Statutory Authority: RCW 74.08.090. WSR 18-08-033, § 388-106-1990, filed 3/27/18, effective 4/27/18.]

CIVIL TRANSITIONS PROGRAM

WAC 388-106-2000 What definitions apply to the civil transitions program? "Aging and long-term support administration (ALTSA)" is an administration within the department of social and health services that promotes choice, independence, and safety through innovative services and partnerships with tribes, advocates, providers, and caregivers to support seniors, and people with disabilities so they can live with good health, independence, dignity, and control over decisions that affect their lives.

"Behavioral health administration (BHA)" is an administration within the department of social and health services that supports sustainable recovery, independence, and wellness. This is done by funding and supporting effective prevention and intervention services for youth and family, and treatment and recovery support for youth and adults with addiction and mental health conditions (also known as behavioral health). BHA operates three state psychiatric hospitals and the office of forensic mental health services that deliver high quality services to adults and children with complex needs.

"Civil transitions program" is a program implemented according to Engrossed Second Substitute Senate Bill 5440 to provide support services to individuals recently subject to criminal charges and found incompetent to stand trial due to an intellectual or developmental disability, traumatic brain injury, or dementia.

"Competency evaluation" is an assessment of the ability of a defendant to understand and rationally participate in a court process under the United States criminal justice system.

"Conditional services" is a term that describes the services available under the civil transitions program for an individual who does not meet functional eligibility criteria under medicaid personal care level of care under WAC 388-106-0210 or nursing facility level of care under WAC 388-106-0355 or is not financially eligible for Washington apple health, or is not functionally or financially eligible.

"Dementia" is a general term for loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life. The term "dementia" is no longer used to refer to the etiological subgroups for which it is standard, but it is instead included under the newly titled term significant neurocognitive disease. For consistency, the term "dementia" is still used in the DSM-5 and can be applied in situations where patients and doctors are familiar with it. The phrase neurocognitive disorder is commonly used, while dementia is the standard word for illnesses such as the degenerative dementias that typically impact older persons (DSM-5-TR).

Neurocognitive disorder is characterized by the progressive and persistent deterioration of cognitive function. Cognitive deficits are sufficient to interfere with independence, do not occur exclusively in

the context of a delirium, and are not attributable to another mental disorder (e.g. major depressive disorder, schizophrenia).

Specific major neurocognitive diagnosis, primary diagnosis:

(a) Major neurocognitive disorder due to Alzheimer's disease;

(b) Major frontotemporal neurocognitive disorder (Pick's);

(c) Major neurocognitive disorder with Lewy bodies;

(d) Major vascular neurocognitive disorder (Vascular);

(e) Major neurocognitive disorder due to traumatic brain injury;

(f) Substance or medication-induced major neurocognitive disorder (alcohol-related);

(g) Major neurocognitive disorder due to HIV infection;

(h) Major neurocognitive disorder due to Prion disease;

(i) Major neurocognitive disorder due to Parkinson's disease;

(j) Major neurocognitive disorder due to Huntington's disease.

"Not Competent" means a legal determination has been made by a court that a defendant is unable to stand trial based on being diagnosed with a mental disease or defect which prevents them from understanding court proceedings or being able to rationally assist in their own defense per chapter 10.77 RCW.

"Not Restorable" means a court has found that a person lacks the capacity to have competency restored via inpatient or outpatient treatment.

"Office of forensic mental health services (OFMHS)" is a division of the department of social and health services' behavioral health administration that oversees the state's adult forensic mental health system.

"Washington apple health" means the public health insurance programs for eligible Washington residents defined in WAC 182-500-0120. Washington apple health or apple health is the name used in Washington state for medicaid, the children's health insurance program (CHIP), and state-only funded health care programs.

[Statutory Authority: RCW 10.77.202, 74.08.090, and 74.09.520. WSR 24-16-002, § 388-106-2000, filed 7/24/24, effective 8/24/24.]

WAC 388-106-2005 Who is eligible to apply to receive services under the civil transitions program? You are eligible to apply for services under the civil transitions program if you:

(1) Are referred to ALTSA from the BHA starting December 1, 2023;

(2) Have been determined by a court as not competent to stand trial due to a diagnosis of dementia, a traumatic brain injury, or an intellectual or developmental disability, and your competency is not restorable;

(3) Complete an assessment of your functional eligibility using the comprehensive assessment reporting evaluation (CARE) tool under WAC 388-106-0050 to determine if you are functionally eligible for:

(a) Nursing facility level of care under WAC 388-106-0355; or

(b) Medicaid personal care level of care under WAC 388-106-0210; and

(4) File an application for Washington apple health so the department can determine if you are financially eligible for medicaid-funded long-term services and supports. The application process is described in WAC 182-503-0005.

[Statutory Authority: RCW 10.77.202, 74.08.090, and 74.09.520. WSR 24-16-002, § 388-106-2005, filed 7/24/24, effective 8/24/24.]

WAC 388-106-2010 What services may I receive under the civil transitions program if I am not functionally and financially eligible for long-term services and supports? (1) If you meet the criteria in WAC 388-106-2005 but are not functionally eligible for medicaid personal care level of care under WAC 388-106-0210 or nursing facility level of care under WAC 388-106-0355, or you are not financially eligible for Washington apple health, you may receive conditional services, subject to available funds, under the civil transitions program.

(2) If you meet the criteria in WAC 388-106-2005 but have yet to complete a CARE assessment and are, or at risk of becoming a "homeless person" as defined in RCW 43.185C.010, you may receive supportive housing services under the civil transitions program, as funding allows.

(3) Conditional services are described in WAC 388-106-2020.

[Statutory Authority: RCW 10.77.202, 74.08.090, and 74.09.520. WSR 24-16-002, § 388-106-2010, filed 7/24/24, effective 8/24/24.]

WAC 388-106-2015 What services may I receive under the civil transitions program if I am functionally and financially eligible for long-term services and supports? If you are referred to ALTSA for services under the civil transitions program and you are both functionally eligible for long-term services and supports under chapter 388-106 WAC and financially eligible for medicaid-funded long-term services and supports, you are eligible for any service offered by ALTSA based on your assessment and identified in your plan of care. Financial eligibility criteria for long-term services and supports is determined under chapters 182-513 and 182-515 WAC.

[Statutory Authority: RCW 10.77.202, 74.08.090, and 74.09.520. WSR 24-16-002, § 388-106-2015, filed 7/24/24, effective 8/24/24.]

WAC 388-106-2020 What conditional services may I receive under the civil transitions program? The legislature has appropriated specific funding for the civil transitions program for the provision of conditional services. If you meet the criteria in WAC 388-106-2005 you are eligible for conditional services as described below, subject to available funding.

(1) If you do not meet medicaid personal care level of care under WAC 388-106-0210 or nursing facility level of care under WAC 388-106-0355, and you are not financially eligible for Washington apple health, you can receive the following conditional services:

(a) Community transition or sustainability services; and

(b) Supportive housing as defined in WAC 388-106-1705.

(2) If you are determined functionally eligible for medicaid personal care level of care under WAC 388-106-0210, but you are not financially eligible for Washington apple health, you may receive the following conditional services if they are included in your plan of care:

(a) Personal care services as defined in WAC 388-106-0010;

(b) Community transition or sustainability services; and

(c) Supportive housing as defined in WAC 388-106-1705.

(3) If you are determined functionally eligible for nursing facility level of care under WAC 388-106-0355 but you are not financial-

ly eligible for Washington apple health, you may receive the following conditional services if they are included in your plan of care:

(a) Personal care services as defined in WAC 388-106-0010;

(b) Nurse delegation as defined in WAC 388-106-0270;

(c) Personal emergency response system (PERS) as defined in WAC 388-106-0270;

(d) Assistive technology as defined in WAC 388-106-0270;

(e) Supportive housing as defined in WAC 388-106-1705;

(f) Community transition services as defined in WAC 388-106-0270; and

(g) Community transition or sustainability services.

[Statutory Authority: RCW 10.77.202, 74.08.090, and 74.09.520. WSR 24-16-002, § 388-106-2020, filed 7/24/24, effective 8/24/24.]

WAC 388-106-2025 Who can provide long-term services and supports when I am eligible for the civil transitions program conditional services? The following types of providers can provide conditional services under the civil transitions program:

(1) Individual providers (IPs) who provide services to clients in their own home as defined in WAC 388-106-0040 and 388-106-0010.

(2) Home care agencies that provide services to clients in their own home. Home care agencies must be licensed under chapter 70.127 RCW and chapter 246-335 WAC and be contracted with the department of social and health services.

(3) Providers who are contracted with the department to provide goods and services.

(4) Durable medical equipment vendors that have a core provider agreement with the health care authority.

(5) Supportive housing providers as defined in WAC 388-106-1715 or 182-559-200.

[Statutory Authority: RCW 10.77.202, 74.08.090, and 74.09.520. WSR 24-16-002, § 388-106-2025, filed 7/24/24, effective 8/24/24.]

WAC 388-106-2030 Where can I receive civil transitions program conditional services? You can receive conditional services under the civil transitions program:

(1) In your own home as defined in WAC 388-106-0030, or an interim setting while you secure permanent housing; and

(2) While you are out of your home accessing the community or working while:

(a) within the state of Washington; or

(b) in a recognized out of state bordering city as defined in WAC 182-501-0175.

[Statutory Authority: RCW 10.77.202, 74.08.090, and 74.09.520. WSR 24-16-002, § 388-106-2030, filed 7/24/24, effective 8/24/24.]

WAC 388-106-2035 When will the department authorize my civil transitions program conditional services? Within available funds, the department will authorize conditional services under the civil transitions program when you have:

(1) Completed an assessment of your functional eligibility using the comprehensive assessment reporting evaluation (CARE) tool under WAC 388-106-0050;

(2) Applied for Washington apple health;

(3) Been found eligible for conditional services under WAC 388-106-2010 and 388-106-2020;

(4) Given consent for services and approved your care plan; and

(5) Chosen a DSHS qualified provider per WAC 388-71-0510.

[Statutory Authority: RCW 10.77.202, 74.08.090, and 74.09.520. WSR 24-16-002, § 388-106-2035, filed 7/24/24, effective 8/24/24.]

WAC 388-106-2040 When will my civil transitions program conditional services end? (1) If, at the time of your initial assessment you were found ineligible for medicaid-funded long-term services and supports, your civil transitions program conditional services, except supportive housing, will end the earlier of:

(a) The date you are found both functionally and financially eligible for medicaid-funded long-term services and supports;

(b) Six months from the start date of your services; or

(c) When the department has exhausted available funds.

(2) For conditional supportive housing services, your eligibility will be reviewed in six-month increments based upon available funding, up to a maximum of 24 months.

[Statutory Authority: RCW 10.77.202, 74.08.090, and 74.09.520. WSR 24-16-002, § 388-106-2040, filed 7/24/24, effective 8/24/24.]

WAC 388-106-2045 Do I have a right to an administrative hearing on civil transitions program conditional services? You have a right to an administrative hearing if you disagree with a decision made by the department about your eligibility for services under the civil transitions program. The department will notify you in writing of the right to contest a decision and provide you with information on how to request a hearing.

[Statutory Authority: RCW 10.77.202, 74.08.090, and 74.09.520. WSR 24-16-002, § 388-106-2045, filed 7/24/24, effective 8/24/24.]

WAC 388-106-2050 Can an exception to rule (ETR) be granted for civil transitions program conditional services? If you receive conditional services under the civil transitions program, an exception to rule under WAC 388-440-0001 will not be granted.

[Statutory Authority: RCW 10.77.202, 74.08.090, and 74.09.520. WSR 24-16-002, § 388-106-2050, filed 7/24/24, effective 8/24/24.]

GUARDIANSHIP AND CONSERVATORSHIP ASSISTANCE PROGRAM

WAC 388-106-2100 What is the home and community services guardianship and conservatorship assistance program? (1) Subject to available state only funds, the department of social and health services

(DSHS) pays for certain fees and costs for professional guardianship and conservatorship services for eligible persons as described in WAC 388-106-2110.

(2) The amounts paid and which services and costs are covered are determined by DSHS in its sole discretion and are contained in contracts with certified professional guardians and conservators (CPGCs).

(3) Subject to available funds, and in its sole discretion, DSHS may file petitions for guardianship with a Washington state superior court for certain patients occupying beds in acute care hospitals who no longer require inpatient hospital care or who require assistance in accessing or maintaining long-term support and services (LTSS) services due to the person's inability to give consent.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2100, filed 7/30/24, effective 8/30/24.]

WAC 388-106-2105 Definitions. (1) **"Aging and long-term support administration"** or **"ALTSA"** means an administration within DSHS.

(2) **"Client"** means a person who is an applicant for, or recipient of, any Washington apple health program, including managed care and long-term care. See definitions for "applicant" and "recipient" in RCW 74.09.741.

(3) **"Contractor"** means a certified professional guardian and conservator who has met contractor eligibility criteria and has executed a contract with DSHS to provide guardianship and conservatorship services through the state funded home and community services guardianship and conservatorship assistance program.

(4) **"Court order"** means any judgment, decree, instruction, or order of a Washington state superior court, a court of comparable jurisdiction of an Indian tribe, another state, or country.

(5) **"Decision-making assistance"** means support for an individual with diminished decision-making ability in making decisions affecting health, safety, or to manage financial affairs. Assistance includes, without limitation, acting as a representative payee, fiduciary, an attorney-in-fact, a trustee, or a certified professional guardian or conservator.

(6) **"DSHS"** means the department of social and health services.

(7) **"Due diligence"** means the acute care hospital has adequately investigated whether a family member or friend would be able and willing to serve as a lay guardian, and, if not, has contacted agencies and individuals providing professional guardianship and conservatorship services, has submitted a referral to the statewide guardianship listserv managed by the office of public guardianship (OPG) through the administrative office of the courts (AOC), and at least 14 days have elapsed without identification of a potential professional guardian for nomination.

(8) **"Estate Recovery"** means the state's process for recapturing the cost of long-term care services, related hospital, and prescription drug services from a recipient's estate. Federal and state laws allow states to recover state-funded services and certain medicaid costs.

(9) **"Guardian"** or **"Conservator"** means a professional individual, agency, or a corporate fiduciary (such as a nonprofit corporation or bank trust department) appointed by a court to assist and protect an individual who the court has determined requires assistance in managing their own affairs.

(10) **"Home and community services"** or **"HCS"** means a division within the DSHS aging and long-term support administration.

(11) **"LTSS"** means long-term support and services under the home and community services division.

(12) **"Neuro-cognitive disorder"** means a primary diagnosis of dementia, Alzheimer's, Parkinson's, Huntington's, traumatic brain injury, or stoke which results in the individual's lack of decision-making capacity impacting accessibility for long-term care benefits.

(13) **"Notice of department decisions"** means a generated written notice provided to an individual client or their legal representative or both identifying them of:

(a) The action taken by DSHS that impacts the individual client's benefits;

(b) The reason DSHS took said action;

(c) The legal authority to take said action;

(d) Date of the notice;

(e) Effective date of the action taken;

(f) Department representative contact information;

(g) Hearing rights; and

(h) Information about continued benefits, if any.

(14) **"Overpayment"** means any payment or benefit to a recipient or to a vendor in excess of that to which is entitled by law, rule, or contract, including amounts in dispute as outlined in chapter 41.05A RCW.

(15) **"Participation"** means the portion of the client's responsibility or financial obligation paid by the client to the provider to cover part or all of their cost of care.

(16) **"Private pay"** means the status for any period of time in which a client is ineligible for medicaid-funded LTSS and must use their own personal resources to pay for their services.

(17) **"Program hold"** means an intervention taken by DSHS to place future payment authorizations on hold whenever an approved state funded guardianship and conservatorship assistance program recipient is identified as financially ineligible for medicaid LTSS per chapter WAC 182-513-1315 (1)-(3). Under a program hold, a recipient's state funded guardianship and conservatorship assistance program slot can be held for up to 90 days from date of financial ineligibility discovery.

(18) **"Program recipient"** means an individual meeting eligibility criteria for inclusion into the state funded home and community services guardianship and conservatorship assistance program.

(19) **"Program slot"** means a program vacancy based on timeframe of needed resources as designated by "tier 1" and "tier 2". A tier 1 program slot is a slot with a maximum service benefit of up to 12 months duration. A tier 2 program slot is a continuous slot 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.

(20) **"Provider one"** means the invoice processing system used by DSHS to process and pay some social service providers and contractors who provide care or services to medicaid clients.

(21) **"Provisional approval"** means 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.

(22) **"Split appointment"** means when two or more individuals are appointed to serve as either a guardian, a conservator, co-guardians,

or co-conservators on a single case appointed under chapter 11.130 RCW.

(23) **"Successor guardian or conservator"** means a successor or replacement guardian or conservator appointed by the court to act on behalf of an individual subject to either guardianship, conservatorship, or both if the existing guardian or conservator resigns, dies, becomes incapacitated, is determined no longer qualified to serve, declines to serve the individual, or due to noncompliance with court reporting requirements or duties.

(24) **"Termination"** means the final termination order of a preestablished guardianship or conservatorship judicial matter or both which negates the previous orders of case establishment. Such an order restores the individual's civil rights and decision-making authority. A termination is completed through a judicial process by which the court determines that a preestablished guardianship or conservatorship matter or both no longer meets judicial grounds under RCW 11.130.265, that termination would be in the best interest of the adult based on a change in functionality or circumstances, or that less restrictive alternative protective arrangement is available to meet the needs of the individual.

(25) **"The certified professional guardian and conservator review board"** or **"CPGCRB"** means the regulatory board tasked by the administrative offices of the court (AOC) to oversee the statutory and regulatory requirements and to investigate guardian and conservator complaints of certified professional guardians and conservators (CPGCs) statewide.

(26) **"The guardianship or conservatorship"** means the establishment of a guardianship or conservatorship matter from the date of appointment of a guardian or conservator agent, not from the date of original petition.

(27) **"Tier 1"** means a one-year contract term for state-funded guardianship and conservatorship services under the state funded guardianship and conservatorship assistance program.

(28) **"Tier 2"** means an ongoing, renewable contract term for state-funded guardianship and conservatorship services under the state funded guardianship and conservatorship assistance program:

(a) When an individual is determined to:

(i) Not have financial ability to pay monthly guardianship or conservatorship fees through alternative participation reduction procedures due to lack of or limited income; or

(ii) Be a noncitizen approved for long-term care through the state-funded long-term care services program for noncitizens under WAC 182-507-0125.

(b) When starting the 13th month from the original appointment date, a contractor will be paid a monthly rate of $235.00, or a medicaid aligned guardianship or conservatorship monthly rate, whichever is greater, for a tier 2 client.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2105, filed 7/30/24, effective 8/30/24.]

WAC 388-106-2110 Eligibility criteria. (1) To be eligible to participate as a contractor in the program a person must:

(a) Hold certification as a professional guardian and conservator approved by the state of Washington supreme court;

(b) Be in good standing with the certified professional guardian and conservator review board (CPGCRB);

(c) Have sufficient insurance coverage to meet DSHS contract requirements;

(d) Hold a program contract with DSHS; and

(e) Comply with the requirements of the program as described in this chapter.

(2) To be eligible to participate as a recipient in the program a person must:

(a) 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;

(b) Not have financial resources to pay for guardianship services, fees, or costs from their estate;

(c) Have a qualifying neuro-cognitive diagnosis as defined in WAC 388-106-2105;

(d) At the time of referral and acceptance into the program, be occupying an acute care hospital bed, and not be in a restricted subgroup 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;

(e) At the time of referral, no longer requires an inpatient level of care at an acute care hospital;

(f) Likely requires the appointment of a guardian or conservator to be able to access and maintain long-term services and support; and

(g) Not have a professional or lay guardian or conservator willing to accept nomination.

(3) To remain eligible to participate as a recipient in the program a person must:

(a) Remain functionally and financially eligible for DSHS LTSS benefits; and

(b) Receive a DSHS LTSS service.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2110, filed 7/30/24, effective 8/30/24.]

WAC 388-106-2115 Referral process. (1) An acute care hospital may submit a referral to home and community services under the following circumstances:

(a) Acute care hospital clinicians have determined that the person likely needs a guardian or conservator;

(b) The acute care hospital has a good faith belief that the person meets the eligibility requirements to participate in the program;

(c) The acute care hospital has documented due diligence in attempting to identify a proposed guardian or conservator;

(d) The acute care hospital has submitted a long-term care medicaid application to DSHS on behalf of the person;

(e) The acute care hospital provides complete referral documents as required by DSHS; and

(f) The acute care hospital has, or will file, a petition for guardianship or conservatorship.

(2) DSHS, in its sole discretion, and subject to available funds, may waive the requirement of subsection (f) of this section and file a

petition for guardianship or conservatorship or both instead of the referring acute care hospital.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2115, filed 7/30/24, effective 8/30/24.]

WAC 388-106-2120 Acceptance into the program. (1) Within available resources, home and community services will accept a person into the guardianship and conservatorship assistance program if DSHS determines that the person meets the eligibility requirements, the referral packet is complete, and there is a program slot available at the time of acceptance.

(2) DSHS prioritizes acceptance into the program on a first-come, first-served basis determined by the date DSHS receives a complete referral packet and DSHS completes an eligibility determination for the person.

(3) If there is not an appropriate program slot available for an eligible person, DSHS will put them on the waitlist for the determined tier slot. Placement on the waitlist does not guarantee that a person will be accepted into the program.

(4) 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.

(5) In the event that 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.

(6) Once a person is accepted into a program slot, DSHS makes a referral to all program contracted certified professional guardians and conservators for consideration of acceptance of nomination. DSHS has the sole discretion to remove a person from the program if after two months of initial contractor referral, no program contracted certified professional guardian or conservator agrees to accept the case for nomination by the court.

(7) Removal from the guardianship and conservatorship assistance program in no way affects the person's ability to be rereferred and reconsidered for inclusion onto the guardianship and conservatorship assistance program at a future date.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2120, filed 7/30/24, effective 8/30/24.]

WAC 388-106-2125 Reconsideration of acceptance determination. A referring acute care hospital may request that DSHS reconsider its decision to accept a person onto the guardianship and conservatorship assistance program. A request for reconsideration must be supported by the referring acute care hospital submission of supplemental documentation to support the person's eligibility. An acute care hospital does not have a right to an administrative hearing to contest any department decision made under this chapter.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2125, filed 7/30/24, effective 8/30/24.]

WAC 388-106-2130 Notice of department decisions. DSHS will provide an applicant or participant in the program, and their guardian or conservator as applicable, with written notice about department decisions about eligibility for acceptance onto, or continuation on, the program.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2130, filed 7/30/24, effective 8/30/24.]

WAC 388-106-2135 Appeal of acceptance determination or discontinuation of program participation. The person who is the subject of a referral for acceptance into or a recipient of services under the guardianship and conservatorship assistance program may request an administrative hearing to contest a department decision that they are not eligible for acceptance or continuation in the program. The person does not have a right to a hearing to contest the adequacy of the services, costs covered, or the amounts paid to the contracted guardian or conservator.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2135, filed 7/30/24, effective 8/30/24.]

WAC 388-106-2140 Overpayment. If DSHS or the guardian or conservator discovers that the person's estate has available and adequate resources to pay for guardianship fees or costs, the payments made under this program on behalf of the client are overpayments to the extent a court determines that the person's estate is able to pay for guardianship fees and costs paid for by the state funded guardianship and conservatorship assistance program.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2140, filed 7/30/24, effective 8/30/24.]

WAC 388-106-2145 Program hold and reinstatement or forfeiture of program participation. If a client ceases to remain financially eligible as required by WAC 182-513-1315 (1)-(3) while occupying a program slot, their program slot can be held for up to a maximum of 90 days from the date it is discovered the client is overresourced. This process is referred to as a "program hold". In the event that a client becomes financially reeligible for LTSS medicaid as outlined in WAC 182-513-1315 (1)-(3) within the designated 90-day hold period, they will be reinstated to their program slot for the remaining portion of the originally approved tier slot term; however, if at the end of the designated 90-day hold period, the client continues to be financially ineligible for the program, DSHS terminates their eligibility for the program.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2145, filed 7/30/24, effective 8/30/24.]

WAC 388-106-2150 Estate recovery. Services provided under this program are exempt from estate recovery as outlined in WAC 182-527-2742.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2150, filed 7/30/24, effective 8/30/24.]

WAC 388-106-2155 Exception to rule (ETR). Services provided under this program are exempt from the exception to rule process in WAC 388-440-0001.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2155, filed 7/30/24, effective 8/30/24.]

WAC 388-106-2160 Personal needs allowance increase or participation reduction. Services provided under this program are paid by state only funds. While DSHS is paying for services under this contract for a client, there will be no reduction in the amount a client must pay towards client responsibility to account for costs and fees associated with establishing and maintaining guardianship or conservatorship as outlined in WAC 182-513-1380 and 388-79A-005.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2160, filed 7/30/24, effective 8/30/24.]

WAC 388-106-2165 Split appointment. This program only pays for guardianship and conservatorship services of one contractor per case. In the event that the court orders a split appointment amongst multiple contracted providers, DSHS will only pay the guardian.

[Statutory Authority: RCW 43.17.060, 43.20B.030, and 74.08.090. WSR 24-16-044, § 388-106-2165, filed 7/30/24, effective 8/30/24.]