PART II

POLICIES AND PROCEDURES
for
INDEPENDENT CARE WAIVER SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: January 1, 2026

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Policy Revision Record
from 2025 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
1/1/2026	602.5.3	Added Conflict of Interest policy	A	Policy
1/1/2026	702.3.3 702.3.5 702.4.1	Modified waiting list procedures. The list is in order of first come, first serve by date of application.	M	Policy
1/1/2026	902.2.10.2.1.11	Added Hospice clarification	A	Policy
10/1/2025	Appendix E	Added requirement for consumer direct members to remain compliant with all policy in the Consumer Directed Care Policy Guidelines and Agreement document	M	Policy
10/01/2025	Appendix S	Waiver representative limit	M	Policy
10/01/2025	703.8	Waiver representative limit	M	Policy
10/1/2025	Appendix Y	Corrected rate on the FI enrollment check	M	Policy
10/1/2025	902.2.8	Removed requirement to report travel to DCH.	M	Policy
10/1/2025	706.3.6	Clarified discharge due to admission to a facility	M	Policy
7/1/2025	Appendix A	Removed the Application Addendum	D	Policy
7/1/2025	N/A	Removed all references to specific appendixes throughout the manual	D	Policy
7/1/2025	Appendix FF	HCBS Person Centered Service Plan	A	Policy
7/1/2025	Appendix GG	HCBS Settings Rule Member Questionnaire	A	Policy
7/1/2025	602.1.19.2.6	Providers in settings (ADH, ALS,	A	Policy

[1] The revisions outlined in this Table are from April 2025 to current. For revisions prior to 2025, please see prior versions of the policy.

		and Out of Home Respite) must complete the HCBS Settings Rule Member Questionnaire form		
7/1/2025	602.1.19.2.7	Providers in settings must complete the HCBS STP Community Integration form	A	Policy
7/1/2025	Appendix HH	HCBS STP Community Integration Plan (CIP) Template	A	Policy
7/1/2025	902.1.19.27	Case managers must complete the HCBS Person Centered Service Plan	A	Policy
7/1/2025	902.1.19.28	Case managers must complete the HCBS Settings Rule Member Questionnaire	A	Policy
7/1/2025	701.9	GAPP transition process starts at six months prior to 21st birthday	M	Policy
7/1/2025	702.4	AHS reviews waiting list eligibility quarterly	A	Policy
7/1/2025	902.1.10	CM must process new transfers the same as initial members	M	Policy
7/1/2025	Appendix A	Removed the Application Addendum	D	Policy
7/1/2025	N/A	Removed all references to specific appendixes throughout the manual	D	Policy
4/1/2025	Appendix R	Case Manager Packet Submission Checklist	M	Policy
4/1/2025	704.2.1.7	Cost share assignment and collection	A	Policy
4/1/2025	702.4	Waiting list procedures	M	Policy
4/1/2025	N/A	Removed GA Families, GA Families 360, and NEMT forms	D	Policy
4/1/2025	Appendix V	Added links to GA Families, GA Families 360, and NEMT sites	A	Policy

Preface

Policies and procedures in this manual apply to all Independent Care Waiver Services Providers. See additional policies and procedures in Chapters under separate cover for policies specific to each service type:

Part I - Policies and procedures for Medicaid/Peachcare for Kids, Chapters 100 through 500

Part II - Policies and Procedures for Alternative Living Services (ALS), Chapter 1200

HCBS Statewide Transition Plan Provider Guidance

601. Introduction to the Independent Care Waiver Program/ Traumatic Brain Injury Program (ICWP/TBI)

The ICWP operates under a Home and Community-Based Waiver [1915(c)] granted by the Center for Medicare and Medicaid Services (CMS). This waiver allows the Division of Medicaid to use Title XIX funds to purchase services for adult individuals with physical disabilities or traumatic brain injuries to live in their own homes and communities as an alternative to nursing facility placement. Individuals served by the program are required to meet the same level of care for admission to a hospital or nursing facility and be Medicaid eligible or potentially Medicaid eligible.

Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state, and local public programs as well as the support that families and communities provide.

A distinction is being made for members who enroll in the ICWP due to a disability and those who enroll due to a Traumatic Brain Injury (TBI). Traumatic Brain Injury. "Brain injury" means a traumatic injury to the brain (cranio-cerebral head trauma), not of a generative or congenital nature, but arising from blunt or penetrating trauma or from acceleration-deceleration forces, that is associated with any of these symptoms or signs attributed to the injury: decreased level of consciousness, amnesia, other neurologic or neuropsychologic abnormalities, skull fracture, or diagnosed intracranial lesions. These impairments may be either temporary or permanent and can result in a partial or total functional disability. It shall be recognized that a person having a traumatic brain injury may have organic damage or physical or social disorders, but for the purposes of the ICWP, traumatic brain injury shall not be considered a mental illness.

The ICWP/TBI is a consumer-oriented program, with the following goals:

601.1. To provide quality services, consistent with the needs of the individual member, which are effective in developing, improving and maintaining the member's independence to live actively, safely and successfully in the community.

601.2. To provide cost effective services to assist individuals in living as independently as possible in the home and community.

601.3. To involve the member or member's representative in the provision and decision-making process regarding member care.

601.4. To demonstrate compassion for those served by treating members with dignity and respect while providing quality services.

The ICWP/TBI operates on a defined fiscal year budget and may not exceed budget allocations. When budget allocations are at maximum use, eligible applicants needing services are placed on a waiting list to be admitted for services only as member discharges occur or additional funding becomes available.

The ICWP/TBI Policies and Procedures Manual defines standard policies and procedures for services provided in the ICWP/TBI. All enrolled providers must adhere to the requirements as outlined in this manual.

601.5. Structures and Administration of the Program

Services under the ICWP/TBI are provided with the cooperation of the following state and local public agencies and private businesses:

601.5.1. The Division of Medicaid is responsible for the overall coordination, administration, and quality assurance of the program. The Division is responsible for enrollment and reimbursement to providers for services provided to those members who have applied and been approved for the Program. The Division conducts utilization reviews of providers to assure that only authorized and appropriate ICWP/TBI services are delivered. of providers to assure that only authorized and appropriate ICWP/TBI services are delivered.

601.5.2. Alliant Health is under contract with DMA to implement the selection process for those individuals seeking to enroll in the program based on criteria established by DMA. Alliant Health performs face-to-face assessments of individuals to determine appropriateness and prioritization for enrollment into the program and to validate program appropriateness for waiver members currently enrolled. Alliant Health develops the initial plan of care, assists members with selecting case managers, determines level of care, reviews prior approvals, determines the appropriateness of services, and provides training/technical assistance to case managers and service providers.

601.5.3. The Division of Family and Children Services (DFCS) of the Department of Human Services determines Medicaid eligibility for potentially Medicaid eligible members entering the ICWP/TBI. The Department of Human Services Division of Aging Services provides Adult Protective Services (APS) to investigate and/or prevent abuse, neglect, and exploitation of members.

601.5.4. The Healthcare Facility Regulation Division (HFR), in the Department of Community Health, licenses and monitors private home care providers.

601.5.5. Alliant Health Solutions is under contract with DMA to assess applicants, maintain the waiting list and authorize reimbursement to Medicaid providers. Alliant Health distributes information about enrollment, reviews enrollment packets for submission requirements and trains Medicaid providers in the billing process.

601.5.6. The Case Manager arranges, coordinates, and monitors the delivery of services to the ICWP/TBI member. The case manager also provides the member and member representative with resource information regarding home and community living. The member's Physician, familiar with the specific health and service needs of a member, provides the required medical information, and consults with the case manager and Alliant Health as requested.

601.5.7. Service Providers enrolled in ICWP/TBI deliver services as ordered on

the care plan developed by Alliant Health and the case manager. By sharing information with the case manager, service providers are a vital component of the member's care team.

If any of the functions performed are governed by a practice act, the provider must comply with that applicable act.

601.6. Services of the Program

The ICWP/TBI offers the services described below as an alternative to institutional care. Providers may seek enrollment in one or more of the services.

EXCEPTION: A case manager may ONLY enroll to provide Case Management services.

601.6.1. Case Management assists eligible members in gaining and coordinating access to needed medical, social, educational and other needed services. Case management is the focal point for service planning and delivery through the ICWP/TBI. An application to enroll as a case manager will be denied if the Division determines that the potential for conflict of interest exists.

Case managers are required to be available to members seven days a week, twenty-four hours a day. If a case manager is temporarily unavailable to a member due to a planned or an unforeseen event, an alternative plan must be made so that another case manager is always accessible. The case manager's absence not of a short duration is not considered temporary. The case manager's absence due to employment and extended absences for other reasons does not meet program requirements. If the case manager becomes unable to provide case management services, the case manager must notify the Division so that members can select another case manager.

601.6.2. Adult Day services provide specialized treatment techniques for members with traumatic brain injuries in congregate community-based settings. Adult Day Services provide training to reduce inappropriate and/or maladaptive behaviors and behaviors which prevent effective use of community resources.

601.6.3. Behavior Management services provide individualized interventions designed to decrease the member's severe maladaptive behavior, which, if not modified, decreases the individual's ability to remain in the community.

601.6.4. Respite Care services provide temporary relief for the individual(s) normally providing care.

601.6.5. Skilled Nursing provides treatments and health care procedures ordered by a physician, monitors the member's health care condition and trains other Independent Care service providers in areas within the scope of nursing such as dietary practices, sanitation and use of emergency

medical services.

601.6.6. Counseling services assist members with developmental or physical disabilities in understanding their capabilities and limitations and addresses problem of adjustment in their interpersonal relationships.

601.6.7. Environmental Modification services provide physical adaptations to the home, specified in the Individual Plan of Care, which are necessary to ensure the health, welfare and safety of the members, or which enable the member to function with greater independence in the home and, without which, the member could require institutionalization. Medicaid does not reimburse for modification to rental property.

601.6.8. Personal Emergency Response System provides two-way verbal and electronic communication with a central monitoring station seven (7) days a week, 24 hours a day to geographically and socially isolated members and lessens the need for 24 hours of care.

601.6.9. Personal Support Services (PSS) provide personal care tasks such as assistance with eating, bathing, dressing, personal hygiene, preparation of meals, light housekeeping tasks, and other activities of daily living.

601.6.10. Specialized Medical Equipment and Supplies provides services for devices, controls, or appliances, specified in the Individual Plan of Care, which enable members to increase their abilities to perform activities of daily living or to perceive, control, and communicate with the environment in which they live. Ceiling track is not covered by Medicaid equipment.

601.6.11. Consumer Directed Care Option (personal Support Services) allows individuals to direct their own care, by hiring training and terminating their care givers. A care giver must assist or provide care for the member as defined under personal support services.

601.6.12. Financial Support Services/ Fiscal Intermediary (FI) Services are provided to ensure that consumers' funds outlined in the Plan of Care are managed and distributed as intended.

602. Conditions of Participation

All ICWP providers must comply with the policies and procedures in the Part I Policies and Procedures for Medicaid and PeachCare For Kids Manual and the HCBS Statewide Transition Plan Provider Guidance Manual. Rev.10/1/24

ICWP personal support providers must provide either personal support services or community living support services in one of the following programs for a minimum of one year prior to enrollment: CCSP, SOURCE, NOW, COMP.

ICWP alternative living services providers must be enrolled in the CCSP program for a minimum of one year prior to enrollment.

602.1. General Conditions

ICWP providers must meet all the following conditions at the time of initial enrollment and demonstrate continued compliance.

602.1.1. Legal Right to Perform Business in the State of Georgia

602.1.1.1. Authorization Document – The service provider, if incorporated, must submit a copy of its Annual Corporate Registration from the Office of the Secretary of State, and its current business license or other proof of legal authorization to conduct business in the state of Georgia.

602.1.1.2. Licensure – If state or local law requires licensure of the agency, organization, facility or staff for the service the agency wishes to provide, the service provider must submit proof of licensure to the DMA, upon application and annually thereafter. The service provider must post current licensure in a conspicuous location open to public view. Licensure requirements for each service are included in Chapter 900.

602.1.2. Compliance with Rules and Regulations – The provider must comply with Part I of the Policies and Procedures and Part II of the Policies and Procedures manual for ICWP/TBI providers, and with all applicable federal, state and local laws, rules, and regulations.

See 105.13 and 106 (LL) Part I Policies and Procedures for Medicaid/Peachcare for Kids Policy Manual to maintain compliance with background screening requirements with the use of Georgia Criminal History Check System/GCHEXS for fingerprint criminal background checks of owners, administrators, onsite managers, directors, case managers, direct access employees, and all other Medicaid providers.

Providers must be in compliance with all Medicaid Programs they currently service before approval to service ICWP. Neither the provider nor its owner(s) or management may be currently under suspension from delivering services in any Medicaid program. In addition, the service provider must have had no deficiencies within the past three (3) years from any licensing, funding or regulatory entity required/associated with enrollment in any Medicaid funded services or with the provision of any related business, unless all such deficiencies have been corrected to the satisfaction of the imposing entity.

602.1.3. Provider Experience – The enrolling entity must have three (3) years of experience providing the specialty service listed on the enrollment application. The experience must be services provided to individuals with physical disabilities and/or traumatic brain injuries. A resume and a list of references are required at the time of application.

602.1.4. Disclosure of Ownership – The service provider must disclose, in writing, the names and social security numbers of all persons with direct or indirect ownership interest of five percent or more.

602.1.4.1. Reports – The ICWP service provider must furnish service reports to the DMA as requested.

602.1.5. Written Member Care Policies and Procedures – The service provider must have written member care policies and procedures, which are reviewed at least annually and address at a minimum:

602.1.5.1. Scope of services offered;

602.1.5.2. Admission and discharge criteria;

602.1.5.3. Supervision of services;

602.1.5.4. Care of members in an emergency, disaster plan;

602.1.5.5. Clinical records management, including progress notes and retention of records;

602.1.5.6. Administrative/Personnel records and supervision;

602.1.5.7. Use and maintenance of supplies and equipment (if applicable); and

602.1.5.8. Coordination of member care with physicians, case managers, and other service providers

602.1.6. Performance Policies and Procedures The service provider must assure that policies and procedures exist to assure:

602.1.6.1. Coverage if staff fail to report to duty; and

602.1.6.2. Quality of service performance.

602.1.7. Staff Qualifications – The service provider must engage a sufficient number of qualified and experienced staff to render services in accordance with currently accepted standards of medical practice. (Refer to the specific service in Chapter 900 for program requirements related to staffing.)

602.1.8. Business Hours/Business Location The service provider must be open for business during normal business hours to ensure access by members during waking hours (generally 8 a.m. to 5 p.m. or 9 a.m. to 6 p.m.) to agencies, organizations and businesses with which services must be arranged, brokered, coordinated or planned for members.

In addition, telephone coverage must be provided a minimum of 8 hours per day Monday through Friday during normal business hours to ensure

access by members, agencies, businesses and the general public. Telephones must be answered during business hours in a professional manner by identifying the business and the individual who is answering the telephone, unless absence from the office requires the use of an automated answering machine, voice mail, or answering service.

An automated answering machine or any other answering device which answers during business or non-business hours must identify the business. The answering device must inform the caller of a secondary contact such as a cell phone or pager or must allow for a message to be left and inform the caller of the approximate time to expect a returned telephone call. Any ICWP provider not in compliance with these procedures does not meet requirements for answering the telephone in a professional manner.

Providers of ICWP services, except case management, must operate their ICWP business at a location that is designed for business use. For example, in a business office park, business district or free-standing location designated for business separate from the provider's home. The business location must be conducive to conducting routine program management activities with employees, agencies, organizations or others with which coordination of care or services must be arranged or planned. This includes employee orientation and training, in-service education and other types of training and personnel matters. If the ICWP Case Manager provider employs case managers, they too must meet business location requirements as reflected above. Business operations of the ICWP is not permitted in the provider's home nor any other site that does not meet requirements as reflected above.

If required or needed, the following providers must be able to deliver service(s) and respond to the needs of individuals as expressed through telephone calls, 24 hours a day:

602.1.8.1. Case Management

602.1.8.2. Personal Support Services

602.1.8.3. Personal Emergency Response System

602.1.8.4. Respite Care Services

602.1.8.5. Skilled Nursing

602.1.9. Access – Providers (including case managers) must have a local or toll-free telephone number for members/representatives and case managers to access and report problems with service delivery.

602.1.10. Response Time – Case managers and service providers must respond to calls from members/representatives and/or families requesting assistance, within 30 minutes of the contact in emergency situations. For routine requests, case managers and service providers must respond to calls from

members/representatives and/or families requesting assistance within 24 hours.

602.1.11. Member Protection Assurance To ensure the protection of ICWP/TBI members, the service provider must submit a copy of its internal policies and procedures and/or agency standards, which must:

602.1.11.1. Prohibit individuals with a prior conviction on charges of abuse, neglect, mistreatment, or financial exploitation from performing direct member care duties.

602.1.12. Require all critical and non-critical incidents, as outlined in Section 604.2, to be reported within 24 hours or one (1) business day of the incident or discovery of the incident to the Department. Notify all appropriate parties in accordance with state law. Investigate the incident with involvement of appropriate parties while taking immediate steps to protect the waiver participant's health, safety and welfare. Submit the Follow-Up and Interventions Report to the Department within seven (7) business days of submitting the incident report. Participate in regulatory agency investigations, when applicable and take appropriate a corrective action if alleged violation is verified.

602.1.13. Standard Assurances – The provider may not discriminate or permit discrimination against any person or group of persons on the grounds of age, race, sex, color, religion, national origin, handicap or member's failure to execute advance directives. All providers are required to submit a signed and dated Standard Assurance and Letter of Understanding signed by the person legally authorized to act for the agency or person to whom responsibility is delegated. The necessary forms are included in the enrollment packet.

602.1.14. Disclosure – If any provider knowingly fails to disclose all requested information, enrollment will not be approved by the Division. Providers submitting such an application will not be allowed to further pursue enrollment for one year after the application is denied. If at any time following enrollment, a provider is found to have falsified or knowingly failed to disclose application information, the Division has the right to terminate that provider from the ICWP/TBI.

602.1.15. Training Newly enrolled providers (providers not previously enrolled to provide ICWP/TBI services, must attend/send supervisory staff to the next scheduled quarterly training session. Alliant Health Solutions will provide a date for the training. All providers must attend at least one scheduled training.

Newly enrolled providers must review the DCH HCBS Incident report system information and instructions that are posted on the DCH website: https://medicaid.georgia.gov/programs/all-programs/waiver-programs/hcbs-incident-reporting-system-resources. Completion of this review and familiarity with this system must be in place before providing services to ICWP members. Newly enrolled Case Managers must send

their contact information that is to be used in the incident report system to the ICWP program specialist.

Participation in provider training sessions is a mandatory requirement. Failure to attend provider training will result in termination from the program.

602.1.16. Guardianship- ICWP providers may not serve as a legal guardian and/or power of attorney for ICWP members.

602.1.17. Insurance Coverage--The applicant must submit proof that the provider agency has at least $1,000,000 per occurrence and $3,000,000 per aggregate in general liability insurance coverage. In addition, Private Home Care providers must submit proof of their agency's worker's compensation insurance coverage. Proof of liability insurance is required at enrollment, expansion and annual re-validation. Rev. 4/1/24

602.1.18. HIPAA Compliant Telehealth Modality-

Telehealth services provided with both audio and visual components must use a modality that is an encrypted (end to end encryption) software product with an established business agreement that protects PHI (protected health information). PHI is information about health status, provision of health care, or payment for health care that is created or collected by a covered entity and can be linked to a specific individual. Use of electronic health records, member portal access or app use are to be encrypted (end to end encryption) with business agreement as well.

Telehealth services provided by phone calls require I-phone or Android encryption cell settings use or landline. Applicant/member, Case Management, or Service Provider with access to landline phone (one way) can be utilized in place of the software requirement. Landline/non internet use is appropriate (copper wires that carry their own power and work during blackouts). If the service requires a visual component, a phone call cannot be utilized.

Refer to the service specific description (Chapter 900) to determine the service that can be provided via telehealth. (rev. 10/2023)

602.1.19. Home and Community Based Final Setting Rule Requirements (Final Rule)-

602.1.19.1. Overview of the Settings Provision: The final rule requires that all home and community-based settings meet the following qualifications:

602.1.19.1.1. The setting is integrated in and supports full access to the greater community.

602.1.19.1.2. It is selected by the individual from among setting options.

602.1.19.1.3. Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint

602.1.19.1.4. Optimizes autonomy and independence in making life choices.

602.1.19.1.5. Facilitates choice regarding services and who provides them.

602.1.19.2. Additional requirement for provider-owned or controlled home and community-based residential settings under the Final Rule:

602.1.19.2.1. The individual has a lease or other legally enforceable agreement providing similar protection.

602.1.19.2.2. The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit.

602.1.19.2.3. The individual controls his/her own schedule including access to food at any time.

602.1.19.2.4. The individual can have visitors at any time.

602.1.19.2.5. The setting is physically accessible

602.1.19.2.6. The settings provider (ADH, ALS, or Out of Home Respite provider) must complete the HCBS Settings Rule Member Questionnaire Form with the member quarterly and maintain in the member's record.

602.1.19.2.7. The settings provider (ADH, ALS, or Out of Home Respite provider) must complete the HCBS STP Community Integration form at initial visit and annually. Maintain in the member's records.

602.1.19.3. Person-Centered Planning

The Final rule specifies that service planning for participants in Medicaid HCBS programs under section

1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs and may include a representative that the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences, including those related community participation, employment, income and savings, health care and wellness, education, and others.
The plan should reflect the services and supports (paid and unpaid), who provides them and whether an individual chooses to self-direct services. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning for states to bring their programs into compliance.

602.2. Enrollment Procedures

602.2.1. Private Home Care Providers who want to provide Personal Support Services are limited to the month of January to complete an application. All other providers can apply at any time.

602.2.2. Before completing an online application, potential providers must review all of these items:

602.2.2.1. Part I Medicaid and Peachcare for Kids Policies and Procedure Manual

602.2.2.2. Part II Independent Care Services Policies and Procedures Manual or Part II Independent Care Services Alternative Living Services Policies and Procedures Manual

Review the provider enrollment checklist in the Appendix. This chart lists all the documents and information that potential providers must provide for each specialty at enrollment. Review the chart and prepare to upload all the documents per your specialty

into the online application. If all the documents are not provided at the time of the application your application will be considered incomplete and will be withdrawn.

602.2.3. Providers applying to be a Fiscal Intermediary please see The FI enrollment checklist in the appendixes.

602.2.4. Complete an online application on the MMIS website at www.mmis.georgia.gov. Select the tab labeled "Provider Enrollment" and use the enrollment wizard. Select Facility > Home and Community Based Services >ICWP > select your specialty. Providers may submit applications and track the progress of an application via the Internet. Gainwell Technologies will acknowledge in writing the receipt of enrollment application.

602.2.5. The application and documentation will be reviewed by the credentialing verification organization. If approved by CVO, the Provider Enrollment Team will review the application and documents for eligibility. If all the documents required for each specialty (review the enrollment checklist in the appendixes) are not provided, the application will be withdrawn. If the documents are provided, but the applicant does not qualify, the application will be denied. Gainwell Technologies will send notification of application disposition.

602.2.6. If the application is withdrawn the potential provider may resubmit an application during the next open enrollment period.

602.2.7. If the application is denied, DCH will notify the applicant of the reason for the denial. The applicant may not resubmit an ICWP/TBI application for one year from the date of the denial. Appeal rights will be attached to the denial.

602.2.8. If the application is approved, DCH will email notification and information to the new provider. Alliant Health Solutions will send the provider an invitation to the next new provider training. New Providers must attend new provider training prior to providing services.

602.3. Expansion Procedures (Enrolled Service Providers) Adding ICWP/TBI Services - Enrolled Service Providers ONLY

If a current ICWP service provider wishes to enroll as a provider of additional ICWP services, the provider must complete a new application for enrollment for the service. (Refer to Section 602.2 for instructions on obtaining enrollment packets). Providers must send a detailed resume at the time of submitting the application.

Note: A case manager MAY NOT enroll as a provider of other services. Providers of other services MAY NOT enroll as a case manager under ICWP.

602.4. Changes in Enrollment Data

602.4.1. Change in Ownership or Legal Status or Buy Out

Any enrolled service provider or case manager undergoing a change (including, but not limited to, dissolution, incorporation, re-incorporation, reorganization, change of ownership of assets, merger or joint venture) so that, as a result, the provider becomes a different legal entity, must furnish written notice to the Department of Community Health, Healthcare Facility Regulation Division if licensure is applicable, ICWP/TBI members and case managers, at least thirty (30) days prior to the change. (See Section D for addresses.) The successor provider must submit a new application for enrollment as a provider of the service under the ICWP.

Note: Medicaid Provider Numbers and Private Home Care Licenses are not automatically transferable. Providers are required to notify the applicable licensing agency of any changes in ownership, legal status, or location.

Purchase of an existing enrolled provider agency requires that the purchaser complete the enrollment process and obtain a Medicaid Provider Number. Without a Medicaid Provider Number, Medicaid reimbursement will not occur.

Even when the change in ownership and/or legal status results in no visible change in services to the member, the provider must notify the individuals/entities identified above.

602.4.2. Change in Provider Data

Providers (including case managers) must ensure that DCH, Alliant Health, members and members' case managers are provided updated, accurate information, which includes, but is not limited to:

602.4.2.1. Correct address of the agency/business location;

602.4.2.2. Correct street address of the service location, if different from above;

602.4.2.3. Current phone number(s); and

602.4.2.4. Name of contact person(s).
Enrolled providers are required to furnish written notice to DCH, Alliant Health, the Health care Facility Regulation Division (if applicable), ICWP/TBI members and case managers, at least thirty (30) days prior to the change. (See Section D for addresses.)

602.4.3. Termination of Provider Number/Enrollment in ICWP/TBI

602.4.3.1. Provider-Initiated Termination

602.4.3.1.1. A provider (including case managers) seeking to terminate enrollment in the

ICWP/TBI must provide written notice to the Department of Community Health, and the Alliant Health Solutions no less than sixty (60) calendar days prior to the termination date, stating it intends to terminate participation in the ICWP. (See Section D for addresses.)

602.4.3.1.2. Alliant Health will notify service providers of the case manager's intent to terminate enrollment.

Service providers must provide written notice of discharge to case managers and ICWP/TBI members at least thirty (30) calendar days prior to the effective date of termination.

The case manager will work with members to locate another service provider to become effective the date of the current provider's termination.

602.4.3.1.3. Alliant Health will notify service providers of the case manager's intent to terminate enrollment.

Case managers, when terminating provider enrollment, must provide written notice of discharge to ICWP members and service providers at least thirty (30) calendar days prior to the effective date of termination.

Alliant Health will work with members to locate another case manager to become effective the date of the current case manager's termination.

602.4.3.1.4. The DCH will authorize Alliant Health to terminate the provider enrollment number and the provider's authorization to receive reimbursement.

602.4.3.2. Termination of Provider Number/Enrollment by the DCH.

The DCH may suspend or terminate a provider as described in Part I, Chapter 400. Failure to correct compliance issues will result in termination from the ICWP.

The DCH will notify Alliant Health to initiate action to locate another case manager/service provider as appropriate.

602.4.4. Send notices of change in ownership/legal status, change of provider data or notices of intent to voluntarily terminate provider number/enrollment in the ICWP to:

Department of Community Health /Division of Medicaid
Attention: ICWP/TBI Program Specialist
2 Martin Luther King Jr Drive, SE
Floor 19
Atlanta, Georgia 30334
Email: ICWP.Messages@dch.ga.gov

and

Alliant Health Solutions
P.O. Box 105406
Atlanta, GA 30348

Also report to the change to HFRD if permitted by HFRD
Department of Community Health, Healthcare Facility Regulation Division
2 Martin Luther King Jr Drive, SE
Floor 17
Atlanta, Georgia 30334

602.4.5. Response from DCH – The DCH will acknowledge receipt of notice of a change in ownership/legal status and forward all changes to Alliant Health within ten business days of receipt.

602.5. Records Management

Providers must maintain records pertaining to the provision of ICWP/TBI services in accordance with the standards in this manual and with accepted professional standards and practices. Records must be kept available to DCH, and its agents as requested. The provider must maintain a copy of all ICWP/TBI records at the Medicaid enrolled provider site(s). Records must be maintained in a manner that assures security, accuracy, confidentiality, and accessibility.

602.5.1. Records Retention

602.5.1.1. The provider must maintain current clinical records for active members and organize the clinical records for easy reference and review. For discharged members, the provider must maintain the clinical record for a minimum of five (5) years from the last date of service. This policy applies even if the provider ceases operation. (Refer to Part I, Medicaid/PeachCare for Kids Policies

and Procedures manual.)

602.5.1.2. In accordance with 45 CFR Part 17, the state and federal governments shall have access to any pertinent books, documents, papers, and records for the purpose of making audit examinations, excerpts, and transcripts. The provider must retain records for five (5) years after submission of the final claim for payment. If any litigation, claim, or audit is initiated before the expiration of the five-year period, the provider must retain records until all litigation, claims, or audit findings involving the records are resolved.

602.5.2. Destruction of Records

602.5.2.1. A provider may destroy records not required to be maintained. The destruction of records must be conducted in such a way that member confidentially is preserved.

602.5.2.2. When records are accidentally destroyed, the responsible party must reconstruct them to the extent possible in a timely manner. Each reconstructed case record must be clearly labeled “reconstructed.”

602.5.3. Conflict on Interest: Any group of acts, facts or circumstances that, according to the State’s determination and judgement, appears to bring into question the actual or perceived independence, objectivity and fair treatment of the Contractor. That includes, but is not limited to, a personal or business interest that may represent a real, potential or apparent Conflict of Interest, as it relates to the performance of the contract or that may create even the appearance of impropriety. It also includes situations where personnel or their relatives or relationships, up to a fourth degree of consanguinity and second degree of affinity, have intentionally affected the procedures to their favor or for their own benefit or the benefit of their family members or friends. This term also incorporates the requirements for conflict of inherent safeguards for enrollment counselors under 42 CFR 438.810.

603. Adverse Actions

603.1. Conditions of Adverse Action

When deficiencies are cited, the DCH will issue adverse action notices that require enrolled providers to correct the deficiencies. Adverse actions may be imposed independently or in conjunction with other regulatory agencies.

Review of compliance is ongoing and may be initiated based on reports and visits in response to specific incidents or complaints.

In determining which adverse action to impose and the duration of the adverse action,

the Division considers the provider's performance record, compliance with policies and procedures, the scope and severity of the deficiency, and other applicable criteria. The DCH will impose the adverse action(s) it believes will most likely achieve correction of the deficiencies.

Adverse action may be imposed for any of the following reasons:

603.1.1. History of Non-Compliance – The service provider is out of compliance and/or has a history on non-compliance with ICWP/TBI policies and procedures and/or standards within the past three years. The review of the provider's record of compliance includes, but is not limited to:

603.1.1.1. Utilization review reports or other audits conducted by the Department of Community Health.

603.1.1.2. Reviews and site visits conducted by HFR within the Department of Community Health.

603.1.1.3. Note Reports from members, member representatives or member families, case managers, and other providers.

The service provider must notify the DCH in writing of any non-compliance, even if temporary, as soon as it occurs (e.g., resignation of a required staff member) to request a temporary written waiver from the DCH. The provider must immediately initiate corrective action to come in compliance.

603.1.2. Failure to Render Services - Failure of a service provider to render services as required by the plan of care in accordance with currently accepted standards of medical practice.

If the service provider experiences temporary staffing problems and is unable to provide the services required by the member's plan of care, the provider must immediately notify the case manager. If the problem is expected to continue for more than ten business days, or the member's condition is such that a delay or interruption of service would adversely affect the member, the case manager will assign the member to another provider.

If a member becomes dissatisfied with the case manager, the member may choose a new case manager by contacting Alliant Health Solutions to obtain a list of case managers.

603.1.3. Failure to Maintain Quality of Care – Care and/or services provided are of such poor quality that the health, safety or welfare of members is placed at risk.

603.1.4. Failure to Maintain Current Licensure – Failure of service provider personnel to maintain current licenses required by Georgia law.

603.1.5. Failure to Act on Charges of Abuse, Neglect of Care or Exploitation of Members – Failure of a service provider to take measures to report and/or stop identified known abuse, neglect or exploitation of members.

603.1.6. Failure to Respond to an Adverse Action – Failure of a service provider to submit a timely plan of corrective action or any other reports or documentation as requested or required by the DCH.

603.1.7. Refusal of Access to Member and Member Records – Failure of a case manager, service provider or its subcontractor(s) to permit staff or contracted personnel acting on behalf of the state of Georgia access to members, member records or other documentation required by participation in the ICWP/TBI.

603.1.8. Falsification of Records or Other Acts of Fraud/Abuse

603.1.9. Inappropriate Charging – Willful overcharging of member services and billing for services that have not been rendered.

603.1.10. Failure to Refund Fees – Failure of a service provider to refund fees to members within thirty (30) calendar days after a determination that a member is due a refund. (Retroactive Medicaid eligibility and/or other reasons may cause a provider to owe refunds to a member.)

603.1.11. Failure to Notify Prior to Termination – Failure of a provider to provide required notice prior to termination of services. Providers who abruptly discontinue services may not request re-enrollment for a period of three (3) years from the date services were discontinued.

603.1.12. Failure to be accessible to members 24 hours a day or failure to be accessible to Alliant Health, case managers, or other providers, as appropriate.

603.1.13. Failure to report an incident as defined in Section 604.2, failure to cooperate with an investigation and development of interventions related to an incident, or failure to prevent an incident from occurring may be grounds for corrective action or other adverse actions.

Note: Travel time to see a member is not a billable service for case management or any other providers.

603.2. Types of Adverse Actions

Types of adverse actions include, but are not limited to:

603.2.1. No Member Referrals – No new ICWP/TBI referrals will be made to the provider for a minimum of six (6) months for the first offense and a minimum of six (6) months for any subsequent offenses.

603.2.2. Sixty Day Delay of Processing or Denial of Approval of Additional Provider Enrollment Applications

603.2.3. Termination of Provider Enrollment

603.2.4. Selection of Another Provider – The DCH shall instruct Alliant Health or case managers to assist members in selecting another case manager/service provider when there is endangerment of the health, safety and welfare of the members.

603.2.5. DCH has the right to assign another provider when there is endangerment of the health, safety and welfare of the members.

Note: Even in the absence of any adverse action, a case manager may assist the member in locating another service provider or Alliant Health may assist the member in locating another case manager at any time the member requests a change in providers.

603.3. Duration of Adverse Action

An adverse action will be imposed for a specific time period, a minimum of six (6) months for the first offense and a minimum of twelve (12) months for any subsequent offenses. The adverse action letter will stipulate the time frame within which the provider is required to correct deficiencies.

Note: The DCH may conduct an unannounced site visit prior to removal of the adverse action to determine whether the provider has achieved compliance. Failure to achieve compliance by the end of the adverse action period will result in a continuation of the adverse action; and/or imposition of additional adverse action or termination.

603.4. Duration of Adverse Action

An adverse action will be imposed for a specific time period, a minimum of six (6) months for the first offense and a minimum of twelve (12) months for any subsequent offenses. The adverse action letter will stipulate the time frame within which the provider is required to correct deficiencies.

Note: The DCH may conduct an unannounced site visit prior to removal of the adverse action to determine whether the provider has achieved compliance. Failure to achieve compliance by the end of the adverse action period will result in a continuation of the adverse action; and/or imposition of additional adverse action or termination

603.5. Provider Notification of Adverse Action and Appeal Rights

The DCH will send to the provider a Notice of Adverse Action in accordance with Part I, Chapter 400, of the Policies and Procedures of Division of Medical Assistance. The notice will include:

603.5.1. Reason for imposing the adverse action.

603.5.2. The effective date and duration of the proposed adverse action(s). Generally, the adverse action will be effective thirty (30) calendar days after receipt of the notice. If the DCH determines that the health, safety or welfare of members may be at risk, or if the provider has a history of

non-compliance with policies and procedures of the ICWP/TBI, the 30-day notice of adverse action may be reduced.

The Division considers issues of non-compliance that have occurred within the past three (3) years of the most recent findings of non-compliance.

If the Division reduces the 30-calendar day period, a written explanation is provided (i.e. number of deficiencies, severity of deficiencies, ongoing/recurring deficiencies). The Division may reduce the 30-day period and have the member immediately select another provider (on the same day of notice to the provider) if the Division determines that the member's health, safety or welfare is in immediate danger. The provider may appeal the action taken by Division, but appealing the action may not stay the action appealed.

The Division may also reduce the time frame for implementation of the adverse action and allow the provider to continue to render services to members if the deficiencies do not pose an immediate threat to members.

603.5.3. The actions required of the provider as a condition of removal of the adverse action.

603.5.4. The address to which requested information is to be sent and the name of a DCH contact person to call for clarification regarding the notice.

603.5.5. The actions and time frame necessary to oppose/appeal the adverse action. If the provider fails to request an Administrative Review or fails to submit the requested information within the time frame specified in the Notice of Adverse Action, the adverse action becomes final, and no further administrative or judicial review will be available. If the provider fails to respond to the notice to correct the deficiencies, the DCH may impose actions beyond those proposed in the letter, including termination of the provider's enrollment in the ICWP/TBI.

Note: Providers terminated from enrollment under the ICWP as a result of an adverse action shall be subject to provisions of Part I, Chapter 300, and 400 of the Policies and Procedures for Medicaid/PeachCare for Kids. Applicable to all Medicaid providers.

Note: Providers shall be entitled to a hearing as indicated in Part I, Chapter 500, of the Policies and Procedures Manual, following any Administrative Review. If the provider fails to request Administrative Review as indicated in 502, the adverse action becomes final, and the provider forgoes the right to a hearing.

604. Member Assurances

604.1. ICWP Member Rights and Responsibilities

604.1.1. Members have rights and responsibilities regarding participation in the

ICWP/TBI. Upon receiving services through the ICWP, the case manager reviews member rights and responsibilities and the Memorandum of Understanding with the member and/or member representative. After the member reads and signs a copy of the member's rights and responsibilities and the Memorandum of Understanding, the case manager maintains copies in the member's file, send copies to Alliant Health, and distributes copies to the member and all service providers. Alliant Health maintains a copy in the member's record.

Member rights include:

604.1.1.1. The right to access accurate and easy-to-understand information.

604.1.1.2. The right to be treated with respect and to maintain one's dignity and individuality.

604.1.1.3. The right to voice grievances and complaints regarding treatment or care that is furnished, without fear of retaliation, discrimination, coercion, or reprisal.

604.1.1.4. The right of choice of an approved provider.

604.1.1.5. The right to accept or refuse services as agreed or as mutually established, recognizing that non-compliance with the memorandum of understanding will be cause for the termination of a member's participation in this program.

604.1.1.6. The right to be informed of and participate in preparing the care plan and any changes in the plan.

604.1.1.7. The right to be advised in advance of the provider(s) who will furnish care, and the frequency and duration of visits ordered.

604.1.1.8. The right to confidential treatment of all information, including information in the member record.

604.1.1.9. The right to receive services in accordance with the current plan of care.

604.1.1.10. The right to be informed of the name, business telephone number and business address of the person/agency supervising the services and how to contact that person/agency.

604.1.1.11. The right to have property and place of residence treated with respect.

604.1.1.12. The right to review his/her records on request.

604.1.1.13. The right to receive care and services without discrimination.

604.1.1.14. The right to be informed on recognizing and reporting abuse, neglect, and exploitation.

604.1.2. Member responsibilities include:

604.1.2.1. The responsibility to notify case manager/service provider(s) of any changes in care needs.

604.1.2.2. The responsibility to treat provider staff in a courteous and respectful manner, as well as cooperate with and respect the rights of the caregivers providing care.

604.1.2.3. The responsibility to be as accurate as possible when providing information on health history and personal care needs.

604.1.2.4. The responsibility to participate actively in decisions regarding individual health care and service/care plan development.

604.1.2.5. The responsibility to comply with agreed upon care plans.

604.1.2.6. The responsibility to notify the member's physician, providers, and/or caregiver of any change in the member's condition.

604.1.2.7. The responsibility to maintain a safe home environment and to inform providers of the presence of any safety hazard in the home.

604.1.2.8. The responsibility to be available to provider staff at agreed upon times services are scheduled to be rendered and to case management staff both in person and using audio visual equipment when allowed by policy.

604.1.2.9. To be available to provider staff at agreed upon times services are scheduled to be rendered.

604.1.2.10. The responsibility to avail the member to the utilization review team to make visits as needed.

604.1.2.11. The responsibility to maintain a safe environment for self and staff, including the responsibility to maintain a drug free environment at all times. If present in the home, alcohol must be concealed and must not interfere with the service delivery process.

604.1.2.12. The responsibility to not willfully have utilities (gas, water, electricity) disconnected for non-payment, or other reasons within the member's control.

604.1.2.13. The responsibility of the ICWP member or member's representative to notify the case manager of any changes in his or her Medicaid status.

Note: E required to sign a Memorandum of Understanding when placed into services. (Refer to appendixes for the Memorandum of Understanding.)

604.2. Reporting and Investigating Incidents

It is recommended that each provider should designate an authorized individual to review the incident report, the results of the Follow-Up and Interventions report, and corrective action plans for accuracy and completeness prior to submission to the Department.

One form may be used to record multiple incident types if they relate to the same overall incident.
When an incident involves more than one waiver member, an incident report must be completed for each waiver member.

See appendixes for definitions of reportable incident types.

Reporting of Incidents

604.2.1. Providers must immediately take steps necessary to protect the waiver member's health, safety and welfare upon witnessing or discovering an incident.

604.2.2. The provider will immediately notify:

604.2.2.1. The individual's guardian and/or next of kin, as legally appropriate:

604.2.2.1.1. Notification of incidents with a severity ranking of 3 and above shall occur within two (2) hours.

604.2.2.1.2. Notification of all other incidents shall occur within twenty-four (24) hours.

604.2.2.2. If the event occurred in an unlicensed facility/agency, Law enforcement and Adult Protective Services in instances of suspected abuse, neglect and/or exploitation of the member.

604.2.2.3. If the event occurred in a licensed facility/agency, Law enforcement, Healthcare Facilities Regulation Division,

and the Long-term Care Ombudsman in instances of suspected abuse, neglect and/or exploitation of the member.

604.2.2.4. If instances of suspected abuse, neglect and/or exploitation of a member who is a minor, Law enforcement and the Child Protective Services.

604.2.3. The provider will submit the Incident Report electronically via the webform located at https://medicaid.georgia.gov/ under Provider links within twenty-four (24) hours of the incident, or the discovery of the incident, but no later than one (1) business day if the incident occurred after business hours or on a weekend or holiday.

604.2.4. A confirmation email with a summary of the incident will be sent to the reporting provider, the contact person identified, and the member's case manager if they are not the reporting provider.

604.2.5. In all cases of suspected abuse, neglect or exploitation follow-up on referrals to law enforcement and regulatory authorities until resolution.

605. Follow-Up and Intervention Reporting

Used to provide additional information learned about the reported incident and to describe actions taken to resolve the incident and action steps taken to reduce or prevent the recurrence of the incident.

In collaboration with the appropriate providers, the case manager submits the follow-up, and interventions report electronically via the link provided in the confirmation email within seven (7) business days of submission of the Incident Report.

605.1. Investigate the cause of the incident

605.1.1. Ensure that no other incidents or abuse take place while the investigation is ongoing.

605.1.2. Determine if risk factors existed prior to the incident, which may have identified potential for incident occurrence.

605.1.3. Identify interventions to reduce or prevent a similar incident in the future.

605.1.4. Identify the individual responsible for implementation of the interventions and the process for evaluating the effectiveness of the plan.

605.2. DCH will confirm within seven (7) business days if the interventions identified are acceptable and provide on-going monitoring until completion of the identified activities.

605.2.1. If the interventions and/or corrective action are deemed to require

modification, the provider will have three business days to resubmit the agency's plan to address the deficiencies cited in the follow-up and interventions report.

605.3. Intervention Types include, but not limited to:

605.3.1. Staff related – staff training, review, changes to staffing patterns, or supervision

605.3.2. Individual related – review of protocols, new/additional assessments (behavioral or medical), coordination of care, review of service plan, increased observation

605.3.3. Equipment/Supplies related – purchase or repair equipment or supplies, obtain new devices

605.3.4. Environment related – evaluate the area, make physical modifications for mobility or safety, temporary or permanent relocation

605.3.5. Policy and Procedure related – review or update written provider policies, procedures, and/or guidelines

605.3.6. Provider Quality Improvement related – internal investigation, internal corrective action plan, systematic assessment or change

605.3.7. Referral to other agencies or community services

605.3.8. Other – any action not identified above

605.4. Participate in regulatory agency investigations, if applicable

605.5. In all cases of suspected abuse, neglect or exploitation follow-up on referrals to law enforcement and regulatory authorities until resolution.

605.6. Maintain documentation of all reports and associated documentation in the client reco

Chapter 700 Eligibility Conditions

701. General

The DCH reimburses enrolled providers for ICWP/TBI services provided to eligible persons only. Eligible persons are those who at the time of application:

701.1. have been determined disabled according to the Social Security Administration or the Department of Human Services, Division of Family and Children's Services, and are financially and resource eligible to participate in the ICWP.

701.2. are 21 through 64 years of age when services begin. Any member admitted to the program prior to the 65th birthday may remain in the program until death or termination from the program

701.3. have severe physical impairment and/or traumatic brain injury that substantially limit one or more activities of daily living and require the assistance of another individual. An individual with both physical and mental impairment must qualify for nursing home or hospital level of care based on physical impairment or TBI alone. Mental disorders, developmental delays, and intellectual delays cannot be used to meet the level of care for the ICWP waiver.

701.4. are medically stable as well as has, or able to have, a stable living environment, but are at risk of hospital or nursing facility placement due to inadequate community-based support services.

701.5. are certified for a level of care appropriate for placement in a hospital or nursing facility

701.6. have a plan of care within the cost limit of the waiver.

701.7. can be safely placed in a home and community setting. “Safely placed” means placed in a setting with sufficient human and technological support if the latter is required to prevent deterioration of the health condition, injury or harm.

701.8. currently in an institution or at risk of being placed in an institutional setting.

Although not required, natural (unpaid) supports help to ensure the safety of the member and provide support in the absence of other assistance when required by the member. ICWP services are formal supports which supplement the natural support of the member. Natural supports help with routine activities of daily living to safely maintain the member in the home or the community when formal supports are not available. Without such natural supports the member may be at risk of rapid deterioration, injury or harm. Rev. (01/2019)

If possible and with the approval of the member, the natural supporter is encouraged to be present at assessment and during development of the plan of care. The natural support system may include family members; significant others; community assistance; or members of social networks. The plan of care is developed in consideration of natural support, paid support by the applicant or family, and technology or environmental support. Revs. (07/2017, 01/2019)
The natural support system, when needed and available, is considered in development of a holistic plan of care that assures the safety of the applicant. Examples of extensive daily care include the need for 24-hour assistance; extensive transfer assistance without which the applicant will be unsafe and/or uncared for; and the need for continuous care of any kind. (Rev 04/2011, 01/2019)

When the member is more independent, the presence of natural support may be less crucial or may be needed to a lesser degree. When possible, however, periodic monitoring and oversight by natural support, whether family member, friend or other designee helps to support the independence of the member in the community. (Rev.01/2019)

Applicants in a nursing home will be assessed under the nursing home level of care and if eligible for ICWP will be approved at the nursing home level of care cost unless the initial assessment determines applicant can be managed safely in the community under hospital level of care. An individual in a nursing home that is currently on a ventilator will automatically be admitted under hospital level of care if the meet the overall ICWP criteria. (Rev. 01/2024)

701.9. Transition of Children from the GAPP into ICWP

EXCEPTION: Six Months prior to a child’s twenty-first (21st) birthday, a transitional process will begin to assess the GAPP child for ICWP services. The following process will take place when the child is transitioned from GAPP into ICWP:

701.9.1. Alliant Health GAPP nurse will forward the child’s medical record to the Alliant Health ICWP team nurse.

701.9.2. The child's medical record will be reviewed by Alliant Health ICWP review nurse to determine if the child meets the general eligibility criteria for the ICWP.

701.9.3. If the child meets the general eligibility criteria, Alliant Health ICWP review nurse will send the family and/or applicant an introductory letter with an ICWP packet six months prior to the applicant's birthday. The application will be mailed to the parent or legal guardian by Alliant Health by the sixth(6th) month prior to the applicant's 21st birthday. The application must be returned by the applicant within 30 days of the date of the letter. Mailing the application will be followed by a telephone call to the applicant/family within ten (10) days to verify receipt. Failure to return the application may result in forfeiture of a slot by the applicant.

701.9.4. A nurse from Alliant Health will contact the applicant or applicant's representative to schedule an assessment date within 30 days of receipt of the returned application.

701.9.5. At the time of the assessment, the Alliant Health nurse will inform the applicant or applicant's representative of the services offered under the ICWP. If the application was not returned by the applicant or applicant's representative, a final letter will be sent notifying the applicant of ineligibility for the ICWP.

701.9.6. Once the assessment is completed an approval or denial letter is sent to the applicant or applicant's representative within 30 days of the completed assessment.

701.9.7. If the applicant is approved for ICWP services, the approval letter will inform the applicant or applicant's representative to select a case manager from the case manager list provided in the letter. The applicant or representative must notify Alliant Health within two weeks of the selected case manager.

701.9.8. Once the case manager has been selected by the applicant or applicant's representative, Alliant Health will send the selected case manager all the required documents to ensure the member will begin services the day he or she turns 21.

701.9.9. The ICWP member services cannot begin before the applicant's 21st birthday.

701.9.10. If the applicant is denied ICWP services a denial letter will be sent to member within 30 days of the assessment, and rights to appeal will be attached to the letter. The Alliant Health nurse may also refer the applicant to apply to another Medicaid program.

701.9.11. A member may NOT participate in more than one Medicaid waiver program at the same time. An applicant must apply to the ICWP and be assessed by the contracting agency. A slot maybe granted contingent

upon eligibility and available funds. If a member is enrolled from another waiver program, ICWP services must begin on the first day of the month following discharge from the other waiver. Waiver services case managers and/or care coordinators along with providers involved in service delivery must clearly communicate with each other to verify service end dates to ensure that ICWP services begin on the first day of the month. Services rendered prior to the first day of the month may not be reimbursed. Medicaid Waiver Programs include:

701.9.11.1. Independent Care Waiver Program (ICWP)
701.9.11.2. Community Care Services Program (CCSP)
701.9.11.3. New Options Waiver (NOW)
701.9.11.4. Comprehensive Supports Waiver (COMP)
701.9.11.5. Georgia Pediatric Program (GAPP)
701.9.11.6. SOURCE

Note: ICWP members and other waiver members are NOT eligible to enroll in a Medicaid CMO.

702. The Selection Process

702.1. Selection Criteria

In addition to meeting the general eligibility criteria in Section 701 above, individuals are prioritized for placement into the program using the following criteria:

Application date on a first come first served basis if slots are available.

Application date and member need based on the Don-R score, if there are no slots available and there is a waiting list.

702.2. Applying for Services

Contact Alliant Health Solutions at the phone number, address, or email address below for application information.

Call, write, or email Alliant Health Solutions to request an ICWP participant application through the mail. The ICWP participant application can also be printed from appendixes in this manual.

A completed application can be mailed, emailed, or faxed to Alliant Health Solutions at the information below.

Alliant Health Solutions
P.O Box 105406
Atlanta, Georgia 30348
Telephone number: 1-888-669-7195
Email address: HCBSWaivers@AlliantHealth.org
Local Fax Line: 678-527-3001
Toll Free Fax Line: 1-800-716-5358

Alliant Health Solutions is responsible for assessing individuals for appropriateness of

services and initiating service delivery to members utilizing the policies and procedures and budgetary limitations established by the Department of Community Health.

702.3. Selection Procedures

702.3.1. Intake Process

702.3.1.1. Within two (2) workdays of receipt of an inquiry via email or voicemail, Alliant Health Solutions (AHS) will contact the individual to complete an initial telephone screening. If appropriate, AHS will mail or email an application to the individual within one (1) workday. Once the application is returned to AHS it will be assigned to a review nurse to complete a Level of Care screening. If the individual is not appropriate, AHS will provide alternative resource information and mail a screening denial letter to the individual along with hearing rights. (Rev. 07/2023)

702.3.1.2. Within ten (10) days of receiving a completed application, the AHS review nurse will conduct a LOC screening using the DON-R tool. The applicant must score a minimum of 15 in Column A, Level of Impairment, along with identified Unmet Need for Care in Column B, before referral for a full assessment. If the applicant does not score a minimum of 15 on the DON-R screening, AHS will notify the applicant in writing within ten (10) workdays. DCH may request an assessment be performed regardless of the LOC screening. If the applicant is determined appropriate based on the LOC screening, and there are available slots, the Alliant review nurse will move forward with an assessment. If there are no available slots the applicant will be placed on the waiting list. See section 702.4 for waiting list procedures.

702.3.1.3. Within forty-five (45) days of receiving the completed application, which includes completion of the LOC screening, and slot availability, AHS will schedule the assessment, perform the assessment, and make a LOC determination. AHS may request medical records to determine the level of care. If the applicant meets LOC, AHS will outline the initial Plan of Care and issue an approval letter. If the applicant does not meet LOC, AHS will issue a denial letter. The approval or denial letter will be mailed to the applicant or applicant's representative within two (2) business days. (Rev. 07/2023)

702.3.1.4. If AHS is unable to schedule the assessment due to a lack of response from the applicant, a letter will be

issued advising the applicant that they have 10 additional days to contact AHS to schedule the assessment. If AHS has been unsuccessful in their attempts to contact the applicant for 45 days after receiving the completed application, the application will be withdrawn.

702.3.1.5. All applicants have appeal rights and may request a hearing. See section 705.2 for more details on appeal rights.

Note: Any applicants or members of the ICWP Waiver Program for whom English is not the applicant's/member's primary language must be provided interpreting services in their native language at all initial assessment for program admission, annual reassessment, and at any time when a change in condition will require a new evaluation of need. The interpreting services must be provided by an independent, conflict free agency, organization, or contractor with no organizational affiliation to the case management or service provider agency. A documented record of the interpreter or interpretation agency, including all contact information (i.e., complete name, address, *CV (Curriculum Vitae), phone number and email), must be maintained by the agency or service provider agency that secured the interpretation service and will be made available to DCH upon its request as part of the applicant's/member's file. If the applicant's or waiver member's care is managed by a legal

702.3.2. Assessment Process, Alliant Health will:

702.3.2.1. Complete the ICWP Participant Assessment Form (PAF). (Refer to appendixes for a copy of the PAF.) In addition to completing the PAF form, Alliant Health will also complete the Personal Care Attendant Hour Allotment work sheet. The Worksheet will assist in determining the number of personal care hours a member may require. (Please refer to appendixes)

702.3.2.2. The Alliant Health nurse will inform the applicant that once he/she is approved for the waiver, it becomes their responsibility along with the case manager to obtain a DMA-6 signed by their physician, physician assistant, or nurse practitioner. The physician will make a recommendation concerning Nursing Facility Care or Intermediate Care Facility for the Mentally Retarded (DMA-6) form. All Medicaid eligible ICWP members must have a pre-admission screening to determine the level of care. The DMA-6 is the standard form used to document that the individual meets the level of care (LOC) for nursing facility placement. (Refer to appendixes for a copy of the DMA-6.) (Rev. 07/2023)

702.3.2.3. Have the applicant sign a Release of Information form. (Refer to appendixes for a copy of the Release of Information form.)

702.3.2.4. Develop the Initial Plan of Care. Alliant Health will develop the Initial Plan of Care to:

702.3.2.4.1. document the amount and type of services needed; and

702.3.2.4.2. ensure that the applicant has a Plan of Care that is appropriate to his or her needs and can be implemented within the allocated budgeted amount. (An applicant in a nursing facility receiving care under the nursing home level of care will be assessed and approved if appropriate for the nursing home level of care).

702.3.3. Within ten (10) working days of the completion of the initial assessment, Alliant Health will notify the applicant of the status of his/her application through regular mail. The priority to be assigned to an application will be based upon the date of application unless there is a waiting list. If there is a waiting list, priority will be according to the date of application. The oldest application will receive the next available slot.

NOTE:
The initial assessment will be conducted by a Registered Nurse. The assessment information will be reviewed by Alliant Health and a determination made regarding the applicant's appropriateness for ICWP services.

702.3.4. When the applicant is Medicaid eligible, if services are to start immediately, Alliant Health and the case manager will do the following:

702.3.4.1. Alliant Health sends the members a notice of approval and a list of available case managers. The member should notify Alliant Health of the case manager selected within two (2) weeks of the notice of approval.

702.3.4.2. The case manager will assist the ICWP member in obtaining a DMA-6 signed and dated by the physician, physician assistant, or nurse practitioner certifying that the member meets the level of care for nursing facility placement.

The case manager and member will submit the signed and dated DMA-6 to Alliant Health Solutions.

The case manager should maintain a copy in the member's file and send the DFCS copy to the member's local DFCS office.

Note: ICWP providers may render ICWP services only to members with a current level of care. A DMA-6 is approved for no more than 12 months and expires on the last day of the expiration month of the POC...The validity of the DMA-6 expires 365 days from the date it is approved by Alliant Health and must be renewed on an annual basis. At the time of renewal, the case manager must submit a completed DMA-6 signed by the member and the member's physician, physician assistant, or nurse practitioner to Alliant Health no more than 90 days prior to the termination of the current level of care.

702.3.4.3. Alliant Health will follow up with the member if the member does not provide notification of the selected case manager within two (2) weeks of the notice of approval.

702.3.4.4. Once the member notifies Alliant Health of the selected case manager, Alliant Health will send the selected case manager a copy of the PAF, Initial Plan of Care, and a current list of service providers.

702.3.5. If there is no opening for services to start immediately and the individual is appropriate for services, Alliant Health will notify the applicant that he or she will be maintained on the waiting list to be admitted for services only as member discharges occur or additional funding becomes available for the program. Slots will be assigned according to the date of application with the oldest date receiving the next available slot. The notice will advise the individual to contact Alliant Health if his or her condition or circumstances change.

NOTE: Applicants transitioning from the Nursing Home to ICWP through Money Follows (MFP) may be placed into the program without going on the waiting list if all requirements and criteria are met.

The MFP coordinator will assist the applicant with coordinating all of his transition needs prior to discharge. Once the member has been placed in his home, the MFP coordinator will transition the member to an ICWP case manager.

702.4. Waiting List

Depending upon availability of ICWP benefit funds, applicants who have been telephone screened and determined eligible for ICWP may be placed on a waiting list for full assessment.
Cost factors and the number of individuals participating in the ICWP affect the availability of funds. If no waiting list exists, clients are admitted to the ICWP in the order they are referred to Alliant Health Solutions (AHS) for full assessments.
Before completing the full assessment, AHS contacts waiting list individuals to determine if their living arrangements and need for services have changed.
Alliant Health Solutions reviews all waiting list individuals quarterly. AHS will send notification of the required review with a deadline to respond. Individuals or their representatives must respond to AHS and provide updated information to remain on the waiting list. Individuals who do not respond or no longer meet eligibility guidelines will be notified and removed from the waiting list.
Once an applicant is awarded a slot, the applicant must choose a case manager. AHS must be notified of slot acceptance 30 days prior to the expiration of the slot approval notification.

702.4.1. Waiting List Procedures

IF	THEN AFTER COMPLETING TELEPHONE SCREENING

There are no budget constraints/no waiting list	Complete applicant assessments on a first- come, first-served basis.
Budget constraints prevent new admissions	Place names of applicants who appear eligible based on the date of application with the oldest date assigned first.
Budget constraints limit the number of admissions	Complete assessments of the applicants with the oldest application date and the most days on the waiting list for initial assessments.
Budget allows new admissions	Complete assessments of the applicants with the oldest application date and the most days on the waiting list for initial assessments.

Discussion of service options should reflect no duplication in service delivery across fund sources, providers, and types of service without documented explanation in the client record. Examples of this duplication include, but are not limited to, services provided via waiver programs, the Veterans Administration, and community and faith-based organizations.

703. Role of Case Manager in Starting Services

The case manager will

703.1. Conduct a face-to-face visit with the member within five (5) working days of selection by the member.

703.2. Assist the member in establishing Medicaid eligibility through contact with the Division of Family and Children Services (DFCS). (Refer to appendixes.)

703.3. Case managers must assist the member with getting the DMA-6 signed by the physician, physician assistant, or nurse practitioner. The signature date should be within 90 days of the start date of service. New admissions, the date of service starts when Alliant Health receives the completed DMA-6.

703.4. Provide the member with a listing of available service providers, also utilizing the resources supplied by Alliant Health Solutions which are made available to the case manager upon admission of the member into the ICWP. Assist the members in selecting providers.

703.5. Applicants transitioning out of the Nursing Home through Money Follows the Person (MFP) will be assisted by the Transition Coordinators in coordinating all services needed for transition. The Transition Coordinator and the ICWP case manager will work closely to ensure the applicant can be served under the nursing home cost limit of the waiver.

703.6. Within thirty (30) days, develop an Individual Plan of Care with the member that includes the selected providers, specific schedule for service delivery of the services approved on the initial plan of care, including those referred by Alliant Health Solutions, other goals and objectives identified, and discharge plans. The Individual Plan of Care must be completed, signed, and returned to Alliant Health electronically. Rev. 1/1/17

When an individual is placed into services, the Individual Plan of Care must be

reviewed and signed by the case manager and the members' Plan of Care and must be reviewed and updated quarterly and every twelve months or more frequently, if warranted. (Refer to appendixes for a copy of the Care Path form.)

703.7. Complete the DMA-80 form and submit it to Alliant Health. This information will be submitted electronically. Rev. 1/1/17. However, providers that are not able to submit via web due to natural disasters resulting in power outage should fax the information to the Alliant Health Review Nurse for that region. using the fax number provided. Refer to Chapter 800 for additional information regarding approval of service. Rev. 1/1/17

703.8. Have the member sign a Freedom of Choice form and send it to Alliant Health. The member and a member representative, chosen by the member, will be informed of alternatives available under the program and given the choice of either institutional or home and community-based services following the level of care determination. The Freedom of Choice form is used to ensure that the member and member's representative have been informed of the choices. Across and within all HCBS Waiver Programs, a non-family representative cannot represent more than three (3) waiver participants.

703.9. The form must be signed and dated by the member, the case manager and an authorized member representative, when applicable. (Refer to appendixes for a copy of the Freedom of Choice form.)

703.10. Review with the member and have the member sign the Member Rights and Responsibilities. Electronic copy must be submitted to Alliant Health Solutions. The case manager should maintain a copy in the member's file and distribute copies to the member and service providers. (Refer to appendixes for the Member Rights and Responsibilities.)

703.11. Review with the member and have the member to sign the Memorandum of Understanding. The Memorandum of Understanding contains responsibilities of the members and guidelines of the ICWP. Failure to comply with the terms of the agreement will result in discharge from the program. Electronic copy must be submitted to Alliant Health Solutions. The case manager should maintain a copy in the member's file and distribute copies to the member and providers. (Refer to appendixes for the Memorandum of Understanding.)

703.12. Have the member to sign an additional Release of Information Form, if necessary.

Note: All of the above forms must be signed by the member prior to starting services and to ensure participation in the ICWP/TBI (excluding the DMA-80).

704. Verification of Medicaid Eligibility

704.1. Medicaid Eligible Members

Medicaid eligibility is determined by the members' local county Department of Family and Children Services (DFCS) office. The provider and case manager verify eligibility monthly by checking with the member to see if any change has been sent to the member from DFCS or the Social Security Administration in the case of SSI Medicaid eligibility. If the member is ineligible for Medicaid benefits, the Division does not

reimburse a provider for services rendered.

704.2. Cost Share Liability

ICWP Potential Medical Assistance Only (PMAO) Members

PMAO members have incomes which exceed the current Personal Needs Allowance (PNA). PMAO Members, screened by Alliant Health and the case manager providers to determine their potential eligibility for ICWP Medicaid benefits, may be required to pay toward the cost of their ICWP services (cost share).

704.2.1. Brokering PMAO Members - PMAO members, who do not yet possess current Medicaid member numbers, are determined eligible for Medicaid services by the county Department of Family and Children Services (DFCS). The case manager will broker services for Potentially Medical Assistance Only (PMAO) members with providers. If the member is PMAO:

704.2.1.1. During the initial assessment, the Alliant Health nurse must inform the member of the possible requirement to pay a portion of the cost of services (cost share) and must discuss the Medicaid eligibility process with the member/representative.

704.2.1.2. The Alliant Health nurse, the ICWP case manager and the service provider must reinforce the member's cost share responsibility by clearly informing the member that if cost share is not paid, the member is at risk of losing ICWP services.

704.2.1.3. The Alliant Health nurse must provide a copy of the PMAO Financial Worksheet (see appendixes) indicating the estimated cost share to the selected case manager.

704.2.1.4. Once the case manager receives the information packet from Alliant Health indicating that the member has been approved to receive services through ICWP, the case manager must assist the member with submitting the Independent Care Waiver Communicator (ICWPC) form (see appendixes) to the local DFCS. Once DFCS verifies that the PMAO member is eligible for Medicaid, the case manager will assist the member with locating an ICWP personal support provider and other provider(s) as needed.

704.2.1.5. The case manager must make a good faith effort to ensure that the member is proceeding with the Medicaid eligibility process. If the case manager determines that the member is having difficulty with the process, a case conference is scheduled with the member and DFCS to define areas where assistance is needed.

704.2.1.6. Within 45 days of the Medicaid application date, the case manager must contact DFCS to ascertain the member's eligibility status. If DFCS has not yet determined the member's Medicaid eligibility, the case manager will contact DFCS at least every two weeks until eligibility is established.

704.2.1.7. Once DFCS determines eligibility and cost share the case manager must notify AHS for PA adjustment. The cost share is deducted from the provider with the highest dollar amount on the PA. The case manager must notify the provider that is responsible for collecting the cost share. The provider must bill the member for cost share.

704.2.2. Accepting a PMAO member - When the provider accepts a referral for a PMAO member, the case manager must give the member a written estimate of the cost share amount prior to the delivery of services.

The provider must inform the member in writing that the member is responsible for the total cost of all services rendered if DFCS later determines that the member is ineligible for Medicaid, or if the member fails to proceed with the Medicaid application.

704.2.3. Cost Share Collection -The provider must have written policies clearly describing cost share billing/collection and refund policies and procedures. For PMAO members, the provider may either:

704.2.3.1. Collect only the estimated cost share from the member. If this method is chosen, services to the members must be delivered before collecting cost share. The provider must bill the member for cost share at least monthly. The provider is not required to wait until the end of the month before collecting cost share but may collect cost share as service is provided until the provider has collected the entire cost share.

EXCEPTION: The Fiscal Intermediary (FI) providers may collect cost share at the beginning of the service month.

Or

704.2.3.2. collect the entire cost of service from the member until DFCS establishes Medicaid eligibility

Prior to delivering service, the provider must furnish the member’s written notice as to which of the above collection methods will be used.

704.2.4. Reconciliation of the Member's Account - Once DFCS notifies the case

manager of actual cost share amount, the case manager will submit the ICWPC form to Alliant Health within three days of receiving information from DFCS. This information will include the amount of the cost share to be billed to the member.

Within 30 calendar days of receipt of the Prior Approval (PAs) showing the actual cost share, the provider must return any excess cost share collected or bill the member for any remaining cost share due the provider. A member determined ineligible for Medicaid is responsible for the entire cost of services delivered.

704.2.5. Reimbursement from Medicaid - The provider may not submit claims for Medicaid reimbursement until DFCS approves the member for Medicaid benefits. The nurse at Alliant Health must generate a PA Form showing the member's Medicaid member number and actual cost share.

704.2.6. Member MAO Eligibility - Once eligibility is established and the actual cost share is determined, the PMAO member becomes MAO eligible.

Note: In situations where a member's cost share is reduced after the member has paid, the case manager will submit the adjustment to the Alliant Health nurse to enter the change in the system. The provider will bill Medicaid for the difference. The provider's cost share policy will state if the overpayment shall be credited or refunded.

704.3. Medical Assistance Only (MAO) Members

A Medical Assistance Only (MAO) member is one who receives Medicaid benefits but who receives no cash assistance such as Supplemental Security Income (SSI). MAO members may be required to pay toward the cost of ICWP services (cost share).

704.3.1. Cost Share Collection

704.3.1.1. The ICWP provider must furnish the member a written statement of the cost share, if any, each month cost share is due.

704.3.1.1.1. The monthly statement will include:

704.3.1.1.1.1. The date of the statement

704.3.1.1.1.2. The amount due

704.3.1.1.1.3. The payment date is due

704.3.1.1.1.4. The statement that, “If the bill is not paid within 30 calendar days, discharge from the agency will be effective the 46th calendar day

from the date of this statement".

704.3.1.2. Providers will bill for cost share at least monthly

704.3.2. Members Failing to Pay Cost Shares

The provider may discharge a member from service for failure to pay cost share after the provider has given appropriate written notice on the monthly statement.

The Alliant Health nurse, the case manager and the provider will advise members and/or member's representatives that providers may discharge members who fail to pay cost share.

If the member does not pay cost share by the 31st day, as indicated on the monthly statement, the provider will notify the case manager that services will be discontinued on the 46th day from the date of the statement.

Note: If the case manager attempts to broker the service with another provider, the case manager will inform the potential/subsequent provider of the member's failure to pay the required cost share to the current provider(s).

Case managers will frequently discuss cost share with members but will not engage in collection activities.

Providers who have difficulty collecting cost share will discuss the problem with the case manager as soon as it occurs.

705. Denial of Services

705.1. Reasons for Denial or Termination

705.1.1. The member fails to meet eligibility criteria specified in Section 701.

705.1.2. The member and/or representatives have not supplied necessary information to complete the determination of eligibility.

705.1.3. The members and/or member representatives have not signed the Initial Plan of Care and other forms specified in Section 703.

705.1.4. The Initial Plan of Care cannot be implemented within the allocated budgeted amount.

705.1.5. If a member fails to show medical necessity or a change in medical condition which justifies an increase in services or an increase in personal support hours

705.2. Right to Appeal

Members have the right to appeal the following actions of the Division:

705.2.1. Refusal to accept an application.

705.2.2. Reduction in services.

705.2.3. Denial of eligibility.

705.2.4. Failure to offer the choice between home and community-based waiver services and institutional services upon approval to receive services through the ICWP.

705.2.5. Termination of services.

Individuals shall receive written notice of any of the above-referenced actions of the DMA and shall have the opportunity for a fair hearing pursuant to 42 CFR, Part 431, and Subpart E.

706. Discharge of Members

706.1. ICWP/TBI providers must maintain a coordinated program of discharge planning to ensure that each member has a planned program of continuing care that meets the member's post-discharge needs.

706.2. The case manager must coordinate discharge planning in consultation with the member, Alliant Health, other providers, the member's physician, other involved service agencies, and other local resources available to assist in the development and implementation of the discharge plan. The case manager must consider the following factors in discharge planning:

706.2.1. problem identification;

706.2.2. anticipated progress;

706.2.3. evaluation of progress to date;

706.2.4. target date for discharge; and

706.2.5. identification of alternative resources for care after discharge.

706.3. Discharge of Members from Participation in the ICWP

Discharge occurs when:

706.3.1. Alliant Health, in consultation with the case manager and service providers, determines that the member is no longer appropriate or eligible for services under the ICWP. Case managers and providers may submit written recommendations of termination from the ICWP/TBI to Alliant Health. The recommendation must include documentation supporting the recommendation to terminate services.

706.3.2. DCH's Utilization Review (UR) staff recommends in writing that a member be discharged from service.

706.3.3. The enrolled member has not received any ICWP Service for thirty (30) consecutive days. Once 30 calendar days is reached Alliant Health Solutions will send a discharge letter that will be effective on the sixtieth (60) calendar day if services have not resumed. Appeal Rights will be provided to the member at the time the letter is sent out. The case manager is required to keep Alliant Health updated on the member's condition at least every two weeks

NOTE: If the member has received only Case Management Services for 30 days, Section 701 must be reviewed to determine the members eligibility to remain on the program. The member must require the assistance of another individual and be at risk for placement in an institutional setting to remain eligible.

706.3.4. Member / member representative consistently refuses service(s), fails to cooperate with the agreed upon plan of care, or fails to adhere to other program requirements for participation in the ICWP.

706.3.5. Member fails to adhere to the conditions of the Memorandum of Understanding.

706.3.6. Member enters an institution (Nursing Facility, Hospital, etc.). The service provider must notify the case manager upon member admission to a facility. The case manager must send a discharge notice to the member and Alliant Health Solutions after thirty (30) days of stay in a facility. The discharge notice is effective after sixty (60) days of stay in the facility. If the member is expected to be discharged from the nursing facility or institution within sixty (60) days of admission, the case manager must notify the providers and Alliant Health.

706.3.7. Member engages in and/or allows illegal activities in the home; or member or others living in the home have inflicted or threatened bodily harm to another person within the past thirty (30) calendar days.

706.3.8. Member/representative requests to be discharged.

706.3.9. Member consistently refuses to comply with treatment(s).

706.3.10. The cost to serve the member exceeds the budget allocation for the individual's slot.

706.3.11. Member expires.

When an ICWP member is discharged from the program, the providers must deliver service through the effective date of discharge EXCEPT when any one of the following occurs:

706.3.11.1. Member enters a nursing facility.

706.3.11.2. Member exhibits and/or allows illegal behavior in the home.

706.3.11.3. Member/representative requests to be discharged.

706.3.11.4. Member expires.
(Refer to appendixes for a copy of the Discharge Notice.)

706.3.12. Member fails to visit physician and obtain his/her signature on DMA-6 to ensure continuity of care and services as required within the ICWP.

706.4. Termination of Case Management/Provider Services.

Case managers and service providers may terminate services to members for the following reasons:

706.4.1. Member requests a change in providers or requests termination of services.

706.4.2. Member/member representative consistently refuses service(s), fails to cooperate with the agreed upon plan of care, or fails to adhere to other program requirements for participation in the ICWP.

706.4.3. Member fails to adhere to the conditions of the Memorandum of Understanding.

706.4.4. Member enters an institutional setting; the provider must send discharge notice immediately to the case manager and Alliant Health. Upon the member's placement in an institution the member's stay may not exceed sixty (60) days.

If a member is institutionalized for thirty days, the case manager must notify Alliant Health. The Alliant Health must provide the member or member's representative with a letter stating the 60-day policy regarding termination if services (personal support or Behavioral Management) are not rendered within 60 consecutive days.

Note: If the member remains in the hospital for 60 consecutive days, a discharge letter will be sent to the member or member's representative with Appeal Rights attached. The member may reapply to the program upon discharge from the institution or while in the institution after the 60th day has expired.

Process:

706.4.4.1. A nurse from Alliant Health will schedule a time to reassess the member for the program.

706.4.4.1.1. If the member is deemed eligible for ICWP thru the reassessment within 30 consecutive days of the original stipulated 60th day of discharge, the

applicant's name will be placed at the top of the waiting list.

If the timeframe stipulated in 1a of this process is not followed, the applicant's name will be placed on the waiting list according to the application date.
The ICWP level of care is no longer valid upon the member's entry into a nursing facility. If the member is expected to be discharged from a nursing facility or institution within sixty (60) days of admission, the case manager must notify the providers and Alliant Health. The case manager must coordinate the member's re-evaluation of appropriateness for services for the ICWP with Alliant Health. The Division of Medicaid will not reimburse for services unless the member has a current level of care approved and signed by Alliant Health and the member's physician.

706.4.5. Member engages in and/or allows illegal activities in the home; or member/others living in the home have inflicted or threatened bodily harm to another person within the past thirty (30) calendar days.

706.4.6. Member consistently refuses to comply with treatment(s).

706.4.7. Provider is no longer able to provide appropriate staff to render the services.

706.4.7.1. Providers must send a written notice to the member/representative/legal guardian and the case manager thirty (30) days prior to actual discharge date.

EXCEPTIONS:

When UR recommends discharge or the member expires.

When termination of the service is requested sooner than thirty (30) days by the member or case manager, the ICWP provider may comply with the request and maintain documentation of the request in the clinical record.

Member engages in and/or allows illegal activities in the home; or member or others living in the home have inflicted or threatened bodily harm to another person

within the past thirty (30) calendar days.

The notice of discharge must include the effective date of discharge and the reason for the discharge.

Upon discharge, the provider will furnish an appropriate discharge summary to those responsible for the member's post-discharge care. The discharge summary must include:

706.4.7.1.1. information of current diagnoses;

706.4.7.1.2. an evaluation of rehabilitation potential;

706.4.7.1.3. description of prior treatment;

706.4.7.1.4. target date for discharge;

706.4.7.1.5. Identification of alternative resources for care after discharge

Chapter 800: Prior Approval

801. General

As a condition of reimbursement, the DCH requires that services covered by the ICWP/TBI be approved prior to delivery. Prior approval does not guarantee reimbursement, eligibility, or reimbursement of submitted charges.

801.1. All requests for prior approval must be submitted via web portal electronically. Detailed instruction for completing the Prior Authorization Request Form (DMA-80) can be found in MMIS under Provider Education. If needed, to supplement the online provider education training, providers also may attend the quarterly New Provider Training conducted by Alliant Health. The duration of the DMA-80 must not exceed the expiration date of the DMA-6. Detailed instructions for completing the DMA-80 are provided in appendixes. (Rev. 07/2015)

801.2. Reimbursement will be authorized for Case Management services rendered no more than thirty (30) days prior to the initiation of additional ICWP services, except for the transition of a nursing home recipient. The nursing home recipients must be discharged from the nursing facility and receive services in ICWP before reimbursement can be made to the case manager.

801.3. Reimbursement is not authorized for delivery of Personal Support Services while the

member is hospitalized, or the caregiver is on vacation.

801.4. The DMA-80 and all forms required in Chapter 700 must be submitted by the case manager electronically via the web portal in order for Alliant Health to complete the review. Do not upload handwritten copies care plan documents except for the signature page. (Rev. 07/2015; 04/2019)

All information must be submitted at least one week prior to the intended date of initiation of services. Do not upload handwritten copies of care plan documents or quarterly reviews. (Rev. 02/2020)

Reimbursement will not be authorized for services rendered prior to the authorized start of care date shown on the DMA-80.

801.5. Alliant Health will review the DMA-80 to determine that services are consistent with the Initial Plan of Care. The DMA-80 will be approved in the web portal by the Alliant Health ICWP nurse. Data Direct sends out a notification to the provider with the member demographics, the approved date of services, number of units and the total cost of services approved by the Alliant Health ICWP review nurse. The Notification is sent to the ICWP member and the case manager. Notification also will be sent regarding disapproval of services by the Alliant Health ICWP review nurse. When the Alliant Health review nurse changes the DMA-80, the nurse will communicate the change via the web portal through "Contact us" messaging to the case manager. (Rev. 07/2015)

801.6. If the applicant is approved for services, delivery of services must begin within sixty (60) days of the level of care determination by Alliant Health. The exception is for members transitioning out of a nursing facility

801.7. If a change in approved services is indicated, the case manager must enter a change request via the web portal, complete DMA 80 noting the extra service, and/or a discharge notice (form in appendixes) from old provider, if necessary, before services are rendered. The need for a change in approved services will be evaluated based on the condition and the needs of the members. Data Direct will generate notification to the providers with Alliant Health ICWP review nurse approval. A denial letter with hearing rights will be mailed to the member if the change request is denied.

Alliant reserves the right to request additional documentation supporting the medical necessity and appropriateness of change requests due to change of condition. This documentation should come from medical professionals involved in the patient's care (e.g., primary care doctor, wound clinic, physical therapist, etc..). Orders by a physician alone may not provide sufficient documentation of medical necessity, regardless of if the order is signed by the treating physician. Alliant may request any reasonable and necessary information to help assess the medical necessity for the PA process. Examples of documentation may include, but not limited to doctor's progress note, treatment progress note, after visit summary, doctors' orders, letter of medical necessity. Information in the patient's medical record must support the medical necessity for the item and substantiate requested change request.

801.8. A re-determination of eligibility (level of care) must be done, at minimum, annually by Alliant Health for the Division to continue reimbursement of service beyond the initial level of care determination before program participation is continued. Once the initial

level of care is determined, the case manager is responsible for initiating subsequent approvals. The case manager must submit a completed DMA-6 signed by the member and the member's physician, physician assistant, or nurse practitioner to Alliant Health no more than 90 days prior to the termination of the current level of care. The DMA-6 letter is sent to the case manager by Gainwell Technologies once the care plan is approved in MMIS. A DMA-6 "In-lieu" letter can be provided upon request by Alliant Health prior to admission instead of a "stamped approved" DMA-6. The Alliant Health generated DMA-6 "In-lieu" letter may be utilized by the case manager along with the completed DMA-6 and ICWP Communicator form for new admissions and renewal care plans. The DMA-6 "In-lieu" letter signed and completed DMA-6 and ICWP Communicator form is sent to DFCS for new and renewal Medicaid applications. The case manager is required to keep the DMA-6 on file for DCH Program Integrity review. Additionally, the case manager must complete the PAF in its entirety for each member served.

Chapter 900: Scope of Services

901. General

The DMA reimburses providers only for ICWP and TBI services:

901.1. rendered by enrolled providers who comply with the policies and procedures contained in the:

901.1.1. Part I, Policies and Procedures Manual Applicable to All Medicaid Providers.

901.1.2. Part II, Policies and Procedures for the Independent Care Waiver Program Services Manual.

901.2. provided and supervised by staff as required for the specific ICWP service.

901.3. ordered and authorized by the Initial and Individual Plan of Care.

901.4. provided to persons who are Medicaid eligible at the time the services were rendered.

901.5. provided to persons who are certified for a level of care appropriate for placement in a hospital or nursing facility.

902. Covered Services

902.1. Case Management

902.1.1. Definition of Case Management: "A collaborative process which includes assessing, implementing, coordinating, monitoring, evaluating options and services required to meet an individual's needs and making referrals as needed. Case management ensures that Independent Care Waiver consumers residing in the community maintain the maximum control possible over daily decisions, scheduling and health. The process will use all available resources for cost effective outcomes." The case manager serves as the pivotal core for service planning and delivery for the ICWP.

902.1.1.1. A case manager may be employed by a private or public agency or may be an individual practitioner.

902.1.1.2. An enrolled case manager may hire an individual to assist with his or her caseload. The individual must meet the same qualifications as outlined below under #5. The enrolled case manager must submit a detailed resume of the applicant to the DCH Program Specialist for review and approval. The approval letter from DCH must be maintained in the enrolled provider's file. The enrolled case manager must sign off with the case manager on all monthly visits. The enrolled case manager is responsible for all deficiencies related to a member's Plan of Care.

902.1.1.3. Members are free to receive case management services from any ICWP case manager.

902.1.1.4. A case manager's caseload shall not exceed a maximum of twenty (20) recipients. However, the department has the option of evaluating each case manager's case load to make exceptions. Exceptions must be submitted in writing to the ICWP Program Specialist for review and approval.

902.1.2. Conflict free case management requirement. As a care management entity, case management providers are required to adhere to the following characteristics of conflict-free case management:

902.1.2.1. Separation of case management from direct services: Structurally or operationally, case managers must not be employees of any organization that provides direct services to the individuals. Ideally, conflict-free case management agencies are stand-alone. A case manager may not enroll as a provider in any other service. Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or

develop the person-centered service plan. Rev.10/2023

902.1.2.2. Separation of eligibility determination from direct services: Eligibility for services is established separately from the provision of services so assessors do not feel pressure to make individuals eligible to increase business for their organization. Eligibility is determined by the Department of Family and Children Services, an organization that has no fiscal relationship to the individual.

902.1.2.3. Case managers cannot establish funding levels for the individual: In the Georgia model, the case manager's responsibility is to develop a recommended plan of supports and services based on the individual's assessed needs.

902.1.2.4. Individuals performing evaluations, assessments and plans of care cannot be related by blood or marriage to the individual or any of the individual's paid caregivers, or financially responsible for the individual.

902.1.3. Types of Case Management

902.1.3.1. Traditional Case Management definition:

Traditional case managers provide an assessment of the ICWP member, including diagnosis and personal history, case management issues and dynamics and a plan to address the members needs and any unresolved issues. In addition to having knowledge and understanding of human interaction dynamics and interpersonal skills, the case manager must have a comprehensive knowledge of community resources and services needed to maintain ICWP members in the community; access points to link members to services and resources; and maintaining ongoing relationships with agencies and resources which are instrumental to the member's care and service provision. Examples of such agencies include but are not limited to: Department of Family and Children's Services (DFACS); the Social Security Administration (SSA); Vocational Rehabilitation agencies; County Boards of Health or other counseling resources; Medicaid, Medicare and similar resources and agencies.
Traditional case managers assist members with addressing issues that present as barriers to their care; accessing needed resources and services; fostering and maintaining family/significant other relationships and support needed to maintain the member in the community; and acts as an advocate in identifying the

member's needs and taking active measures to address the member's needs. These activities provide a description of case management but are not intended to be all inclusive. Case management includes engaging in and performing a range of activities and interventions to meet the members' needs and advocating on behalf of the member to ensure that those needs are met.

902.1.3.2. Enhanced Case Management definition:

In addition to the basic case management activities and functions described above, enhanced case management includes advanced training, knowledge and skills required to address the severity of the disability and complexities that present in the provision of care and management of the member's physical and emotional health as well as interventions and activities that foster prevention and gross deterioration of the member's health. An enhanced case manager typically provides more intensive and coordinated care management services at patients with complex health needs. They should work closely with the member's PCP and other healthcare specialties, coordinating care, managing transitions between care settings, and identifying as well as addressing potential care gaps or barriers. They should also provide health education and counseling to both the patient and their caregivers and help connect the patient with community resources and support services. This can include access to affordable housing, transportation assistance, food assistance, mental health services, and other resources. They may collaborate with community organizations, government agencies, and other stake holders to address social determinants of health and improve health outcomes in the community. The specific duties of an enhanced case manager can vary based on the patient population being served. (Rev. 07/2023)

Examples of conditions which may require enhanced case management are members with complex health needs and/or chronic conditions; multiple comorbidities; a history of hospitalizations or emergency department visits, or those required in special care coordination ventilator dependency and/or tracheostomy care; severe maladaptive behavior as determined by diagnosis and/or Alliant Health assessment. Documentation must support or provide evidence of the presence of the condition. In addition, the condition must require frequent and an enhanced level of monitoring, intervention and follow-up which must be fully described and clearly documented in the member's case management file.

These examples are not intended to be all inclusive. The ICWP Case Manager must submit a plan of care outlining interventions they will provide as an enhanced case manager. The need for enhanced case management is determined by Alliant Health at the initial assessment, annual review, and as needed. (Rev. 07/2023)

902.1.3.3. Enhanced Case Management Agency Model definition:

Enhanced Case Management under the agency model describes the requirements for case management agency participation in the ICWP. Agencies may elect to hire enhanced case managers who meet the individual qualifications outlined in 902. An alternate model of Enhanced Case Management may be provided under the following clinical supervision model. In this model agency enrollment is based on the following requirements:

902.1.3.3.1. Agency model requirements:

902.1.3.3.1.1. A minimum of five (5) years of experience in the health care, behavioral health or case management field which includes:

902.1.3.3.1.2. providing home and community-based case management services for individuals with disabilities or similar HCBS populations, and demonstrate success in supporting individuals in community inclusion and person-centered planning;

902.1.3.3.1.3. serving individuals at risk due to medical, functional, and/or behaviorally complex conditions.

902.1.3.3.1.4. Have established or will establish working relationships with local community and advocacy groups,

experience advocating for individuals in the community, and preparing individuals for self-advocacy;

902.1.3.3.1.5. Have experience and demonstrated success with outcome-based planning, and developing service plans based on the individual's goals, choices and direction;

902.1.3.3.1.6. Have experience with measuring quality of services and satisfaction with services, ensuring that the services that are provided are consistent with quality measures and expectations of the individual;

902.1.3.3.1.7. Demonstrated experience in serving diverse cultural and socioeconomic populations.

902.1.3.3.1.8. The applicant agency must assure compliance with conflict free case management as outlined in 42 CFR §441.301(b)(1).

902.1.3.3.1.9. If licensed, the agency will maintain the license as applicable in-home health, private homecare, neurobehavioral center, or other. If out-of-state, must provide a letter of recommendation from current oversight agency along with the last audit/review.

902.1.3.3.1.10. The provider must assure a sufficient number of clinically licensed or certified supervisors to assure a ratio or no more than 1 supervisor to 5 case managers.

902.1.3.3.1.11. Proof of licensure is required for Enhanced Case Management Clinical Supervisors in the designated specialty area.

902.1.3.3.2. Agency Model Staff Qualifications and Responsibilities

In addition to the base requirements for Case Management, Enhanced Case Management requires the following staff qualifications and positions:

902.1.3.3.2.1. Enhanced Case Management Clinical Supervision: Enhanced Case Management agencies will employ or contract with at least one Clinical Supervisor in each specialty. Specialized Clinical Supervisors will provide technical assistance and support to any enhanced case manager as needed regardless of direct supervision assignment.

902.1.3.4. ECM – Medical/Clinical Supervisor Requirements:

Must be one of the following: Registered Nurse, physical or occupational therapist, physician assistant or other mid-level healthcare provider with:

Minimum of 2 years' experience in acute care, long term care, or medical rehabilitation.

You must have at minimum three (3) years' experience providing home and community- based case management services for individuals with disabilities. Must have a minimum of 2 years professional experience with individuals with complex medical issues in a setting related to individuals with specialty clinics, or other rehabilitation/habilitation settings.

902.1.3.5. ECM-Behavioral Clinical Supervisor Requirements:

Must be one of the following: Board Certified Behavior Analyst, Psychologist, Licensed Professional Counselor, Licensed Associate Professional Counselor, Licensed Clinical Social Worker, Licensed Master Social Worker or a Registered Nurse with:

Minimum of 2 years' experience in behavioral care, psychiatric setting, long term care, or neurobehavioral rehabilitation.

You must have at minimum three (3) years' experience providing home and community- based case management services for individuals with disabilities. Must have a minimum of 2 years professional experience with individuals with complex behavioral issues in a setting related to individuals with, specialty clinics, or other rehabilitation/habilitation settings.

902.1.3.6. Role of the Clinical Supervisor:

Assume a consultative relationship and participate in case conferences on behalf of medically or behaviorally at risk ICWP members.

Hold case conferences to discuss members in any of the following situations:

Transition following hospitalization or other acute setting

Members experiencing health or behavioral decline, particularly in the case of sudden onset

Members who may require additional referrals, coordination of healthcare or behavioral healthcare services, or communication with the larger healthcare system.

Perform joint visits with enhanced case managers quarterly to evaluate any additional or unmet needs

Meet with enhanced case managers monthly either individually or as a team to discuss difficult situations, community resources, policy changes or other timely issues.

Co-attend and/or coordinate specialized trainings or workshops on topical areas pertinent to needs of high-risk members.

Act as a clinical consultant for each of the enhanced case managers and each of the participants served within the ECM team's caseload.

Responsible for conducting a minimum of one quarterly joint visit with each ECM participant on their supervisory caseload.

Provide ongoing consultation to determine risks and unmet needs and collaborate in identifying and securing resources.

Follow up, either telephonically or on site, during and following acute changes in a participant's medical, behavioral or functional status. Provide continuous consultation to the ECM following such acute changes in condition. Collaborate with Alliant in the case of ongoing or acute changes that require immediate changes to the Service Plan.

Actively participate in hospital transition and discharge planning.

Maintain familiarity with nursing or behavioral health care plans developed by provider agencies to ensure that ECMs understand the purpose and evaluate the efficacy of the plans.

Maintain availability between supervisory sessions to help ECMs solve problems around key participant issues, resolve service problems, and visit participants as part of their interdisciplinary team for clinical consultation and planning.

Act as a resource for ECMs in navigating Medicaid State Plan/Medicare and coordinating services within the healthcare and/or behavioral services system

Establish working relationships with local advocacy groups. Advocate for community inclusion of individuals with disabilities and preparing individuals for self-advocacy.

Offer guidance to ECMs on outcome-based person-centered planning and developing plans based on the individual's assessed needs, goals, choices and direction.

902.1.4. Qualifications for Traditional Case Managers. Applicants must meet all the following criteria:

902.1.4.1. Licensed as a registered nurse or have a BA or BS degree in a health care or human services related discipline from an accredited college or university

902.1.4.2. Three years of experience in healthcare service delivery or human services case management pertinent to the disabilities and conditions of the populations served by the ICWP; severely disabled adults and adults with traumatic brain injuries

902.1.5. Qualifications for Enhanced Case Managers. Applicants must meet all criteria for Traditional Case Managers in addition to the following criteria:

902.1.5.1. Bachelor of Science degree in nursing or Master's or Doctoral level degree in other related disciplines such as social work, psychology, or counseling from an accredited college or university and be certified in rehabilitation or case management. RN license can substitute for the degree.

902.1.5.2. Five years of experience in healthcare service delivery or human services case management pertinent to the disabilities and conditions of the populations served by the ICWP; severely disabled adults and adults with traumatic brain injuries

902.1.5.3. Individual Enhanced Case Management Providers must hold the following: Nurse Practice Act OCGA.43-26-1 for all registered nurse case managers or, Licensure under the Georgia Composite Board for counselors, social workers and marriage and family therapists or, Licensure in psychology

902.1.6. Submission Requirements – Individuals seeking to provide case management services must submit documentation verifying qualifications.

902.1.6.1. Detailed resume following standard resume format and must include:

902.1.6.1.1. The name and address of the employer

902.1.6.1.2. Dates of employment for each employer using the month/year beginning and end dates format

902.1.6.1.3. The supervisor's name and contact information, i.e., telephone number and/or e-mail address

902.1.6.1.4. If the employment was less than full time, the type of employment must be specified, e.g., part-time or contract work, etc.

902.1.6.2. A copy of the degree and documentation that the degree was obtained from an accredited college or university. Copy is any additional certification of licensure used to meet qualifications.

902.1.6.3. Enhanced Case Management Agency Model must submit evidence of meeting all agency requirements as outlined in the Enhanced Case Management Agency Model requirements section.

902.1.6.4. The applicant must submit proof that the provider agency has at least $1,000,000 per occurrence and $3,000,000 per aggregate in general liability insurance coverage.

902.1.6.5. A complete list of documents required at application submission is located in appendixes

902.1.7. Subcontracted Case Managers. Traditional and Enhanced Case Management Providers may hire and subcontract with qualified case managers.

902.1.7.1. The enrolled case management provider must screen each individual to ensure that the subcontractor meets either traditional or enhanced case manager qualifications as outlined in policy.

902.1.7.2. Subcontracted case managers can work for only one CM provider

902.1.7.3. Case managers cannot be employed by DHS, DCH or other agencies with access to Medicaid eligibility systems

902.1.7.4. The case management provider must notify Alliant Health Solutions of the new subcontracted CM to include them on the active CM list and to invite them to the next new provider training.

902.1.7.5. Initially and ongoing the case manager provider must sign off with the subcontracted case manager on all monthly visits and is responsible for all deficiencies

related to a member's plan of care.

902.1.8. Training. After Notification of Approval from DCH both Traditional and Enhanced Case Managers must:

902.1.8.1. Attend New Provider Training (NPT). The location, date, and time of training will be sent by the company contracted to perform ICWP training. Subcontracted or Case Manager employees who are not providers must be trained by the Case Manager employer before providing services and attend the next available New Provider Training.

902.1.8.2. New Case Managers must complete the DCH case manager modules within sixty days of approval. Contact HCBS.CaseManagement@dch.ga.gov to register for the modules.

902.1.8.3. Complete Certification to perform Consumer Directed Options (CDO) within six months of approval. Information on the CDO training will be provided at NPT.

902.1.8.4. Review Incident report training located on the DCH HCBS web site. Report contact information to the HCBS incident report administrator at HCBS.IncidentReports@dch.ga.gov

902.1.9. Business Equipment – Case managers must maintain an office to conduct ICWP business. This includes appropriate office equipment, including a computer; fax, scanner, copier; telephone; and other common supplies and equipment required to operate a professional business office.

902.1.10. Case Manager Specific Responsibilities for initial and continuing ICWP members. Newly transferred members must be treated as initial members. The case manager's roles include:

902.1.10.1. Conduct a face-to-face interview with the member within five (5) working days of selection by the member.

902.1.10.2. Inform the member of duration of service and assist the member in coordinating the hours of services with providers. This includes reviewing the SS hours the contracting agency approved for the member's Plan of Care. The case manager will assist the member in working with the approved PSS hours to meet the member's needs.

902.1.10.3. Review the Member Rights and Responsibilities and the Memorandum of Understanding with the members and obtain signatures.

902.1.10.4. Provide the member with a list of enrolled service providers and assist the member in utilizing the Alliant Health Solution's resource list, to select an appropriate community support provider.

902.1.10.5. Assist the member in making informed decisions and ensure that the member's choices are respected throughout service delivery.

902.1.10.6. Investigate and/or assist the member in accessing community resources that may assist the member in remaining in the home and community. Provide on-going case management as needed and as approved in the Initial Plan of Care.

902.1.10.7. Coordinate case conference(s) with the member/member representative and providers, as appropriate to coordinate service delivery or resolve issues related to service delivery.

902.1.10.8. Send all required documents (Refer to Chapter 700 and 800) to Alliant Health, the member and providers as appropriate. All Plans of Care, DMA 80, PAF's, DMA-6s required signed forms and variances reports must be submitted to Alliant Health in a timely manner.

902.1.10.9. Monitor hospitalizations and report members who have not received services for 30 days to Alliant Health to send an initial 30-day discharge notice. If after 60 days the member remains hospitalized, submit the appendixes Discharge Notice to Alliant Health to initiate a final discharge notice to the member via certified mail.

902.1.10.10. Communicate to and request approval of changes in the members' services from Alliant Health. All changes in the amount and type of services must be approved by Alliant Health prior to implementation.

902.1.10.11. Review the Individual Plan of Care at least every ninety (90) days with the member/member representative to determine and document compliance, progress, and continued appropriateness of the plan.

This must be a face-to-face visit to the member's place of residence. The Individual Plan of Care must be updated every twelve (12) months or more frequently, if warranted. During the quarterly review, the case manager should discuss member satisfaction with the provision of services and assist the member in addressing issues regarding services with the applicable

service providers. The case manager will provide a copy of the reviewed and revised Plan of Care for the Personal Support Provider and Alliant Health. The case manager and the Personal Support Provider will keep a copy of the current Plan of Care on file.

902.1.10.12. Communicate with the personal support provider after each quarterly review to address issues or Plan of Care changes.

902.1.10.13. Provide detailed documentation that identifies dates of service, duties performed, and actual hours rendered providing service to a member to be reimbursed for services rendered.

902.1.10.14. Communicate with the members and agencies providing direct services to the members and resolve problems relating to coordination of services.

902.1.10.15. Monitor the delivery of services to ensure that services are rendered according to the Individual Care Plan and the member's satisfaction.

902.1.10.16. Maintain a cooperative relationship with the members, other service providers, and the utilization review team.

902.1.10.17. Coordinate the discharge of a member. This includes making arrangements when the member requires other services (discharge or transfer to a hospital, nursing facility, or other community-based care) as well as linking the member to other community resources. When a member is transferring from one waiver to another waiver the original case manager must complete and submit the Waiver Transfer Form (located in appendixes) to Alliant Health Solutions. The original case manager must also provide a copy of the waiver transfer form and one year of copied records to the receiving case manager. The original case manager will bill for the month the transfer occurred if the performance assessment has taken place for that month. The receiving case manager will bill the following month. It is recommended that transfers occur on the first day of the month with communication between case managers occurring in the month prior to transfer.

902.1.10.18. Assist the member with submitting requests for hearings to appeal adverse actions affecting the members' services.

902.1.10.19. Make referrals to Adult Protective Services and other non-ICWP services as appropriate.

902.1.10.20. Conduct a visit once per month. Visits made to members receiving traditional case management must be in person visits at the initial visit and then at a minimum of quarterly ongoing. Monthly visits that are not conducted in person must be conducted with audio visual methods that allow the case manager to view the member and are compliant with telehealth HIPAA requirements listed in 602.1 R. Visits made to members receiving Enhanced case management must be conducted in person at the initial visit and all subsequent monthly visits. Review and obtain members signature on the Informed Consent form at each in person visit. (Rev. 10/2023)

902.1.10.21. Notification of a reportable incident: Submit an incident report, as outlined in Section 604.2, within 24 hours or one (1) business day of the incident or discovery of the incident to the Department. Notify all appropriate parties in accordance with state law. Investigate the incident with involvement of appropriate parties while taking immediate steps to protect the waiver participant's health, safety and welfare. Submit the Follow-Up and Interventions Report to the Department within seven (7) business days of submitting the incident report. Participate in regulatory agency investigations, when applicable and take appropriate corrective action if alleged violation is verified.

902.1.10.22. Make sure that any time a member requests a change of PSS providers, the current PSS provider is notified of this request within 3 days of the request for change. The reason for the change must be documented and a copy forwarded to Alliant Health to be placed in the members' file.

902.1.10.23. Evaluate the members' Plan of Care. The case manager must make sure that an ICWP member is receiving only the medical supplies and equipment necessary for the current month. The case manager is responsible for making inventory of the equipment and supplies the member receives each month. This will ensure that the department is being billed for only the equipment and supplies required to meet the member's needs.

902.1.10.24. Ensure that Alliant Health receives all required documents within 30 days for new members.

902.1.10.25. Keep Alliant Health informed of any member's change in status.

902.1.10.26. Obtain signed Member receipt of forms (Document in

appendixes). Retain it in member's file.

902.1.10.27. Complete the HCBS Person Centered Service Plan with all members at initial and annual visits. Maintain the member's record.

902.1.10.28. Complete the HCBS Settings Rule Member Questionnaire at quarterly visits. Maintain the member's record.

902.1.11. Member Funds

A case manager may not become involved in the handling or management of an ICWP member's personal funds including government issued payments. Funds management must be left to the member's designated family member if the member has made such a selection either through choice or a legal process. Social Security payments and other government issued payments must be managed by the member's payee representative as approved and designated by the Social Security Administration (SSA). Other fund sources may be contacted as applicable as a resource for establishing a payee for other types of non-Social Security payments if required, e.g., VA. To avoid a conflict of interest, under no circumstances will the ICWP Case Manager be approved to handle or manage member funds. The case manager may not become a payee through SSA or any other fund source. Disciplinary action will be initiated up to and including suspension or termination from the Medicaid program for any case manager found to be in violation of this policy.

902.1.12. Case Management Adverse Action.

902.1.12.1. A case manager or case management agency that fails to comply with the roles and responsibilities of ICWP and required timelines outlined previously will be subject to the consequences listed below:

902.1.12.1.1. First occurrence: two (2) failures to meet set deadlines will result in a Verbal Reprimand with documentation of conversation documented at Alliant Health and DCH.

902.1.12.1.2. Second occurrence: three (3) failures to meet deadlines will result in a Formal Written Reprimand.

902.1.12.1.3. Third occurrence: four (4) failures to meet set deadlines will result in being placed in a probationary status or suspended status according to the severity of the infraction, ultimately

placing a moratorium on new admissions to the case manager.

902.1.12.1.4. Fourth occurrence: five (5) failures to meet set deadlines will result in termination as a case management provider.

902.1.12.2. Disciplinary action will occur over a rolling 12-month period. An exception to the implementation of the disciplinary action will be made if the member is delinquent in their responsibilities thus preventing the case manager from meeting their deadlines. An example of this would be the member who fails to adhere to his/her annual physical and therefore, the physician refuses to sign the DMA-6 until s/he sees the member. In this case providers should be notified that payment cannot be made without an active and current DMA-6 and they should make all attempts to obtain the DMA-6 prior to the expiration date (Documentation is required to verify this circumstance).

902.2. Personal Support Services

902.2.1. Description – Providers of Personal Support Services perform personal care tasks such as assistance with eating, bathing, dressing, personal hygiene, preparation of meals, light housekeeping tasks, and other activities of daily living. The Provider is responsible to ensure that staff members are appropriately trained and/or certified to provide care in accordance with all practice acts including the Nursing Practice Act Decision Tree. Please refer to appendixes.

902.2.2. Licensure – ICWP/TBI personal support providers must hold a current Private Home Care Provider's License pursuant to O.C.G.A. §§ 31-2-4, 31-2-5, 31-2-7 and 31-7-300 et

seq. from the Healthcare Facility Regulation Division (HFR) within the Department of Community Health when applying to be a Medicaid provider. Provisional Permits are not acceptable. In the event that HFR should take action to change the provider license/permit from a permanent license or permit to a provisional status the ICWP provider is at risk of being discharged as a Medicaid Provider. The provisional permit must be temporary and must not exceed a period longer than three months. The Registered Nurse Licenses for the nurses who deliver services are also required at the time of submitting an enrollment application.

902.2.3. Electronic Visit Verification (EVV)

902.2.3.1. EVV Requirement.

In December 2016, the 114th US Congress enacted the 21st Century CURES Act. Section 12006 of the Act requires States to implement Electronic Visit Verification (EVV) for Medicaid-financed Personal Care Services. The mandate contributes to Georgia Medicaid's mission of providing access to affordable, quality health care services for Medicaid Members. EVV will help to reduce billing errors and improve claims payment accuracy as well as reduce Medicaid fraud, waste and abuse by verifying services that were rendered.

Electronic Visit Verification (EVV) is a technology that automates the gathering of service information by capturing time, attendance, and care plan information entered by a home care worker at the point of care. EVV gives providers, care coordinators, and DCH access to service delivery information in real time to ensure there are no gaps in care throughout the entire course of the service plan. The technology contributes to Georgia Medicaid's mission of providing access to affordable, quality health care services for Medicaid members.

Georgia DCH selected Tellus, www.4tellus.com, as the State selected EVV system, The state selected system is available at no cost to the Personal Support Provider/Consumer Direct member. DCH allows the provider to either select their own EVV system or use the DCH system. However, the provider is responsible for any costs associated with using the alternate EVV system.

It is the provider's responsibility to ensure their selected EVV system meets both DCH and the 21st Century Cures Act requirements. More information regarding system requirements, FAQs, EVV readiness and training can be obtained at https://medicaid.georgia.gov/programs/all-programs/georgia-electronic-visit-verification-evv/evv-service-providers.

The Lifeline Assistance Program and Link-Up Georgia help qualified residential telephone customers. Refer to https://psc.ga.gov/about-the-psc/consumer-corner/telephone/consumer-advisories/lifeline-assistance-program-link-up-georgia/ or www.galifeline.com

902.2.3.2. EVV Non-compliance.

Consequences for repeated failure to use Electronic Visit

Verification (EVV). As a result of identified deficiencies with using EVV and submitting claims via an improper method of billing, providers may be subject to various sanctions, including but not limited to: (1) Pre-payment Review; (2) Corrective Action Plan; (3) Termination.
There is no specific format for the Corrective Action Plan. However, the Corrective Action Plan must be specific and must correct the deficiencies identified. It must also: (1) be responsive to the cited deficiencies; (2) state and describe the result; (3) indicate reasonable completion dates; and (4) fully describe the methodology used to accomplish complete and permanent corrective action. You will receive a letter by certified mail informing you whether your proposed Corrective Action Plan is acceptable or not acceptable.

The proposed Corrective Action Plan is to be submitted within fifteen (15) business days of the date of the letter from DCH requesting same per Part I Policies and Procedures for Medicaid/ PeachCare for Kids, Chapter 400, Section 402, Corrective Action Plans.

The Provider may request an Engagement Conference with DCH MAPs. The purpose of the Engagement Conference is to discuss the proposed adverse action with the goal of informally resolving this matter. To request an Engagement Conference, the Provider must send written notification to DCH, via email to Valerie Harrell (vharrell@dch.ga.gov) within seven (7) calendar days of receipt of the letter. DCH will schedule the Engagement Conference within ten (10) calendar days of the request. Engagement does not waive the Provider's right to Administrative Review, but the deadline of thirty (30) calendar days still applies.

If the Provider disagrees with these findings, and requests an administrative review, please refer to Part I, Policies and Procedures for Medicaid/ PeachCare for Kids, Section 505, of the Manual which states in part:

For a provider to obtain Administrative Review, a written request must be received at the address of the office that proposed the adverse action or denial of payment within thirty (30) days of the date the notification of the proposed adverse action, the denial of payment, remittance advice or initial review determination was mailed to the provider. The request must include all grounds for Administrative Review and must be accompanied by all supporting documentation and explanation that the provider wishes the Division to

consider. Letters requesting Administrative Review that are not accompanied by supporting documentation will not be accepted or considered… In cases involving an audit of a provider any documentation submitted for Administrative Review may, at the Department's discretion, subject the case, in whole or in part, to re-audit.

FAILURE TO RESPOND TO THIS LETTER OR TO COMPLY WITH THE REQUIREMENTS OF ADMINISTRATIVE REVIEW, INCLUDING THE FAILURE TO SUBMIT ALL NECESSARY DOCUMENTATION WITHIN THIRTY (30) DAYS, SHALL CONSITUTE A WAIVER OF ANY AND ALL FURTHER APPEAL RIGHTS, INCLUDING THE RIGHT TO AN ADMINISTRATIVE HEARING.

All requests for Administrative Review and supporting documentation and explanations that a Provider wants the Department to consider should be sent to the following address:

Georgia Department of Community Health
MAPS Division
Attn: Maxine Elliott
19th Floor
2 MLK Jr Drive SE
Atlanta, Georgia 30334

902.2.4. Submission Requirements – Providers seeking enrollment to provide personal support services must submit the following with the Provider Enrollment Application:

902.2.4.1. Copy of a Current Private Home Care License

NOTE: A Provisional License will not be accepted.

902.2.4.2. PSS providers must operate as an EDWP PSS provider, GAPP provider or NOW/COMP CLS services for one year prior to approval and maintain compliance with EDWP policies and procedures as detailed in Part II – Chapter 1400 Policies and Procedures for EDWP (CCSP and SOURCE) Personal Support Services.

902.2.4.3. The applicant must submit proof that the provider agency has at least $1,000,000 per occurrence and $3,000,000 per aggregate in general liability insurance coverage. In addition, private home care providers must submit proof of their agency's worker's compensation insurance coverage.

902.2.4.4. Training Package or Proposal – Training programs must be developed by all personal support providers and must include all areas of training specified in the policies and procedures manual. Providers must submit a training schedule/plan that outlines the training plans for the provider agency. The plan must include training, frequency of training, the specific topics that will be covered, and how training will be coordinated to ensure that all staff members receive training.

902.2.4.4.1. Individuals providing PSS services must have completed training in the following areas prior to delivery of services:

902.2.4.4.1.1. CPR and Basic First Aid

902.2.4.4.1.2. Emergency procedures

902.2.4.4.1.3. Assistance with medications

902.2.4.4.1.4. Specialized procedures.

The following training requirements must be completed within ninety days of direct member care:

902.2.4.4.1.5. Infection Control

902.2.4.4.1.6. How to give personal care

902.2.4.4.1.7. Transfer techniques

902.2.4.4.1.8. The need for confidentially regarding the services being provided

902.2.4.4.1.9. Agency policies and procedures

902.2.4.4.1.10. Observation skills

902.2.4.4.1.11. Safety and accident prevention

Staff shall receive

ongoing quarterly training. Topics for this training include, but are not limited to:

902.2.4.4.1.12. Human needs and behavior

902.2.4.4.1.13. Family relationships

902.2.4.4.1.14. Stress management

902.2.4.4.1.15. Meal planning

902.2.4.4.1.16. Community resources

902.2.4.4.1.17. Fire safety

902.2.4.4.1.18. Conflict resolution

902.2.4.4.1.19. Documentation

902.2.4.4.1.20. Time management

902.2.4.5. A resume and copy of the license of the Registered Nurse (RN) on staff. If the providers employ more than one nurse, whether R.N. or L.P.N., a copy of the current licenses must be submitted along with the application. The provider RN is responsible for preparing and selecting the training curriculum for the Aide to ensure adequate care is provided to all ICWP members. The RN and LPN must have a valid Georgia License with no restrictions.

902.2.4.6. A detailed resume of the Provider Agency Director or Administrator.

902.2.5. Staffing Qualifications and Responsibilities

The Personal Support Provider agency ensures that individuals entering members' homes accomplish tasks timely and competently while maintaining the rights, safety, choice, and dignity of each member.

Screen each potential employee for criminal background history (Georgia Criminal History Check System/GCHEXS). Evidence of a satisfactory criminal history background check determination must be maintained in the employee's personnel file.
Individuals who have been convicted of specific crimes and providers received an 'unsatisfactory determination' from the background/fingerprint check are ineligible for employment by an ICWP client/employer. A list of disqualifying crimes can be located online. https://dch.georgia.gov/georgia-criminal-background-check-system-

gchexs/georgia-criminal-background-check-system-gchexs

If the criminal background check reveals that the individual has been issued a "deferred adjudication" by the court, it is not a felony. This citation falls under O.C.G.A. § 16-13-2 (Crimes and Offenses/Controlled Substances). The law provides the following:

Whenever any person who has not previously been convicted of a crime relating to narcotic drugs, marijuana, or stimulant, depressant, or hallucinogenic drug, pleads guilty to or is found guilty of possessing a narcotic drug, marijuana, or stimulant, depressant, or hallucinogenic drug, the court may (with the consent of the defendant) defer further proceedings and place the person on probation with reasonable terms and conditions as the court may require. Once the terms and conditions are fulfilled, the court shall discharge the person and dismiss the proceedings against him. Depending on the charges and facts, the judgment may be deferred for a maximum of three or five years.

A discharge and/or dismissal under this code section shall not be deemed a conviction. Additionally, a discharge and/or dismissal under this code section may not be used to disqualify a person in any application for employment or appointment to office in either the private or public sector. Please understand that this does not mean you have to hire the person. It means that you cannot use this as the sole basis for disqualifying the person or denying the application for employment.

902.2.6. Personal Support Service Supervision

As cited from Chapter 111-8-65 RULES AND REGULATIONS FOR PRIVATE HOME CARE:

A licensed registered professional or practical nurse shall supervise the provision of personal care tasks for clients determined to be medically frail or medically compromised. If such supervision is provided by a licensed practical nurse, the licensed practical nurse shall report to a licensed registered professional nurse who will continue to be responsible for the development and management of the service plan.

By virtue of eligibility for the ICWP, those members receiving personal support services are considered medically frail and/or medically compromised.

902.2.7. Monitoring – The provider shall monitor services performed by the personal support staff at a minimum of every ninety (90) days. The monitoring must be conducted by supervisory staff of the provider agency. The ninety (90) day visit made by the personal support provider must be a face-to-face visit in the member's place of residence. The provider should document the date of the visit, name of the staff performing tasks observed, the tasks observed, other observations made during the visit, corrective measures implemented (if applicable), the name and discipline of the staff conducting the home visit.

Documentation of the monitoring visit must be maintained in the service provider's files and a copy sent to the case manager within ten (10) working days of the visit. Providers are required to meet with the ICWP case managers to discuss the plan of care at least quarterly. The personal support providers and case managers must document changes and progress of each member's POC.

902.2.8. Travel - Members receiving traditional Personal Support Services or Consumer Direct PSS can travel throughout the country/US and its territories. Prior notifications to Case Management are required for time out of the home (member and aide together) for vacation/family circumstance purposes. Traditional PSS and CD PSS must establish a schedule in the EVV system to be eligible for reimbursement. Providers are not responsible for travel costs. Out of Country travel with Medicaid is prohibited.

Note: The ICWP Waiver does not include transportation in the rate for personal support or extended personal support services. NEMT is available to all Medicaid participants under the state plan to provide transportation to medical appointments and for waiver services such as adult day health. A provider who allows an aide to make use of a member's or aide's car for transport needs to be sure the member's or aide's auto insurance assumes liability in case of an accident. Consider having the member or their family sign an agreement that discusses the assumption of liability in case of an accident. The provider should also carry adequate liability and worker's comp insurance to cover any accidents. Any such transportation activities are at the risk of those who engage in them. Providers should consult their legal teams to determine the extent of liability to which their agency may be exposed through such transportation activities, particularly if an aide assumes that this is part of their normal duties.

902.2.9. PCH - Personal Support Services cannot be provided in subcontracted or un-subcontracted Personal Care Homes.

902.2.10. Hospice Benefits and ICWP Services:

NOTE:
ICWP
If an individual is enrolled in the Independent Care Waiver Program and is later diagnosed with a terminal illness, he/she may elect to enroll in the Hospice program. He/she may continue to receive waiver services that are not duplicative of the hospice services. Waiver services that the Department has determined not duplicative of hospice services are: Adult Day Care; Behavior Management; Respite Care (In home only)
Personal Support Services. (Rev.10/2015)

902.2.10.1. Request or claims for waiver services other than those identified above will be denied if the individual is enrolled in the Hospice Program.

902.2.10.2. When an individual enrolled in the waiver elects hospice services the hospice agency assumes full responsibility for the professional management of the individual's hospice care in accordance with the hospice Conditions of Participation. The hospice agency and the waiver provider must communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy and is based on an

assessment of the individual's needs and unique living situation.

902.2.10.2.1. Covered Hospice Services include:

902.2.10.2.1.1. Routine Home Care

902.2.10.2.1.2. Continuous Home Care

902.2.10.2.1.3. General Inpatient Care

902.2.10.2.1.4. Nursing Care

902.2.10.2.1.5. Medical Social Services

902.2.10.2.1.6. Physician Services

902.2.10.2.1.7. Counseling Services (For the purpose of helping the individual and those caring for him/her to adjust to the individual's approaching death.)

902.2.10.2.1.8. Medications

902.2.10.2.1.9. Physical Therapy, Occupational Therapy, Speech-Language (For purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills).

902.2.10.2.1.10. Hospice home health aide services are not covered in combination with ICWP services. Such services are considered duplicative of personal support services. Rev. (10/2015)

902.2.10.2.1.11. Hospice aide services cannot be provided at the same time as ICWP PSS services but can be provided on the same day.

902.2.10.2.2. Waiver Residential Services:

An individual's home is where he or she resides. An individual may continue to receive residential services in a waiver program if the individual elects Hospice services. When this occurs, the hospice agency assumes full responsibility for the professional management of the individual's hospice care in accordance with the hospice Conditions of Participation. When an individual elect's hospice, the hospice agency and the waiver resident must communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy and is based on an assessment of the individual's needs and unique living situation.

A plan of care must be written and be consistent with the hospice philosophy of care. The plan of care must be written in accordance with the CFR and include the individual's current medical, physical, psychosocial and spiritual needs. The hospice must designate an RN from the hospice to coordinate the implementation of the plan of care. The plan of care should reflect the participation of the hospice and the facility and the consumer to the extent possible.

Evidence of the coordinated plan of care must be in the clinical records of both providers. The facility and the hospice must communicate with each other when any changes are indicated to the plan of care and each provider must be aware of the other's responsibilities in implementing the plan of care.

All hospice services must be provided directly by hospice employees and cannot be delegated. The hospice may involve the facility staff in assisting with the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely utilize the services of the patient's family/caregiver in implementing the plan of care.

The facility must offer the same service to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The hospice patient should not experience any lack of facility services or personal care because of his/her status as a hospice patient.

902.3. Skilled Nursing Services (Rev.04/2019)

902.3.1. Description:

Skilled nursing services are provided to ICWP members by a private home care provider licensed to provide skilled nursing or by a Home Health Agency. Private home care providers in accordance with O.C.G.A. 31-7-300 et seq, effective 7/95, must be licensed by the Georgia Department of Community Health, Health Care Section, Health Facility Regulations Division. In accordance with Section 105A of Part I Policies and Procedures for Medicaid/Peachcare for Kids, providers must be fully licensed without restriction

902.3.2. Licensure Requirement:

Agencies enrolling to provide nursing services, hourly or per visit, must hold and maintain in good standing licensure in one of the following categories:
Home Health Agency under the Official Code of Georgia (O.C.G.A.) § 31-7-150 and Licensure Rules under Chapter 111-8-31 of Healthcare Facility Regulation, or

Private Home Care agency under O.C.G.A. § 31-7-300 et seq. and Licensure Rules under Chapter 111-8-65 of Healthcare Facility Regulation.

902.3.3. Definition and Scope of Services:

Skilled nursing services are rendered in accordance with the provisions of the Georgia Registered Professional Nurse Practice Act, O.C.G.A. 43-26-1 and Georgia Practical Nurses Practice Act, O.C.G.A. 43-26-30,

when ordered by a physician in a plan of care. All services rendered to the member require certification by a physician. Physician orders/certifications are specific for procedures performed and are time limited.

Home health care is the preferred first choice for nursing visits but if home health is unable to provide service to the member, the member will be referred to a private home care provider licensed to provide skilled nursing services. Skilled nursing services necessary to meet the medical needs of the member may be provided in the most appropriate setting including but not limited to the member's home, day care center or other settings in the community. Nursing services are indicated when necessary for treatment of an illness or injury, or for delivery of tasks that require the professional judgement and skill level of a registered nurse.

In certain cases, a licensed practical nurse in accordance with the plan of care and applicable professional licensing statutes and associated rules. The use of a proxy caregiver to provide care for the member can be utilized in many situations unless expressly prohibited by the Rules and Regulations for Proxy Caregivers used in Licensed Healthcare Facilities, Chapter 111-8-100 of the Rules of the GA Department of Community Health.

902.3.4. Nursing Services:

Skilled Nursing Services may be delivered under a per-visit model or a per-hour model as determined through individually assessed need of the member. Effective April 1, 2019, hourly nursing services are included as an available service in the ICWP. Hourly nursing is available to members whose medical needs and conditions require skilled nursing services of greater duration than one visit per day. Nurses caring for members through hourly nursing must have experience in caring for patients with special health care needs. ICWP provider agencies will maintain documentation of the professional nurses' ongoing qualifications to provide services to skilled members. The services authorized and provided will vary based on the specific medical needs of the member as determined through assessment by Alliant Health Solutions and authorized to receive such services.

902.3.5. The Clinical Process and Record:

902.3.5.1. The medical management agency, currently Alliant Health Solutions, determines the number of skilled hours needed during the initial assessment and the necessity of an LPN or RN to complete the skilled nursing service. When LPN skilled nursing is approved but provided by an RN, the reimbursement will be paid at the LPN rate. Rev. (10/2024)

902.3.5.2. The private home care provider provides the service,

also establishes, and maintains a current clinical record on all members admitted to the agency for ICWP reimbursed services. These records must include at a minimum:

902.3.5.2.1. Appropriate member identifying information.

902.3.5.2.2. Name and telephone number of member's attending physician.

902.3.5.2.3. Pertinent past and current findings, including the admission assessment done by the provider RN.

902.3.5.2.4. A plan of care signed and dated by the attending physician at least every ninety (90) days or every three (3) months that includes drug, diet, treatment and activity orders;

902.3.5.2.5. Member care plan, reviewed, updated, signed, and dated at least every 62 days by the provider RN.

902.3.5.2.6. Signed and dated clinical notes written by the close of the business day immediately following the day the service was rendered by the providing member of the health team and incorporated in the record no less often than weekly.

902.3.5.2.7. Copies of summary reports sent to the physician at least every sixty-two (62) days or every two (2) months; and

902.3.5.2.8. Copy of skilled nursing evaluation must be sent to the case manager every 90 days.

902.3.5.2.9. A discharge summary when applicable.

902.3.5.3. The ICWP Case Manager must submit the following documents to AHS on admission and every 90 days if the member is continuing to meet criteria for ICWP Skilled Nursing hours: (rev. 10/2023)

902.3.5.3.1. Copy of skilled nursing evaluation completed by the skilled nursing agency must be sent to AHS every 90 days.

902.3.5.3.2. Copy of updated the MD order noting the approval of 90 days of skilled nursing must be sent to AHS every 90 days along with the skilled nursing evaluation.

Registered Nurse Qualifications

Private home care provider registered nurses must have a current license to practice as a registered nurse in the State of Georgia, two years of experience in home health, rehabilitation, long term care or a related field. One year of experience in an administrative or supervisory capacity is preferred. Preference should be given to individuals with home care experience.

Registered Nurse Responsibilities
Activities that can be performed by a registered nurse include but are not limited to:

Any service in accordance with and outlined in the Official Code of Georgia Annotated (O.C.G.A.), Section 43-26-1, Georgia Registered Professional Nurse Practice Act

902.3.5.3.3. Initial plan of treatment;

902.3.5.3.4. Preparation of clinical progress notes;

902.3.5.3.5. Coordination of services;

902.3.5.3.6. Informing the physician and other personnel of changes in the member's condition or needs.

902.3.5.3.7. Member and family teaching.

902.3.5.3.8. Development of teaching plan and caregiver(s) Competency Checklist

902.3.5.3.9. Administration of medications and treatments as prescribed by a physician in accordance with currently accepted standards of medical practice.

902.3.5.3.10. Total member care.

902.3.5.3.11. Supervising and teaching other nursing personnel.

902.3.5.3.12. Reviewing and revising the member care plan at least every 62 days and communicating revisions to appropriate staff.

Licensed Practical Nurse (LPN) Qualifications

Private home care provider licensed practical nurses render services in accordance with the provisions of the Georgia Practical Nurses Practice Act, (O.C.G.A.) Section 43-26-30, and must have a current license to practice as a licensed practical nurse in the State of Georgia. One year of experience in home health services, public health, geriatrics, long-term care or a related field is preferred. Preference should be given to individuals with home care experience.

902.3.5.3.13. Any service in accordance with and outlined in the Official Code of Georgia Annotated (O.C.G.A.), Section 43-26-30 through 39, Georgia Practical Nurses Practice Act;

902.3.5.3.14. Documenting clinical and progress notes

902.3.5.3.15. Assisting the registered nurse

902.3.5.3.16. Assisting the member in learning appropriate self-care techniques

902.3.5.3.17. Teaching the member and family

902.3.5.3.18. Performing and/or assisting with range-of-motion exercises and ambulation

902.3.5.3.19. Administering and setting up medications ordinarily self-administered and which have been ordered by a physician and supervised by the RN

902.3.5.3.20. Reporting of changes in the member's condition and needs to the RN

902.3.5.3.21. Taking and recording vital signs

Activities Which May Not be Performed by a Licensed Practical Nurse (LPN) Include:

902.3.5.3.22. The initial evaluation visit.

902.3.5.3.23. Initial development of the Treatment Plan

902.3.5.3.24. Initiation of the plan of care; and

902.3.5.3.25. Re-evaluation of member

Submission Requirements – A provider seeking enrollment to provide skilled nursing services must submit a copy of its current Private Home Care License with the Provider Enrollment Application.

902.4. Specialized Medical Equipment and Supplies

902.4.1. Description – The specialized medical equipment and supplies includes the provision of devices, controls, or appliances, specified in the Individual Plan of Care, which enable members to increase their abilities to perform activities of daily living or to perceive, control, and communicate with the environment in which they live. Included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of items and durable and non-durable medical equipment not available under the Medicaid State Plan. Reimbursement through the ICWP/TBI does not include items that do not provide direct medical or remedial benefit to the member. Ceiling Track lifts are not included in equipment reimbursed by the ICWP. The ICWP will assist in payment for basic equipment to assist a member to meet his or her needs within the cost limit of the member's budget.

NOTE:
ICWP members must exhaust available equipment and supplies available through the Durable Medical Equipment (DME) Program prior to accessing these items through the ICWP/TBI. Alliant Health will request that equipment and supplies covered through DME be submitted for approval through the DME Program. (Refer to Section 904.)

902.4.2. Standards – Providers of specialized medical equipment and supplies must meet Underwriter's Laboratory or Federal Communications Commission standards where applicable. Modification and equipment must meet acceptable industry standards

902.4.3. Submission Requirements – A provider seeking enrollment to provide specialized medical equipment, and supplies must submit a copy of its current Business License with the Provider Enrollment Application. A provider must submit a detailed resume. A provider must have at least two years' experience around medical supplies and equipment. The applicant must submit proof that the provider agency has at least $1,000,00 per occurrence and $3,000,000 per aggregate in general liability insurance coverage.

902.4.4. Training – The provider of specialized medical equipment and supplies must attend a provider training session provided by Alliant Health and any subsequent training, as warranted.

902.4.5. Services - Specialized medical equipment and supplies include the

following services:

902.4.5.1. Vehicle Adaptations – This service is provided for the member's privately owned vehicle and may include hydraulic lifts ramps, special seats, and other interior vehicle modifications or devices to allow for access into and out of the vehicle, for driving the vehicle if appropriate, and for security while the vehicle is moving.

Exclusions and Special Requirements:

902.4.5.1.1. The need for specific modification is documented in the Individual Plan of Care.

902.4.5.1.2. Repair or replacement costs for vehicle adaptations for member-owned vehicles are allowed as necessary when specified in the Individual Plan of Care.

902.4.5.1.3. The costs of acquiring a vehicle is not covered.

902.4.5.1.4. Reimbursement to cover replacement of equipment within three (3) years of purchase is not covered unless specific written prior approval is obtained from the Division of Medicaid.

902.4.5.1.5. See the current rate sheet in the appendixes for the current annual maximum allowable reimbursement.

902.4.5.2. Specialized Medical Equipment

902.4.5.2.1. Only medical equipment that cannot be obtained under Georgia's approved Medicaid Plan, or that is needed more than State Plan limitations, is covered under this program.

902.4.5.2.2. Reimbursement is limited to the maximum allowable monthly cost (see rate sheet I in the appendixes) for specialized medical equipment and supplies. Equipment costs may not exceed the maximum annual allowable amount of twelve times the monthly max of the members' annual budget allocation. Reimbursement for both medical supplies and equipment is based

on medical necessity as determined and approved by Alliant Health. 7/1/2023 Only the most cost-effective equipment which will meet the members' needs will be considered and approved for reimbursement after all other resources or DME have been exhausted. Alliant Health may require the provider to obtain cost estimates from up to three equipment suppliers, including online suppliers, to ensure the most cost-effective equipment is reimbursed. 4/1/17

902.4.5.3. Specialized Supplies – Specialized supplies are critical to the health and wellbeing of the member and necessary to prevent institutionalization.

902.4.5.3.1. Examples include:

902.4.5.3.1.1. Special clothing

902.4.5.3.1.2. Diapers

902.4.5.3.1.3. Bed wetting protective chux

902.4.5.3.1.4. Other items as specified in the Individual Plan of Care.

902.4.5.3.2. Exclusions and Special Requirements:

902.4.5.3.2.1. The need for specialized supplies and equipment must be documented in the Individual Plan of Care.

902.4.5.3.2.2. All medication, tube feeding, wound care supplies should have a doctor's order. A detailed written order should be provided at initial request, yearly and as needed. Detailed written order for medication should include product item, as well as the route to be

	administered, diagnosis, length of need (not to exceed 12 months as recertification is required annually), signature of physician, and the date the physician signed. Detailed written order for wound care supplies should only be submitted after home health and Medicaid options have been exhausted. Order should include product item, diagnosis, frequency of dressing change, length of need (not to exceed 12 months as recertification is required as needed and annually), signature of physician, and the date the physician signed. Detailed written order for tube feeding should include product item, as well as the route to be administered, diagnosis, length of need (not to exceed 12 months as recertification is required annually), signature of physician, and the date the physician signed. Oral nutrition will be considered for coverage when it is ordered by a physician and there is sufficient documentation to provide evidence that the member has nutritional need. Orders will need to be updated annually.
902.4.5.3.2.3.	Only supplies and equipment that cannot

be obtained under the Medicaid State Plan may be covered under ICWP.

902.4.5.3.2.4. Reimbursement is limited to actual costs or the maximum allowable monthly cost (see rate sheet in the appendixes) for current max) for medical supplies and equipment. Equipment cost may not exceed an annual amount of twelve times the monthly maximum.

902.5. Environmental Modification

902.5.1. Description – Providers of environmental modifications services provide physical adaptations to the private home specified in the Individual Plan of Care, which are necessary to ensure the health, welfare, and safety of the member, or which enable the member to function with greater independence in the home and without which, the waiver participant would be at risk of institutionalization. Those modifications include items or equipment not otherwise available through the Medicaid State Plan and not available through other fund sources, whether public or private foundations or grants. Such improvements or adaptations do not increase the square footage of the private home.

902.5.2. Requirements – At application all providers of environmental modification services must meet state or local requirements for licensure or certification, if applicable, including building contractors, plumbers, engineers, and electricians. The provider must be in good standing with the local Better Business Bureau. The provider must complete all modifications, improvements, or repairs in accordance with local and state housing building codes and special requirements. Providers must also meet the requirements listed in Section 602.1 – General Conditions. Rev. (07/20023)

902.5.3. Submission Requirements – A provider seeking enrollment to provide environmental modification services must submit all the documents listed for their specialty on the provider enrollment checklist in the appendixes. This includes a business license, all building licenses that are applicable to environmental modifications, and proof that the provider agency has at least $1,000,000 per occurrence and $3,000,000 per aggregate in general liability insurance coverage. See the provider enrollment checklist for the complete list.

902.5.4. Training - The provider of environmental modification must attend a new

provider training session provided by Alliant Health prior to delivery of ICWP services and any subsequent training, as warranted.

902.5.5. Services – Environmental modifications may include the following:

902.5.5.1. Installation of ramps and grab-bars
902.5.5.2. Widening of doors

902.5.5.3. Modification of bathrooms facilities

902.5.5.4. Installation of specialized plumbing and electrical systems necessary to accommodate medical equipment.

902.5.5.5. ICWP will provide the basic modifications and installations to assist a member in their ADLs.

902.5.6. Excluded Services-

902.5.6.1. ICWP will not reimburse for modifications that are considered cosmetic or at a higher cost than can be provided within industry acceptable supplies or products. The signed contract must list the cost for supplies and labor before the project begins. Any additions or higher cost products cannot be included in the ICWP service. Rev. (07/2023)

902.5.6.2. Adaptation or improvements to the home which are not of direct medical or remedial benefit to the member are not covered (e.g., carpeting, roof repair, air conditioning controls, etc.).

902.5.6.3. Home modification funds cannot include the basic construction costs of room additions or new buildings.

902.5.6.4. The total amount allowable for home and environmental modifications is limited to the actual costs of the modification or a maximum lifetime expenditure per member per lifetime. (See appendixes for current rate)

902.5.6.5. Resources such as the Georgia Residential Finance Authority, local homebuilders' associations, and other volunteer sources should be used before drawing upon ICWP funds. Written documentation must be maintained indicating the provider has exhausted these resources before billing Medicaid.

902.5.7. Procedures

902.5.7.1. Case Managers are expected to assist the member with obtaining three bids to complete environmental modifications to ensure that members have a selection of

qualified and experienced contractors from which to choose. The member is required to accept the lowest bid of the three qualified contractors. Further, the case manager shall assist the member with obtaining in writing from the contractor the specific agreed upon work to be performed by the contractor and all costs associated with the environmental modification. Any changes to the original bid must be in writing as well. Efforts must be made to identify three contractors for bid. However, if three contractors are not available, e.g., as may be the case in certain rural areas of the state, the case manager must document their efforts to comply with this policy and submit the documentation to the review nurse along with the submission requirements stated below.

902.5.7.2. The selected environmental modification provider/contractor must review the approved project and complete an itemized contract that details the work that will be completed. The contract must include:

902.5.7.2.1. Description of the work to be completed.

902.5.7.2.2. Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour.

902.5.7.2.3. Estimate for building permits, if needed.

902.5.7.2.4. Estimated start date and timeline for completing the project.

902.5.7.2.5. Name, address and telephone number of the Home Modification Provider.

902.5.7.2.6. Signature, including option for digital signature, of the Home Modification Provider.

902.5.7.2.7. Signature, including option for digital signature, of the client or other indication of approval.

902.5.7.2.8. Signature, including option for digital signature, of the homeowner or property manager if applicable. Rev. (10/2024)

902.5.7.3. The case manager must monitor the modification progress weekly to ensure that the work is completed as stipulated in the contract. The member, case manager, and provider cannot make changes to the approved scope of work listed on the contract without DCH authorization. Unapproved excess charges will not be reimbursed.

902.5.7.4. The environmental modification provider must complete the modification within 60 days of the begin date.

902.5.8. Case Manager Submission of Home Modification Requests to Alliant Health

Case managers must collect and submit the information listed below to the Alliant Health Review Nurse for a determination regarding the necessity of the home modification. Specifically, the case manager must submit:

902.5.8.1. A written narrative of the work that the member is requesting to be completed along with an explanation of why the home modification is needed. Submit change request in the portal for Alliant to review.

902.5.8.2. Pictures of the area that is to be modified.

902.5.8.3. An itemized contract indicating the work that will be completed. This is to be provided to the case manager from the home modification provider.

902.5.8.4. The case manager, member, and contractor must sign the itemized contract agreeing with the work that will be completed.

902.5.8.5. Proof of home ownership or agreement with owner required. If the member does not own the home, the property owner must agree to the planned modification and give their approval in writing before the service is approved. Maintain the property owner's approval in the member's file.

902.5.8.6. Home modifications services for provider owned housing is not allowable.

902.5.8.7. Submission of the DMA-80. The date the provider intends to start the project must be on the DMA-80. The DMA-80 can be approved no more than 60 days prior to

the planned start date. The initial PA can be no more than three quarters (3/4) of the total project budget. The case manager must notify DCH if the project does not start within 30 days of the planned start date. Claims submitted on projects that so not start within 30 days of the planned start date will be recouped. Rev. 10/1/24

The case manager is responsible for gathering all of the required documentation to submit to the review nurse. The complete packet of information must be submitted at one time in order for the review nurse to make a determination Submission of the Final Packet to Alliant Health by the Case Manager

The case manager is responsible for the submission of final information and documentation that the work was completed to the satisfaction of the member and home modification provider. Further, the packet will include additional information required for the review nurse to approve the completed home modification. The final submission will include:

902.5.8.8. Pictures showing the completed work.

902.5.8.9. Written documentation that the work is safe and usable by the members and that all parties, i.e., member, home modification provider and case manager agree that the work was completed according to the agreed upon contract. This document must be signed by the member, home modification provider, and case manager. The members' satisfaction shall be based on acceptable standards of professional practice, i.e. the work is safe and sound in workmanship (to the best of the members' knowledge) and appearance as well as acknowledgement that the actual work that was agreed upon initially was completed.

Upon completion of all the above requirements, the Alliant Health Review Nurse will approve the work and release the balance of the funds to be reimbursed to the home modification provider.

902.6. Counseling

902.6.1. Description – Individual providing counseling services help members with developmental or physical disabilities and their families to understand their capabilities and limitations or assist in the alleviation of problems of adjustment and interpersonal relationships.

A need for counseling must be documented in the Individual Plan of Care. The service must be prior to approved by Alliant Health.

902.6.2. Qualifications - Individual providing counseling services shall have at least a master's degree in one of the behavioral sciences and one year of related counseling experience.

902.6.3. Submission Requirements - A provider seeking enrollment to provide counseling services must submit proof of licensure/certification with the Provider Enrollment Application. The applicant must submit proof that the provider agency has at least $1,000,000 per occurrence and $3,000,000 per aggregate in general liability insurance coverage.

902.6.4. Training - The provider of counseling services must attend a new provider training session provided by Alliant Health prior to working with members and any subsequent training, as warranted, and must understand and subscribe to the independent living philosophy and goals of the ICWP.

902.6.5. Services - Counseling services are available to members needing treatment for personal, social or behavioral disorders to maintain and improve effective functioning. Counseling services can be provided via telehealth with or without a visual component. Telehealth HIPAA requirements listed in 602.1 R must be met. The counselor shall keep a written record of the services provided. The record shall contain summaries of each scheduled session and any other significant contact. The record shall include, but is not limited to, the following data: (rev. 10/2023)

902.6.5.1. Date of contact

902.6.5.2. Names, addresses and phone numbers of the people involved in contact

902.6.5.3. Duration of contact

902.6.5.4. Progress toward objectives of the counseling case plan

902.6.5.5. Recommendation for changes in counseling or the Individual Plan of Care.

The counselor shall send a written report to the case manager at least every six (6) months. The report shall contain a statement on the progress toward the goals of the Individual Plan of Care and recommendations for changes in the plan.

902.7. Personal Emergency Response System (PERS)

902.7.1. Description – PERS is an electronic device that enables high-risk members secure help in the event of an emergency. PERS providers provide two-way verbal and electronic communication systems with a central monitoring station seven (7) days a week, 24 hours a day to geographically and socially isolated members. The member may wear a

portable “help” button to allow for mobility. The system is connected to a member’s phone and programmed to signal a response center once a “help” button is activated.

NOTE:
PERS services are limited to those members who live alone, or who are alone for significant parts of the day and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision.

902.7.2. Qualifications – PERS providers must utilize devices that meet Underwriter’s Laboratory or Federal Communications Commission standards and must be in good standing with the local Better Business Bureau. The response center must be staffed by trained professionals.

902.7.3. Submission Requirements - A PERS provider seeking enrollment in the ICWP must submit a copy of its current Business License with the Provider Enrollment Application. A PERS provider must provide an estimated number of active employees for their company. The applicant must submit proof that the provider agency has at least $1,000,000 per occurrence and $3,000,000 per aggregate in general liability insurance coverage.

902.7.4. Training - The PERS provider must attend a new provider training session provided by the Alliant Health prior to working with members and any subsequent training as required.

902.7.5. Responsibilities – The PERS provider is responsible for the following:

902.7.5.1. Designating or operating an emergency response center (monitoring station) where signals are received, and response is made according to specified operating protocol.

902.7.5.2. Calling the member at least once a month to test system operation.

902.7.5.3. Providing operational and technical manuals and training to appropriate PERS staff.

902.7.5.4. Any replacement or repair needs that may occur. The supplier shall present the members with instructions on how to request replacement or repair of the equipment. Such replacement and repair must occur within three (3) working days of notification of malfunction.

902.7.5.5. Assessing the member’s ability to use the system correctly and documentation of such.

902.7.5.6. The cost of all long-distance charges associated with the use and monitoring of PERS.

902.7.6. Equipment Specifications – The provider must be trained and knowledgeable of the detailed manuals received from PERS equipment vendor relating to operational aspects of the system, including technical specifications, installation and testing.

Home Unit Specifications

902.7.6.1. The voice button or other simple device that can be worn or attached to the member shall activate the home equipment.

902.7.6.2. The system shall be usable by persons who are visually and/or hearing impaired, or physically disabled.

902.7.6.3. The communicator shall provide two-way communication and shall have a receiver to receive wireless signals.

902.7.6.4. The communicator shall be attached to existing telephone lines and shall not interfere with normal use of the telephone.

902.7.6.5. The communicator shall have a battery to provide a minimum of eight to twelve hours of operation in the event of a power failure. It should utilize a self-charging system and report its condition to the monitoring station after two hours of power loss.

902.7.6.6. The communicator shall be equipped with a self-diagnostic program that it performs in each twenty-four period.

902.7.7. Twenty-four Hour Monitoring Equipment Specifications

902.7.7.1. Maintain detailed technical and operations manuals that describe program elements, including equipment functioning, response protocol, record keeping and reporting procedures, equipment testing and installation in the member's home.

902.7.7.2. The emergency response center's equipment shall consist of a primary receiver, a back-up receiver, a clock printer, a back-up power supply and a telephone line monitor.

902.7.7.3. The primary receiver and back-up receiver shall be independent and interchangeable.

902.7.7.4. The printer should print out the time and date of the emergency signal, the member's identification code, and emergency codes indicating active or passive alarm or

responder reset.

902.7.7.5. The emergency response center shall have the backup supply power capacity to operate in excess of eight hours.

902.7.7.6. The telephone monitor shall give visual and audible signals in the event an incoming telephone line is disconnected for more than ten seconds.

902.7.7.7. The receiving and printing stations at the monitoring center shall have a minimum of two incoming telephone lines that are automatically interchanged in the event of telephone or equipment malfunction or unusual load demands.

902.7.8. Other Requirements

902.7.8.1. PERS providers are not required to replace a system unless there is a malfunction/defect in the current unit, unit upgrade by the provider agency or act of nature issue with the existing unit. If the unit is damaged or lost by the member/caregiver, neither the provider nor Medicaid will be responsible for the cost of a new unit/install. A member remaining active in the waiver program but requesting ERS service termination and then return of the ERS service within a 12-month period (excluding a temporary nursing home stay) will be subject to the cost of the second installation fee.

902.7.8.2. The need for Personal Emergency Response System is identified in the Individual Plan of Care and prior approved by the Division.

902.7.8.3. The provider shall maintain a written monthly log of all emergency signals received and appropriate actions taken, i.e., incident reports.

902.7.8.4. See appendixes for the maximum allowable cost for installation and monthly monitoring.

902.7.9. Temporary reimbursement while member is out of the home

902.7.9.1. When ICWP member receiving PERS services on a monthly basis is temporarily out of the home due to medical circumstances or orders (i.e. hospitalizations, convalescence), the PERS provider may continue to bill up to 62 days to avoid second installation costs. The PERS provider must maintain close communication with the case manager regarding the status of the member's absence from the home.

902.8. Behavioral Management

902.8.1. Description - Providers of behavioral management services provide individualized interventions designed to decrease the traumatic brain injury member's maladaptive behavior, which, if not modified, will decrease the individual's ability to remain in the community. Behavioral management services may be provided by any non-for-profit or proprietary health and service agency, such as a licensed or certified home health agency, a hospital, nursing facility, or a diagnostic treatment center.

902.8.2. Staff Requirements - Providers of behavioral management services must have direct clinical oversight and supervision by:

902.8.2.1. A psychiatrist who has one year providing neurobehavioral services, or

902.8.2.2. A licensed psychologist, certified rehabilitation counselor, or licensed professional counselor who has one year of experience in providing neurobehavioral services or traumatic brain injury services. (The psychologist, psychiatrist or counselor must be licensed in Georgia and readily available to the member unless the member has been approved to receive services out of state.) (Rev. 01/2018)

The members receiving behavior support services must also receive services from a professional meeting the qualifications in 1) and 2) above. That professional must oversee the member's behavior supports plan and assist all service providers, family members and caregivers in implementing and adjusting the plan as the member's behavioral needs change. (Rev. 01/2018)

Behavior specialists will have at least one year's experience working with individuals with traumatic brain injuries, other disabilities, and/or behavioral difficulties. These individuals must successfully complete 40 hours of training in TBI, behavior analysis, and crisis intervention techniques provided by a Behavior Management program. The Georgia Division of Medical Assistance's Waiver management staff may request to review the training manual. The Behavior Specialist must work under a professional who meets the director's qualifications listed above. (Rev. 01/2018)

902.8.3. Submission Requirements - Individuals seeking enrollment to provide behavior management services must submit with the Provider Enrollment Application, a detailed plan that demonstrates the ability to provide behavioral training to the member with a TBI as well as individuals who have significant contact with TBI members. The applicant must submit proof that the provider agency has at least $1,000,00 per occurrence and $3,000,000 per aggregate in general liability insurance coverage.

902.8.4. Training - Providers of behavior management services must attend a new provider training session provided by the Alliant Health prior to working with members and any subsequent training as required.

902.8.5. Services – Behavior Management services can be provided via telehealth with or without a visual component. Telehealth HIPAA requirements listed in 602.1 R must be met. Behavior Management should consist of the following services: (Rev. 10/2023)

902.8.5.1. A comprehensive assessment of maladaptive behavior(s).

902.8.5.2. Development of a structured behavioral intervention plan, which has as its primary focus, teaching socially appropriate behaviors and eliminating maladaptive behaviors and eliminating maladaptive behaviors.

902.8.5.3. Implementing the plan of care.

902.8.5.4. Ongoing training and supervision of the TBI members, family members, caregivers, and all other service providers.

902.8.5.5. Periodic reassessment of the plan.

Once a member reaches his or her maximum functional capacity, the practitioner will develop maintenance Plan of Care for the member to continue to receive behavioral training in their home by the caregiver. The personal support provider will make sure the caregiver receives instructions based on the Plan of Care to reinforce the training in real life situations.

All services must be documented in the Individual Plan of Care.

902.8.6. Supervisory Visits – The frequency and intensity of supervision will be determined by the planning team and documented in the Individual Plan of Care. Supervisory visits, notes, and contacts must be labeled as such, documented, signed and dated by the supervising person. Names and titles must be legible, and initials should not be used without a corresponding signature.

NOTE:
Behavioral management services may be reimbursed up to 16 units per day with a maximum of 80 units per week and 368 units per month. 1 unit =15 minutes

902.9. Adult Day Services

902.9.1. Description – ICWP Adult Day Services are provided in two models. Adult Day Services (ADS) and Adult Day Health Services (ADH). Both models are provided during the day through programs that are offered at facilities within the community. At the end of each day, the member

returns to his/her home. A member receiving ADS or ADH may not receive PSS simultaneously during the same hours under the ICWP; however, they may receive both services at different times of the day unless a lack of continual one on one assistance presents a significant safety risk to the member or other people being served. A Personal Support Provider may not bill for PSS hours during the time a member is receiving ADS or ADH unless the absence of a personal support attendant disqualifies the member from participation due to significant physical limitations or behavioral dysfunction. Justification which requires one-on-one assistance during adult day services must be documented in the member's medical record.

902.9.2. Location – ADS and ADH facilities/Mobile ADH cannot be located on the grounds/roofline* of or adjacent to any ALS Home. Members must have freedom of choice when selecting services and providers. Members cannot be coerced or encouraged to select services from a provider that has the same ownership or other relationship to the ADH provider. (Rev. 4/2022)

Grounds are defined as within the same parcel/lot or sharing of common address. Roofline is defined as the same physical dwelling even if adjoined by a structural walkway connecting the two sites. No shared spaces for meals, activities, etc. permitted.

902.9.3. Adult Day Services Model (ADS) provide services specializing in treatment techniques for members with traumatic brain injuries and a major neurological deficit. Providers of ADS develop and provide staff training which focuses on the needs of individuals with a traumatic brain injury or neurological deficit identified in the Plan of care, and the specific way this service will meet the member's individual needs. The program focuses on adaptive skills and is distinct from work production objectives.

902.9.3.1. Requirements – Adult Day Services must be provided by an enrolled not for profit or proprietary health and human services agency, such as a licensed or certified home health care agency, hospital, nursing facility, or diagnostic and treatment center specializing in treatment techniques for persons with a major neurological deficit. These providers must have at a minimum, one year experience providing services to individuals with a traumatic brain injury. They must directly supervise all direct care staff and must meet the following criteria: (Rev. 01/2018)

902.9.3.1.1. Psychologist with a specialty in Cognitive Remediation,

902.9.3.1.2. Certified Rehabilitation Counselor,

902.9.3.1.3. Certified Rehabilitation Registered

Nurse (CRRN), or

902.9.3.1.4. Licensed Professional Counselor (LPC), or

902.9.3.1.5. An individual with a master's degree and two years of experience providing services to individuals with a major neurological deficit. (Rev. 01/2018)

902.9.3.2. Submission Requirements - Individuals seeking enrollment to provide Adult Day services must submit proof that staff meets the qualifications in B above with the Provider Enrollment Application. If state or local law requires licensure of the agency, organization or health facility, the provider must also submit proof of licensure at the time of application and annually thereafter. The applicant must submit proof that the provider agency has at least $1,000,000 per occurrence and $3,000,000 per aggregate in general liability insurance coverage.

902.9.3.3. Training - The provider of adult day services must attend a New Provider Training session provided by Alliant Health prior to working with members and any subsequent training as required.

902.9.3.4. Specific Tasks - Providers of Adult Day services will:

902.9.3.4.1. Develop individual service plans for each ICWP member with input from the member to the extent possible. (Rev. 01/2018)

902.9.3.4.2. Develop and provide staff training that focuses on the needs of individuals with a TBI and/or a major Neurological deficit and must specify the way this service will meet the member's individual needs.

902.9.3.4.3. Develop a detailed plan that reflects the specific habilitation needs of the members and the activities and/or other approaches for meeting those needs. (The Plan of Care must be reviewed by the case managers and Alliant Health before approving services).

902.9.3.4.4. Ongoing services will be supervised by a Behavior Specialist. The program director will provide ongoing

supervision to the Behavior Specialist

902.9.3.4.5. Provide sufficient space to meet the needs of the members and staff. The program must provide adequate protection for the member's safety, accessibility and fire safety, and must be in a building that meets all provisions of the Georgia Fire Prevention and Building Code.

902.9.3.5. Services - All Adult day services must be included in the Plan of Care. Services may include the following:

902.9.3.5.1. a habilitation program in the areas of social, emotional, physical and intellectual development,

902.9.3.5.2. training in the areas of daily living skills (including leisure/ recreation skills), mobility, programming to reduce inappropriate and/or maladaptive behaviors and training in the independent use of common community resources,

902.9.3.5.3. lunch meal.

902.9.4. Adult Day Health Model (ADH) is a community-based medically oriented day program that provides social, health and rehabilitative services to individuals who are functionally impaired. ADH services support individuals living with chronic illness and assist individuals to recover from acute illnesses or injuries. The ADH program provides services that promote medical stability, maintain optimal capacity for self-care and maximize the individual's highest level of functioning and independence as reflected on the individual's Care Plan. ICWP ADH is reimbursed at one level and does not include physical, speech, or occupational therapies.

902.9.4.1. Description of ADH services increase opportunities for individuals to participate in multifaceted activities, including social and cultural activities. All ADH services reflect the individual's needs as indicated in the Care Plan developed by the case manager and approved by the individual's physician. ADH providers offer (or arrange when needed) all the standard services listed below:

902.9.4.1.1. Health-Related Services, including nursing, health monitoring and medication administration (Rev 04/2015)

902.9.4.1.2. Assistance with Activities of Daily Living (ADLs)

902.9.4.1.3. Therapeutic Activities

902.9.4.1.4. Food Services, including nutrition management (Rev 04/2015)

902.9.4.1.5. Transportation

902.9.4.1.6. Education of Caregivers

902.9.4.1.7. Emergency Care

902.9.4.1.8. Preventive and Rehabilitative Services.

902.9.4.2. Adult day health facilities must be licensed (permitted) by the Healthcare Facility Regulation Division of the GA Department of Community Health as an adult day center that is approved to provide adult day health services. Facility owners who wish to enroll as an ICWP adult day health provider must be permitted without restriction and be in full compliance with the Rules of the GA Department of Community Health, Adult Day Health Services – Oct 1, 2023, XI-3 Chapter 111-8-1, Rules and Regulations for Adult Day Centers. ADH facilities and owners must operate as an EDWP provider and maintain compliance with EDWP policies and procedures as detailed in Part II – Chapter 1100 Policies and Procedures for EDWP (CCSP and SOURCE) ADULT DAY HEALTH SERVICES for a minimum of one year prior to approval as an ICWP facility. These policies include:

902.9.4.2.1. Physical Environment

902.9.4.2.2. Hours/Days of Operation

902.9.4.2.3. Components of Adult Day Health Service

902.9.4.2.4. Supervision of the Service

902.9.4.2.5. Clinical Records

902.9.4.2.6. Infection Control

902.9.4.2.7. Required Equipment and Standards

902.9.4.2.8. Notification of Member Rights

902.9.4.2.9. Program Evaluation and Member Satisfaction Section

902.9.4.2.10. Staffing and Staff Member Ratios

902.9.4.2.11. General Staffing Policies

902.9.4.2.12. Qualifications and Duties of Staff

902.9.4.2.13. Development and Annual In-Service Training

902.9.4.3. ADH Model Service Limitation – ICWP members living in ALS facilities may receive services at an Adult Day Health Services facility for up to two (2) full days or four (4) half days per week.

902.10. Respite Care

902.10.1. Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of the people normally providing care.

902.10.2. Licensure – In-Home Respite Care providers must be licensed by the Healthcare Facility Regulation Divisions (HFRD) within DCH as a Private Home Care Provider to provide personal support services or a licensed personal care home. Out of Home Respite Care Providers must be a Medicaid certified nursing facility, a certified hospital, a licensed respite care facility, or other facility approved by the contracted review team. Licensure must be posted in a conspicuous location open to public view.

902.10.3. Submission Requirements – Providers seeking enrollment to provide respite care services must submit the following with the Provider Enrollment Application:

902.10.3.1. In Home Respite providers must submit their current Healthcare Facility Regulation Divisions license.

902.10.3.2. Out of Home Respite providers must submit a description of facilities including the number of available beds and a staff coverage plan to accommodate overnight services in addition to documents to verify that the agency is a Medicaid certified nursing facility, a certified hospital, a licensed respite care facility, or other facility approved by the contracted review team.

902.10.3.3. Training Package or Proposal – Training programs must be developed by all respite care providers and must

include all areas of training specified in the policies and procedures manual. The service provider must certify that individuals have met and completed all training requirements. Staff must indicate by signature and date the completion of each area of training. All training must be maintained in the personnel file.

902.10.3.4. The applicant must submit proof that the provider agency has at least $1,000,000 per occurrence and $3,000,000 per aggregate in general liability insurance coverage.

902.10.4. Training

902.10.4.1. New Provider Training – Providers of respite care services must attend a New Provider Training session provided by Alliant Health prior to working with members and any subsequent training, as warranted, and must understand and subscribe to the Independent Living Philosophy and goals of the ICWP.

902.10.4.2. Specific Training Requirements – Individuals providing respite care services must have completed training in the following areas prior to delivery of services:

902.10.4.2.1. CPR and Basic First Aid

902.10.4.2.2. Emergency procedures

902.10.4.2.3. Assistance with medications

902.10.4.2.4. Specialized procedures.

The following training requirements must be completed within ninety days of direct member-care:

902.10.4.2.5. Infection Control

902.10.4.2.6. How to give personal care

902.10.4.2.7. Transfer techniques

902.10.4.2.8. The need for confidentially regarding the services being provided

902.10.4.2.9. Agency policies and procedures

902.10.4.2.10. Observation skills

902.10.4.2.11. Safety and accident prevention

Staff shall receive ongoing quarterly training. Topics for this training include, but are not limited to:

902.10.4.2.12. Human needs and behavior

902.10.4.2.13. Family relationships

902.10.4.2.14. Stress management

902.10.4.2.15. Meal planning

902.10.4.2.16. Community resources
902.10.4.2.17. Fire safety

902.10.4.2.18. Conflict resolution

902.10.4.2.19. Documentation

902.10.4.2.20. Time management

services are provided by the Respite Care Worker during the caregiver's absence. The extent and schedule of respite care will be determined by a member's particular needs.

Services providers are expected to provide services in compliance with policies procedures and goals of the ICWP and of any other applicable regulatory agency.

902.10.5. Levels of Service - Respite services are provided and reimbursed on the following levels: (Rev. 01/2023)

LEVELS OF CARE	DESCRIPTION
Level I	Cognitive and/or behavioral issues that require general safety oversight
	Requires Medication Remainders
	Moderate to total assistance with ADLs such as feeding, bathing, bowl care, grooming; and general housekeeping
	Moderate to total transfer assistance to maintain continence and hygiene
	Needs assistance with feeding and meal prep
	Needs assistance with elimination such as catheter/colostomy/urostomy care
	Care of stage I or II decubitus ulcer

Level II	Requires a minimum of four hours a day of behavior management due to TBI
	Unstable medical condition requiring three or more hospitalizations per year
	Complex skilled needs such as trach care, ventilator care, or suctioning

	Care of state III, or IV decubitus ulcer
	Receiving parenteral nutritional supplementation

NOTE:
Respite service for S5151 and S5151 U1 and S5151 TF is limited to 14 days per year. Under these codes respite services must be provided out of the home. In a Community Care residential facility approved by the state that is not a private residence. The following codes must be billed as follows:

S5151 = 1 to 4 hours
S5151 U1 = 4 to 16 hours
S5151 TF = 6 to 24 hours

903. Non-Covered Services

The following services are not reimbursable:

903.1. Services for which prior authorization was not obtained,

903.2. Services provided prior to the effective date of enrollment,

903.3. Services not contained in the Individual Plan of Care,

903.4. Services for which another payer is liable,

903.5. Services provided while a member is incarcerated,

903.6. Case finding, legislative advocacy, training, medical treatment,

903.7. Payment for services which are an integral and inseparable part of another Medicaid covered service, and

903.8. Services provided in a manner, which is in violation of the provisions contained in this manual.

903.9. Services provided by family members (spouses, children, etc.).

904. Durable Medical Equipment (DME)

904.1. Procedures relating to purchase, rental, repair maintenance, and delivery of equipment and appliances, refer to the DMA Policies and Procedure Manual for Durable Medical Equipment.

904.2. The DME service manual may be located on the www.Alliant Health.georgia.gov Web site.

904.3. Equipment and supplies covered through DME must be submitted for approval through the DME Program prior to accessing items through the ICWP.

The case manager must assure provision of DME as follows:

904.3.1. If the DME item is directly related to the service being provided under the ICWP, and is reimbursable under the Medicaid program, the case manager must assist the member in obtaining the item through a DME vendor enrolled with the Division of Medical Assistance. If requested by the DME vendor, the case manager must assist the member in obtaining a prescription or Certificate of Medical Necessity from the physician.

904.3.2. The case manager must also send a copy of the PAF and the initial Plan of Care to the DME vendor. The DME vendor should submit this information and all other required forms and documentation necessary for approval through the DME Program. The DME vendor must send copies of the approval/disapproval through the DME Program to Alliant Health and the case manager within five (5) working days of receipt.

904.3.3. If needed equipment and/or supplies are not directly related to the service being provided, the case manager will assist the member in obtaining the item(s) through a Medicare or Medicaid approved vendor.

905. Non-Emergency Transportation Services (NET)

For more detailed information, contact the NET broker serving the members' location. (Refer to the NEMT form in the appendixes for NET Brokers.)

906. Documentation

906.1. General Record Keeping Standards

All provider records for the member must contain a copy of the submitted DMA-6 and DMA-80. The Mailer Data form that Alliant Health Solutions sends out to providers must be attached and kept with the submitted copies of the DMA 6 and DMA 80 in the member record. This will verify approval from Alliant Health. If a DMA 80 is amended this must also be kept in file with the new Mailer Data form and the correspondence from Alliant Health stating that the DMA was amended. All providers, excluding Environmental Modification providers, must establish and maintain a current record for everyone evaluated and admitted for services.

906.1.1. The record may be duplicated and maintained in various provider locations responsible for providing services.

906.1.2. There must be sufficient documentation in the record to demonstrate the quality of care being provided and to allow the appropriateness of care to be maintained and evaluated.

906.1.3. Documentation for personal support services must include the following: type of service identified, arrival time/departure time, and total hours for services rendered. Records of the member and provider approval from the EVV portal must be made available to auditors.

906.1.4. Documentation for case management must include time spent on telephone calls related to the members' care. The face-to-face monthly

visit must be dated and signed with the ICWP member.

906.1.5. For providers of Case Management, Personal Support, Respite, Skilled Nursing, Counseling, Behavior Modification and Adult Day Services, all member records must contain the following basic information:

906.1.5.1. Appropriate member identifying information, including the name of the member's attending physician, pertinent past and current findings.

906.1.5.2. A copy of the Participant Assessment Form (PAF);

906.1.5.3. An electronic copy of the DMA-6 submitted to Alliant Health and the approved Mailer Data form must be attached and on file to verify approval

906.1.5.4. Electronic copy of the Member's Rights and Responsibilities and the Memorandum of Understanding;

906.1.5.5. An electronic copy of the original DMA-80 submitted to Alliant Health and the approved Mailer Data form must be attached to verify approval.

906.1.5.6. Individual Plan of Care authorized by Alliant Health Solutions, signed and dated by the case manager, the member and the planning team at least every twelve (12) months;

906.1.5.7. Electronic copy of the Freedom-of-Choice form.

906.1.5.8. Electronic copy of the Release of Information form.

906.1.5.9. Documentation of services provided by each health team discipline, signed and dated the day the service is rendered.

906.1.5.10. Member information regarding critical medical issues, such as allergies, life-threatening diseases, special precautions and next of kin or person to notify in case of emergency.

906.1.5.11. Documentation of the members' involvement in the provision of services.

906.1.5.12. Monitoring of services documentation.

906.1.5.13. Discharge plan when applicable.

906.1.5.14. Advance Directives (The Georgia Living Will. See form

in the appendixes)

906.1.5.15. Directions to the member's home. Directions must contain specific instructions on how to reach the member's home from the provider agency/office. Adult Day Service providers are excluded from this requirement.

906.1.5.16. Providers must keep a copy of the GChex file for each employee.

906.1.5.17. A copy of the employees' CPR and first Aid card must be maintained on file for PI review

907. Utilization Review

907.1. The DMA performs periodic utilization reviews of ICWP member services to assure the medical necessity for continued care and the effectiveness of the care being rendered. Each provider is reviewed as frequently as deemed appropriate or necessary, with on-site reviews or audits sometimes conducted with no prior notice.

907.2. During each review visit, the DMA examines member records and conducts in-home or on-site individual member assessments.

907.2.1. The DMA examines member records to assure that they contain the following:

907.2.1.1. an approved Level of Care;

907.2.1.2. physician's orders, if applicable;

907.2.1.3. provider care plans;

907.2.1.4. documentation of services provided, their frequency, and appropriateness of service revisions; and

907.2.1.5. documentation of supervisory visits.

907.3. ICWP providers are required to submit prior authorization requests and certain other documentation electronically to Alliant Health for review and approval. These documents along with other documents required as a part of the assessment, reassessment and service delivery process are to be maintained in members records as well. A complete list of documents (templates located in the appendixes) which must be in the record include: (Rev. 01/2016)

Review Period: From_____ To_____

907.3.1. DMA-6 and any mailer data forms

907.3.2. DMA-80) and any mailer data forms

907.3.3. Individual Plan of Care/ICWP Community Care path

907.3.4. Participant Assessment Form/PAF

907.3.5. Memorandum of Understanding

907.3.6. Personal Care Attendant Hour Allotment **

907.3.7. Rights and Responsibilities Form

907.3.8. Advanced Directives Form

907.3.9. Release of Information Form

907.3.10. Freedom of Choice Form

907.3.11. Service Record Forms (record of billable time, activity notes)

907.3.12. Supervisory Visits

907.3.13. Progress Notes

907.3.14. Directions to the home (if applicable)

907.3.15. Physician Orders (if applicable)

907.3.16. MARs (if applicable)

907.3.17. Licenses/Permits for provider facilities

907.3.18. Discharged Records (if applicable)

907.3.19. Power of Attorney (if applicable)

OTHER: Providers may be asked to coordinate member assessments, home visits or facility tours that are needed during the review.

NOTE:
The following items are determined to be recoupable: Deficiencies related to the DMA-6 and DMA-80, required quarterly review, documentation of services, Supervision of personal support services and qualities issues.

907.3.20. The DMA conducts on-site assessments of members to determine if the member's condition warrants continuation of the current level of services rendered by all ICWP providers. The assessments determine whether:

907.3.20.1. additional needs exist;

907.3.20.2. care provided is adequate;

907.3.20.3. services have been effective; and/or

907.3.20.4. Alternative methods of care should be considered.

907.4. Upon completion of the on-site visit, the DMA forwards to the provider a written report of the Utilization Review findings. The provider must submit a corrective plan of action to the Division of Medical Assistance within fifteen (15) calendar days of the date of the utilization review report. The Division will review the corrective plan and notify the provider of the plan's acceptability.

The provider's failure to comply with the request for a corrective plan of action may result in adverse action, including suspension of referrals or termination from the program.

907.5. When Utilization Review reports include recommendations for changes in member services, the DMA will mail the report to the provider five (5) business days prior to mailing the member letter(s). The member has the right to appeal any adverse action recommendations made by the DMA. Adverse actions imposed by DMA include:

907.5.1. reducing service(s).

907.5.2. terminating service(s); and

907.5.3. determining service is inappropriate

907.5.3.1. If the member appeals by filing a hearing within ten (10) calendar days of the date of the member letter, the member may continue to receive services until the Administrative Law Judge (ALJ) makes a decision. Providers must consult with the case manager to confirm that the member has requested a hearing within ten (10) calendar days and wishes to continue service. The DMA will reimburse the provider for services rendered during the DHR hearing process if the member's request for a hearing was filed timely.

907.5.3.2. If the member does not file for a hearing within the ten (10) calendar days of the adverse action letter, the DMA's recommendation becomes effective at the end of the ten (10) calendar days as stated in the utilization review report and the DMA notice to the member. However, the member has the right to request a hearing within thirty (30) calendar days from the date of the member's letter.

Chapter 1000: Basis For Reimbursement

1001. Conditions of Reimbursement:

Reimbursement is made to ICWP providers who have:

1001.1. completed the ICWP enrollment process;

1001.2. been assigned an ICWP provider number;

1001.3. delivered services ordered on the Individual Plan of Care;

1001.4. provide services to a member enrolled in ICWP;

1001.5. provided services approved prior to delivery;

1001.6. exhausted all other sources of health care reimbursement; and

1001.7. provided services covered by the provisions of this manual.

1002. Reimbursement

1002.1. Reimbursement and Claim Form

The DMA reimburses for services rendered at rates established by the DMA in accordance with the policies and procedures of this manual. See current rate sheet in the appendixes for current procedure codes and reimbursement rates.

Effective May 1, 2015, the department will only accept electronic claims. Any paper claims submitted to the fiscal agent for payment after this date will be returned to the provider. Please refer to the Medicaid and Peachcare for Kids Part I Policies and Procedures manual, Section 112 for more information. (Rev. 07/2015)

A DCH approved EVV vendor must be used to submit all Personal Support Services claims to be eligible for reimbursement. (Rev. 10/2021)

1002.2. Service limits apply to the following services: (See current rate sheet in the appendixes)

1002.2.1. completed the ICWP enrollment process;

1002.2.2. Environmental Modification;

1002.2.3. Vehicle Adaptation;

1002.2.4. Specialized Medical Equipment and Supplies.

1002.2.5. Personal Emergency Response Services.

1002.2.6. Skilled Nursing

1002.2.7. Personal Support Services

1002.2.8. Case Management

1002.2.9. Respite Care

1002.2.10. Behavior Management

1002.2.11. Counseling

1002.3. Reimbursement is not authorized for the following:

1002.3.1. any date of service in which the member was/is inpatient in a nursing facility, hospital, or other institution

1002.3.2. Room and board; and

1002.3.3. Georgia Medicaid will not reimburse for personal care services or any waiver services when provided to recipients by legally responsible relatives, i.e., spouses, parents of minor children, or legal guardians when the services are those that these persons are already legally obligated to

1002.3.3.1. Services provided by relatives, except as noted above, may be covered when the following criteria are met:

1002.3.3.1.1. The relative must meet all required training and qualifications before he/she assumes the role of paid caregiver for the member

1002.3.3.1.2. the relative is hired, trained, supervised, and reimbursed by an approved ICWP Private Home Care Agency

1002.3.3.1.3. payment is limited to the relative in return for specific services rendered

1002.3.3.2. In the case of self-directed care, all of the following criteria must be met:

1002.3.3.2.1. The family member or friend must meet the provider's qualifications and training standards specified in the waiver for that service;

1002.3.3.2.2. The family member must meet the training qualifications prior to rendering services to an ICWP member;

1002.3.3.2.3. An agreement must be in place between the member, employee and or the provider before services is rendered.

1002.3.3.2.4. The member must pay the caregiver at a rate that does not exceed that which would otherwise be paid to a provider of a similar service.

1002.3.3.2.5. An individual caregiver, including family members, may not provide more

than 40 hours of paid personal support services in a seven-day period. Employees that work inadvertent overtime must be paid in accordance with Department of Labor Rules and Regulations:

1002.3.3.2.6. The caregiver must review and approve the time worked by the caregiver in the FI EVV system.

1003. General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers (Rev. 01/2014)

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18) C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim cannot be paid.

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

For the NEW CMS-1500 claim form:
Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK, Referring = DN or Supervising = DQ).

For claims entered via the web:
Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim details were updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:
The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

1004. Rounding Rules

To provide the most accurate and fair methodology for billing for services rendered. The state

utilizes the following Rounding Rules as it relates to those services provided in 60-minute increments. For those Personal Support Services (PSS) billed hourly, less than 30 minutes rounds down to the next whole unit. Thirty (30) minutes will round up to the next whole unit.

Documentation with actual time spent rendering services will be reflected in the member's service notes. All other services not billed in 60 - minute increments are to be billed as indicated within the Reimbursement Rate Table located in the appendixes.

II.

III.
V.
VI.

X. _____

Appendix A
ICWP (Category 660) Provider Application Checklist (Rev. 7/2025)

INSTRUCTIONS:
ICWP Provider applications must contain all the required general documents and specific documents per specialty. Applications that are submitted with missing documents will be withdrawn at the time of review.
All providers must submit the general documents that are listed in Section 1.
Providers must also submit the required document listed in Section 2 for the specialty or specialties that are selected on the application. If any document for the specialty is missing, the specialty will be withdrawn.
Section 1 – General documents all providers (except specialty 310) must submit.

IRS Form W-9. The payee name on the W-9 must match the business name as registered with the IRS
147-C Letter from the IRS

Power of Attorney for Payee. Must be completed **if** the designated payee is different from the applicant (signed and notarized).
National Plan and Provider Enumeration System and taxonomy code (NPPES)
Electronic Funds Transfer Agreement. The EFT is in GAMMIS under Provider Enrollment.
Voided check or a letter from the bank for the account in which funds are to be deposited
Applicable Georgia business license as required by the local city or county government in which the services are provided.
General Liability Insurance Certificate - Must have 1,000,000 in coverage and 3,000,000 aggregate
The enrolling entity must have three (3) years of experience providing the specialty service listed on the enrollment application. The experience must be services provided to individuals with physical disabilities and/or traumatic brain injuries. A resume and a list of references are required at the time of application.
Policies and Procedures - All service providers must have written member care (602.1 -F), performance (602.1-G), and member protection assurance (602.1-L) policies and procedures. Policies and Procedures must also cover specific service responsibilities listed for each service in Chapter 900 of the ICWP manual. ALS providers must include policy listed in Section 1254.2 of the ALS manual.
Standard Assurance Form
Letter of Understanding Form
Assurance of Compliance with Title VI of the Civil Rights Ac t of 1964 Form

Section 2 – Specialty Documents. Submit all documents required for your specialty/specialties.

197 – Personal Support Services

and

243- Respite, In-Home

Active DCH HFRD Private Home Care Permit
Current Worker's Compensation Insurance certificate
Proof of one-year active experience providing EDWD PSS, or NOW/COMP CLA waiver services. Provide active Medicaid number.
Resume for Registered nurse on staff detailing experience providing services to severely disabled and TBI individuals
RN License-Supervisory nurse
HFRD Survey, clear of deficiencies or corrective action plan included
Staff Training Plan with topics and timelines

244-Respite, Out-of-Home

Resume for Registered nurse on staff detailing experience providing services to severely disabled and TBI individuals
RN License-Supervisory nurse
Staff Training Plan with topics and timelines
Licensed as a Medicaid certified nursing facility, a certified hospital, a licensed respite care facility, or Personal Care Home
Description of facilities including the number of available beds, and a staff coverage plan to accommodate overnight services

312- Alternative Living Services – Management Agency

Owners Resume must include one year of ALS Management experience under another waiver
Sample Pre-placement screening form (located in appendixes of the ICWP-ALS manual)
Sample Subcontract with PCH
Resume for Registered nurse on staff detailing experience providing services to severely disabled and TBI individuals
RN License-Supervisory nurse
Staff Training Plan with topics and timelines
Letter of Agreement Form

310– Alternative Living Services-Family Home Model (2-6 beds) *Note-Group Homes (7-24 beds) not allowed.

*See the bottom of the checklist for detailed instructions about how to enter a PCH application. Applications for

specialty 310 must be submitted by providers approved for specialty 312.

Subcontract with PCH
Fire Safety Inspection
Private Care Home permit that lists only 2 – 6 beds
Diagram of PCH Floor Plan
Pre-placement screening form (see appendixes of the ICWP-ALS manual)
HFRD Survey, clear of deficiencies or corrective action plan included
Local city or county business license of the PCH

005- Adult Day Services and Adult Day Health Services

Resume for Registered nurse on staff detailing experience providing services to severely disabled or TBI individuals
RN License-Supervisory nurse
Fire Safety Inspection
Adult Day Services focus on adaptive services for individuals with TBI's, neurological deficits, or sever disabilities for members with TBI's: License and resume for one of the following: 1) Psychologist with a specialty in Cognitive Remediation 2) Certified Rehabilitation Counselor 3) Certified Rehabilitation Registered Nurse (CRRN) 4) Licensed Professional Counselor (LPC) 5) An individual with a master's degree and two years of experience providing services to individuals with a major neurological deficit. **Or** Adult Day Health services for members with disabilities. Services not focused on adaptive services: HFRD Adult Day Health Services Permit – Permit must specify "health."
Include your maximum capacity in your policies and procedures

030-Traditional Case Management

RN license or BA/BS degree in a health care or human services related discipline from an accredited college or university.
Resume those details three (3) years of experience in healthcare service delivery or human services case management pertinent to the disabilities and conditions of the populations served by the ICWP, severely disabled adults and adults with traumatic brain injuries.

331- Traditional and Enhanced Case Management

Licensed as a registered nurse or have a BA or BS degree in a health care or human services related discipline from an accredited college or university.
Resume those details five (5) years of experience in healthcare service delivery or human services case management pertinent to the disabilities and conditions of the populations served by the ICWP; severely disabled adults and adults with traumatic brain injuries.

Individual Enhanced Case Management Providers must hold the following: Nurse Practice Act OCGA.43-26-1 for all registered nurse case managers or, Licensure under the Georgia Composite Board for counselors, social workers and marriage and family therapists or, Licensure in psychology.

332- Agency Model Case Management

If licensed, the agency will maintain the license as applicable in-home health, private homecare, neurobehavioral center, or other.
If out-of-state, must provide a letter of recommendation from current oversight agency along with the last audit/review
Must employ or contract with at least one Medical/Clinical Supervisor who has the following qualifications and experience: Registered Nurse, physical or occupational therapist, physician assistant or other mid-level healthcare provider. Minimum of 2 years' experience in acute care, long term care, or medical rehabilitation. Must have at minimum three (3) years' experience providing home and community- based case management services for individuals with disabilities. Must have a minimum of 2 years professional experience with individuals with complex medical issues in a setting related to individuals with, specialty clinics, or other rehabilitation/habilitation settings.
Must employ or contract with at least one Behavioral Clinical Supervisor who has the following qualifications and experience: Board Certified Behavior Analyst, Psychologist, Licensed Professional Counselor, Licensed Associate Professional Counselor, Licensed Clinical Social Worker, Licensed Master Social Worker or a Registered Nurse Minimum of 2 years' experience in behavioral care, psychiatric setting, long term care, or neurobehavioral rehabilitation. Must have at minimum three (3) years' experience providing home and community- based case management services for individuals with disabilities. Must have a minimum of 2 years professional experience with individuals with complex behavioral issues in a setting related to individuals with, specialty clinics, or other rehabilitation/habilitation settings.

058-DME, Specialized Medical Equipment and Supplies

List the specialty medical equipment, or other supplies such as gloves, incontinence supplies, etc., that your agency will provide.
Two years' experience in the area of medical supplies and equipment.
Any industry required licensure that is required for a supply on your supply list.

064- Emergency Response Services

Statement certifying that the devices your agency uses meet Underwriter's Laboratory or Federal Communications Commission standards.
Proof of good standing with the local Better Business Bureau

249-Skilled Nursing Services-Per Diem

Active DCH HFRD Private Home Care Permit.
Nursing listed as an approved service on the PHC permit
Current Worker's Compensation Insurance certificate
Resume for Registered nurse on staff detailing experience providing services to severely disabled and TBI individuals
RN Licenses -Supervisory nurse

349-Skilled Nursing-Per Diem plus Hourly

Active DCH HFRD Private Home Care Permit.
Nursing listed as an approved service on the PHC permit
Current Worker's Compensation Insurance certificate.
List the total number of LPN's and RNs on staff to provide skilled nursing services.
Licenses for nurses on staff.
Resumes for nurses on staff that detail experience in caring for severely disabled patients and/or TBI patients with special health care needs. Nurses should also have experience in home health services, public health, geriatrics, long-term care or a related field
Your back-up plan or your agency's plan to provide coverage in the event the nurse that is scheduled to provide services is unable to work his/her schedule.

216-Fiscal Intermediaries

Must complete the process in PI Enrollment Checklist located in the appendixes of the ICWP Manual and have prior approval from DCH

289- Behavior Management

Documentation of direct clinical oversight and supervision by a psychiatrist who has one year providing neurobehavioral services or a licensed psychologist, certified rehabilitation counselor, or licensed professional counselor who has one year of experience in providing neurobehavioral services or traumatic brain injury services. (The psychologist, psychiatrist or counselor must be licensed in Georgia and readily available to the member unless the member has been approved to receive services out of state.)
Documentation that the behavior specialists has at least one-year experience working with individuals with traumatic brain injuries, other disabilities, and/or behavioral difficulties.
Documentation that behavior specialists successfully complete 40 hours of training in TBI, behavior analysis, and crisis intervention techniques provided by a Behavior Management program

041- Counseling

Minimum of a Master's degree in one of the behavioral sciences
Resume that details one year of related counseling experience provided to disabled individuals or individuals with TBI's).

067- Environmental Modifications

Building license or Contractor license
Resume of owner that details relevant experience providing home modifications such as installation of ramps and grab-bars, widening of doors, modification of bathrooms facilities, and installation of specialized plumbing and electrical systems necessary to accommodate medical equipment

275-Vehicle Adaptations

List the vehicle adaptations that agency is licensed to provide
Any industry required licensure that is required for a supply on your supply list.

ALS – Family Home Model, Specialty 310 Detailed instructions

Description: An ALS management agency must complete an application in GAMMIS for each sub-contracted family model personal care home. The ALS management agency is the provider. The ALS management agency provides medical supervision, ensures care plan compliance, bills for services provided to Medicaid members that live in the PCH, and pays the PCH the rate that is on the sub-contract.
Instructions: The ALS Management Agency must be an approved provider (specialty 312) at the time of the specialty 310 application.
The ALS Management Agency must provide their NPI, Tax ID, W-9, IRS form, EFT, Bank information, Liability Insurance on the application.
The ALS management agency's name should be the name of the business on the application.
The name of the family model PCH should be listed as the DBA name.
The address on the application must be the address of the family model PCH.

can be entered into the application if you choose to link the new contract to a current payee number.
Documents required from the ALS management agency:

Documents required from the ALS management agency:

IRS Form W-9. The payee name on the W-9 must match the business name as registered with the IRS
147-C Letter from the IRS
Power of Attorney for Payee. Must be completed **if** the designated payee is different from the applicant (signed and notarized).
National Plan and Provider Enumeration System and taxonomy code (NPPES)
Electronic Funds Transfer Agreement. The EFT is in GAMMIS under Provider Enrollment.
Voided check or a letter from the bank for the account in which funds are to be deposited
Resume for Registered nurse on staff detailing experience providing services to severely disabled and TBI individuals
RN License-Supervisory nurse
Staff orientation and training Plan with topics and timelines
General Liability Insurance Certificate - Must have 1,000,000 in coverage and 3,000,000 aggregate

Documents required from the Personal Care Home:

Subcontract with PCH
Fire Safety Inspection
Private Care Home permit that lists only 2 – 6 beds
HFRD Survey, clear of deficiencies or corrective action plan included
Pre-placement screening form (see appendixes in ICWP-**ALS** manual)
Diagram of PCH Floor Plan
Local city or county business license of the PCH

Specialty 310 applications DO NOT require the Assurances, Policies and Procedures, three years of experience in this specialty, or one year of experience providing services in another waiver. They are ALS Management Agency requirements which had to be met prior to their approval as a specialty 312 provider.

AppendixB
Standard Assurance

_____
(Legal Name of Provider Agency)

The assures and certifies with respect to this agreement that as a Provider of Home and Community Based Services, this agency must:

i. Comply with all Independent Care Waiver Services policies and procedures and service standards.

ii. Employ appropriate staff as required for the specific service types for which the agency has requested enrollment.

iii. Comply with Title VI of the Civil Rights Act of 1964. (See Attachment C)

iv. Be familiar with Section 504 of the Rehabilitation Act of 1973 and comply with the provisions set forth in it.

v. Understand that my agency staff is a mandated reporter of abuse, neglect, mistreatment, and/or exploitation.

_____

Signature of person legally authorized to act for the organization or person to whom responsibility for these assurances is delegated

_____

Typed name of above person

_____

Title

_____

Date

Assurance Of Compliance With Title Vi
Of The Civil Rights Act Of 1964

_____ (Hereinafter called the "Agency")

(Legal Name of provider agency)

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part

80) issued pursuant to that Title, to the end that, in accordance with Title VI and that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity financed in whole or in part by Federal funds, which the Agency provides or participates directly through a contractual or other arrangement.

The Agency agrees to make no distinction on the ground of race, color, or national origin with respect to admission policy or procedure or in the provision of any aid, care, service, or other benefits to individuals admitted or seeking admission to the Agency.

This assurance is given in consideration of and for the purpose of receiving any and all payments from State agencies receiving Federal grants. The Agency recognizes and agrees that State agency financial payments will be extended in reliance on the representation and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Agency, its successors, transferees, and assignees. The person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Agency.

_____
Name of Provider Agency

_____
Signature of Director or Administrator

_____
Typed name of Director or Administrator

_____
Signature of Owner or Chairman of Board

_____
Typed name of Owner or Chairman of Board

_____
Date

Letter Of Understanding

The _____
(Legal Name of Provider Agency)

understands and certifies with respect to this agreement that the following terms and conditions shall be met in order to receive recommendation for enrollment in the Independent Care Waiver Services Program:

1. Provider has consistently received a satisfactory rating for any other services it provides which is regulated by the Department of Human Services or the Department of Community Health.

2. Provider must participate in Independent Care Waiver Services Program New Provider training provided by the Alliant Health Solutions.

3. Provider understands that Medicaid enrollment does not guarantee client referrals.

_____
Signature of person legally authorized to act for the organization or person to whom legal authority is delegated

_____
Typed name of above person

_____
Title

_____
Date

Appendix C
Member Rights and Responsibilities

A. Member's rights include:

i. The right to access accurate and easy-to-understand information.

ii. The right to be treated with respect and to maintain one's dignity and individuality.

iii. The right to voice grievances and complaints regarding treatment or care that is furnished, without fear of retaliation, discrimination, coercion, or reprisal.

iv. The right of choice of an approved provider.

v. The right to accept or refuse services.

vi. The right to be informed of and participate in preparing the care plan and any changes in the plan.

vii. The right to be advised in advance of the provider(s) who will furnish care and the frequency and duration of visits ordered.

viii. The right to confidential treatment of all information, including information in the member record.

ix. The right to receive services in accordance with the current plan of care.

x. The right to be informed of the name, business telephone number and business address of the person/agency supervising the services and how to contact that person/agency.

xi. The right to have property and place of residence treated with respect.

xii. The right to review member's records on request.

xiii. The rights to receive care and services without discrimination.

xiv. The right to be informed on recognizing and reporting abuse, neglect, and exploitation.

B. Member's Responsibilities include:

i. The responsibilities to notify case manager/service provider(s) of any changes in care needs.

ii. The responsibility to treat provider staff in a courteous and respectful manner, as well as cooperate with and respect the rights of the caregivers providing care.

iii. The responsibility to be as accurate as possible when providing information on health history and personal care needs.

iv. The responsibility to participate actively in decisions regarding individual health care and service/care plan development.

v. The responsibility to comply with agreed upon care plans.

vi. The responsibility to notify the member's physician, providers, and/or caregiver of any change in one's condition.

vii. The responsibility to maintain a safe home environment and to inform providers of the presence of any safety hazard in the home.

viii. The responsibility to be available to provider staff at agreed upon times services are scheduled to be rendered and to case management staff both in person and using audio visual equipment when allowed by policy.

ix. By signing this form, member has read and understands member rights and responsibilities.

This _____ day of _____ 20_____

_____ _____

Print Name of Member/Legal Guardian

_____

Signature of Member
Legal Representative

_____ _____

Print Name of Case Manager Date Signature of Case Manager Date

Appendix D
Memorandum Of Understanding

(Rev. 10/2023)

Member_____ Medicaid Number_____

Purpose:

It is the intent of this agreement to provide an assurance that members understand the expectations and guidelines of the Independent Care Waiver Program (ICWP). The members must follow specific guidelines in order to ensure compliance with the Plan of Care. Failure to follow these guidelines may result in termination from the program. Signing this agreement indicates that you understand and will abide by the terms and conditions for participation in the ICWP as implemented by the Georgia Division of Medical Assistance. The following does not intend to address all of the conditions of participation, therefore please discuss with your case manager if you have any questions or concerns.

Special Participation Eligibility Criteria:

1. Medicaid eligible or potentially Medicaid eligible;
2. Between twenty-one (21) and sixty-four (64) years of age when services are started;
3. Have a severe physical disability and/or traumatic brain injury that substantially limits one or more activities of daily living and requires help from another person;
4. Medically stable but in or at risk of hospital or nursing home placement;
5. Does not have a primary diagnosis of a mental disorder or mental illness;
6. Certified for a level of care appropriate for placement in a hospital or nursing home;
7. Have a Plan of Care within the cost limit of the waiver;
8. Are able to be safely placed in a home and community setting; and
9. Currently in an institution or being placed in an institutional setting.

General Understanding:

1. Alliant Health develops the Initial Plan of Care.
2. Approval is needed in writing from Alliant Health for all services rendered under this program.
3. All services must be rendered according to the Individual Plan of Care signed by the member, case manager and the planning team.
4. Cost of care must be provided within the allocated budgeted amount.
5. A member may not participate in more than one Medicaid Waiver Programs at the same time.
6. The Utilization Review team will make in-home visits as needed and required.

Discharge of Members:

Discharge may take place when any of the following occurs:

1. Alliant Health in consultation with the case manager and other providers, determines that the member is no longer appropriate or eligible for ICWP

2. The Utilization Review (UR) staff recommends discharge (10 day notice is required).

3. The member has not received ICWP services for sixty (60) consecutive days.

4. The member has behavior that is disruptive, illegal, threatening, and /or dangerous to self or others.

5. The member refuses to comply with treatment/agreed upon plan of care.

6. The member chooses to be discharged or enters long-term facility.

7. The cost to serve member exceeds the allocated budgeted amount.
   The member will receive the discharge notice thirty (30) days prior to the effective date of discharge, stating the reason for the discharge, with the exception of #2 (Utilization Review).
   Additional terms_____
   As an ICWP consumer, it is your responsibility to be actively involved in achieving goals related to good health and community living. Goals identified for all participants in ICWP are:

1. Maintain maximum control over daily schedules and decisions.

2. Participate socially and be connected and involved in community activities of your choice.

3. Assume responsibility of cost-effective medical services and supplies.

4. Be responsible for behavior so that it will not place you at risk of social isolation, neglect or physical injury to yourself or others.

5. Maintain a diet that is balanced and appropriate for decreasing the risk of further disability.

6. Participate in interventions that maintain skin in a healthy condition, avoiding breakdowns

7. Understand and observe the medication regimen.

8. Participate in interventions of daily living without interruptions due to cognitive or physical impairments (self or informal caregiver report, observation by case manager, provider reports, etc.).

9. Maintain bowel and bladder program that promotes skin integrity, cleanliness and positive health status.

10. Perform transfers and mobility safely and when needed.

It is the responsibility as ICWP case managers to:

1. Respond to phone calls and requests in a timely manner.

2. Respect your choices throughout the development and maintenance of your individual community plan.

3. Provide you with options and information in order for you to make informed decisions.

4. Meet with you and your significant other and notify you of any changes in your service.

5. Consider ceasing ICWP services after a 30-day notice is given if any of the following activities are taking place; use of drugs or other harmful substances, consumer or household involvement in any type of illegal activity, lack of effort or concern in maintaining your physical health or emotional health, lack of effort or concern in actively participation in your life, or abuse of any services provided by ICWP.
   Mutual Responsibilities:
   The term of this agreement is for one year from the year of approval date and must be renewed annually or as warranted by mutual written consent of the member and the case manager.
   As a recipient of the ICWP, you may be assessed intermittently, but at least annually to determine if your care can be managed under the policy and fiscal limitations of the ICWP.

   This_____ day of_____20_____

_____ _____
Print Name of Member/Legal Guardian Signature of Member Date
Legal Representative

_____ _____
Print Name of Case Manager Signature of Case Manager Date

AppendixE
Consumer Directed Care Memorandum of Understanding

Member_____ Medicaid Number_____

Purpose:

It is the intent of this agreement to provide an assurance that members understand the expectations and guidelines of the Consumer Directed Care option under the Independent Care Waiver Program (ICWP). The members must follow specific guidelines in order to ensure compliance with the Plan of Care. Failure to follow these guidelines may result in a member returning to the traditional option or termination from the program. A member's signature on this agreement indicates that the member understands and will abide by the terms and conditions for participation in the Consumer Directed Care option as implemented by the Georgia Division of Medical Assistance. The following is not intended to address all of the conditions of participation. Members should discuss any concerns or questions with their case manager.

In order to be eligible for Consumer Directed Care under ICWP the member must meet the following criteria:

1. Meet all ICWP eligibility criteria
2. Be motivated to self-direct care
3. Be willing to assume responsibility for cost effective use of Personal Support Services
4. Does not have a history of behavior that places self or others at risk
5. Must fulfill the training requirements of Consumer Directed Care by successful review and demonstration of understanding of the training sessions
6. Is able to maintain maximum control over daily schedule and decisions
7. Must stay within the established budget to remain eligible for Consumer Directed Care.
8. Is able to make an informed choice to accept Medicaid Waiver services in a Plan of Care.
9. Must be willing to sign this Memorandum of Understanding (MOU) which outlines the roles and responsibilities of Consumer Directed Care.

General Understanding:

1. Alliant Health Solutions (AHS) develops the Initial Plan of Care.
2. Prior approval is needed from AHS for all services rendered.
3. All services must be rendered according to the Individual Plan of Care signed by the member, case manager, and approved by AHS.
4. Cost of care must be provided within the allocated budget. The funding for employee salaries, taxes and the FI agency fee cannot exceed the approved care plan budget.
5. A member may not participate in more than one Medicaid Waiver Programs at the same time.
6. The Utilization Review team will make in-home visits as needed or as required.
7. The member or his/her representative, to be referred to as the employer, is responsible for hiring, training, supervising, disciplining, terminating and paying their attendant through the FI.
8. The Employer will have the freedom to choose an enrolled Medicaid Fiscal Intermediary (FI).
9. The Employer will be responsible for staffing/scheduling employees as well as developing a backup plan in the event the employee is unavailable.
10. CDC services will not be paid during the time the member is admitted to a hospital. Member and/or employer must not approve time worked during inpatient medical stays.
11. If the FI has provided the employer with any equipment to be used in submitting employee time,

the employer will be responsible for maintenance, proper use and replacement of the equipment.

12. The employer will be responsible for any cost associated with fingerprint-based background checks that exceed 5 per Plan of Care year.
13. If the fingerprint-based background check has not been confirmed by the FI, the employer will be responsible for paying any employee.

Discharge of Members:

Discharge may take place when any of the following occurs:

1. AHS, in consultation with the case manager, determines that the member is no longer appropriate or eligible for ICWP

2. The Utilization Review (UR) staff recommends discharge (10-day notice is required).

3. The member has not received ICWP services for sixty (60) consecutive days

4. 4. The member has behavior that is disruptive, illegal, threatening, and /or dangerous to self or others.

5. The member refuses to comply with agreed upon plan of care.

6. The member chooses to be discharged or enters long-term facility.

7. The cost to serve member exceeds the allocated budgeted amount.

8. The member knowingly and freely commits fraudulent activities.

9. If the Case Manager notifies the AHS Review Nurse that the member has failed to meet the following care path goals for two consecutive quarters:

Failure to maintain maximum control over daily schedule and decisions

- Preventable decline in health outcomes
- Failure to assume responsibility for cost effective use of medical services and supplies
- Unable to stay within budget for two consecutive months
- Allowing and authorizing payment to caregiver during inpatient medical stay
- Exhibition of problem or symptomatic behavior which places the ICWP participant at risk of social isolation, neglect, or physical injury to themselves or others

After reviewing the documentation submitted to AHS, the review nurse will determine if the member should remain in Consumer Directed Care or be returned to Traditional Services.

NOTE: If a member has been moved into the traditional option, the member must remain in CDC for one year before requesting to return to CDC.

ICWP Member Goals and Responsibilities:

As an ICWP member, it is your responsibility to be actively involved in achieving goals related to good health and community living. Goals identified for all participants in ICWP are:

1. Maintain maximum control over daily schedules and decisions.

2. Participate socially and be connected and involved in community activities of your choice to avoid social isolation.

3. Assume responsibility for the cost-effective use of medical services and supplies.

4. Avoid behaviors that may place you or others at risk for neglect or physical injury.

5. Maintain a diet that is appropriate for decreasing risk of further disability.

6. Participate in interventions to avoid skin breakdown.

7. Understand and follow the medication regimen.

8. Activities of daily living are not interrupted due to cognitive or physical impairments.

9. Maintain a bowel and bladder program that promotes skin integrity, and cleanliness.

10. Transfers and mobility will occur safely and as needed.

11. Remain compliant with the guidelines and rules on the Consumer Directed Care Policy Guideline and Agreement document.

It is the responsibility of ICWP case managers to:

1. Respond to phone calls and requests in a timely manner

2. Respect members' choices throughout the development and maintenance of individual care plan.

3. Provide members with options and information to allow for informed decisions.

4. Meet with members and their support system to discuss changes in their service.

5. The case manager must notify AHS if any of the following activities are taking place:
    - use of drugs or other harmful substances,
    - consumer or household involvement in any type of illegal activity,
    - lack of effort or concern in maintaining your physical health or emotional health,
    - lack of effort or concern in actively participating in your life,
    - or abuse of any services provided by ICWP.

ICWP will review the provided information and determine if probationary status is needed or if termination of services should be initiated.

Mutual Responsibilities:

The term of this agreement is for one year from the year of approval date and must be renewed annually or as warranted by mutual written consent of the member and the case manager.

As a recipient of the ICWP, you may be assessed intermittently, but at least annually to determine if your care can be managed under the policy and fiscal limitations of the ICWP.

As a member of the Consumer Directed option, I understand that I, or my documented representative, assume the responsibility of Employer and all the related duties required of my attendants. This process has been explained to me and all of my questions have been answered.
This__day of__20_____

Print Name of Member/Legal Guardian		Signature of Member Legal Representative	Date
Print Name of Case Manager		Signature of Case Manager	Date

Appendix F

Participant Assessment Form (PAF) (Independent Care Waiver/ Traumatic Brain Injury Program)

Identify Assessment site:		Facility Name:	
Assessment Mode:			
Assessing RN:		Date	

Identifying Information

Client Name: Social Security #

Street Address: Apt#

City: State: Zip:

County:

Date of Birth: Age: Sex:

Phone #: Email:

Marital Status Primary Language: Interpreter needed?

Note:

Highest Level of Education Completed:

Area of study OR Primary Career/Job:

Medicaid #
Note:

Medicare?
Private insurance?

Do you have a legal guardian?
Note:

Guardian's Name:

Do you have a Power of Attorney?
Note:

POA Name:

Person(s) assisting with this assessment:

Name	Relation to applicant	Phone#	Miscellaneous

Current Diagnoses:

Diagnoses	*Date of Onset*	*Diagnoses*	*Date of Onset*

Neurological

Level of consciousness (LOC):

Oriented to:		Person			Place			Time
Responds to:		Verbal stimulation			Touch stimulation			None
		Follows commands Appropriately			Does not follow commands			
Face:		WNL/ symmetrical			Asymmetrical			
					Rt/ side droop			Lt/ side droop

Section Note:

Hearing, Speech, and Vision

Ability to hear:	
Hearing aid or other hearing appliance used?	
Speech Clarity: -	
Making Self-understood:	

Vison:		WNL		Wears/needs glasses		Glaucoma		Cataracts	
	Other:								
Dental:		WNL		Other:					
Section Note:									

Respiratory:	**WNL**- breathing spontaneous and unlabored						
	Short of breath on exertion		Short of breath at Rest		COPD		Asthma
	Nonproductive Cough		Productive Cough		Uses CPT Vest		
	Tracheostomy:		Requires supplemental oxygen/ ventilation assist:				
	Nasal Cannula		Face mask		CPAP		BiPap
	Ventilator:		Trilogy:				
Section Notes:							

Cardiovascular:	**WNL**					
	High BP		Heart attack		CHF	Anemia
	High Cholesterol		Stents		CAD	AFib or other dysrhythmias
	Edema		Bypass		PVD/ PAD	
Section Notes:						

Gastrointestinal:	HT:		WT:		WNL- Weight stable with no issue		
	Obese		Difficulty swallowing food or pills		Reflux		
	Underweight/Malnourished		Decreased appetite		Heartburn		
	Cirrhosis/ Ascites		Increased appetite		Ulcers		
Section notes:							

Nutritional Needs: Please describe any special dietary needs, including allergies, need for modified food, and preferences. For tube feeding include rate/ amount, bolus or cyclic.

Diet:

Food Allergies?			
Feeding Tube:			
Tube Feeding Name:		Amount:	Rate:
Feeding tube Flushes:			
Section Notes:			

Physical Status: For at least 60% of assessment, client was:

	In bed		Resting in chair		Up ambulating		Other:

Musculoskeletal: | | WNL: Full ROM to all 4 extremities without difficulty

	SCI at level:

	Paralysis		Waist down		Mid-chest down		Neck down		Left side		Right side

Dominant side:		Right		Left
Affected side:		Right		Left

Physical Status:		WNL/ No impairment. Skip to section devices/aides used by client

Physical Status **Upper** *extremities*					
LUE		WNL/ No impairment	RUE		WNL/ No impairment
		No Independent movement			No Independent movement
	Paralysis		Weakness Spasticity		Paralysis	Weakness Spasticity
Amputation:			Amputation:		
Prosthesis:			Prosthesis:		
Contracted:			Contracted:		
Edema:			Edema:		
Not able to move fingers			Not able to move fingers		
Not able to bend at elbow			Not able to bend at elbow		
Not able to shoulder shrug			Not able to shoulder shrug		
Not able to do Passive ROM to the affected side by using the stronger side			Not able to do Passive ROM to the affected side by using the stronger side		
Comment:			*Comment:*		

Physical Status **Lower** *extremities*			
	LLE	WNL/ No impairment	RLE WNL/ No impairment
		No independent movement	No independent movement

Paralysis ☐ Weakness Spasticity	Paralysis Weakness Spasticity
Amputation:	Amputation:
Prosthesis:	Prosthesis:
Contracted:	Contracted:
Edema:	Edema:
Not Able to toe tap	NotAble to toe tap
NotAble to bend at knee	NotAble to bend at knee
NotAble to bend at hip	NotAble to bend at hip
NotAble to do Passive ROM to the affected side by using the stronger side?	NotAble to do Passive ROM to the affected side by using the stronger side?
Comment:	*Comment:*

Indicate devices and aids used by the Client. Check all that apply

	Manual wheelchair	Walker
	Motorized wheelchair and/or scooter	Orthotics/ Prosthetics
	Mechanical lift	None / Other
Comments:		

Ambulation/Locomotion Indicate Primary mode of locomotion:

1. Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
2. With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
3. Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces
4. Able to walk only with the supervision or assistance of another person at all times.
5. Chairfast, unable to ambulate but is able to wheel self independently.
6. Chairfast, unable to ambulate and is unable to wheel self.
7. Bedfast, unable to ambulate or be up in a chair.

If 1, 5,6, or 7 is selected then skip to section:

	Coding for Mobility. Activities may be completed with or without assistive devices.
1.	**Independent** – Patient completes the activity by themselves with no assistance from a helper.
2.	**Supervision or touching assistance** – Helper provides verbal cues, touching, steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
3.	**Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
4.	**Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
5.	**Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.
6.	**Not asked, N/A**. Provide explanation in comments.

Bed Mobility

Roll left and right: The ability to roll from lying on back to left/right side, and return to lying on back on the bed.
Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with no back support.
Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
Section comments:

Transferring:

Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
Section Comments:

Ambulating:

Walk 10 feet: Once standing, the ability to walk across a room.

Walk 50 feet with two turns: Once standing, the ability to cross 2 rooms and/or hallway- making at least two turns.
1 step (curb): The ability to go up and down a curb or up and down one step.
4 steps: The ability to go up and down four steps with or without a rail
12 steps: The ability to go up and down 12 steps with or without a rail.
Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
Section comments:

Notes:

Functional Abilities

Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
Meal prep: planning meals, assembling ingredients, cooking, setting out food and utensils

Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front- opening shirts and blouses, managing zippers, buttons, and snaps.
Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes.

Grooming: Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth/ denture care, or fingernail care).
Section Notes:

Bed bathtub Walk in shower tub/shower Grab bars

Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).

	Able to bathe self in shower or tub independently, including getting in and out of tub/shower.	
	With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.	
	Able to bathe in shower/ tub with the intermittent assistance of another person:	
		intermittent supervision, encouragement or reminders
		to get in and out of the shower or tub
		for washing difficult to reach areas.
	Able to participate in bathing self in shower or tub but requires presence of another person throughout the bath for assistance or supervision.	
	Unable to use the shower or tub, but able to bathe self independently at the sink, in chair, or on commode.	
	Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.	
	Dependent- Unable to participate effectively in bathing and is bathed totally by another person.	

Section notes:

Bladder and Bowel

Toilet Transferring:	Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

Toileting Hygiene:	Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

Urinary Continence

Catheter: External/condom Indwelling Intermittent suprapubic
Dialysis: Days: Shunt:

Bowel Incontinence Frequency

Bowel Program _____

Diaper/pull-up/brief ☐ disposable chux ☐ reusable pad

Section notes:

Pain WNL/ No issue

Chronic- Location: ____

Takes scheduled narcotic pain medication Pain is managed by pain clinic

Takes PRN prescription pain medications Pain is managed by Primary doctor/ facility

Take OTC medications as needed Other: _____

Ask: "Over the past 5 days, have you limited your day-to-day activities because of pain?"

Notes:

Skin: WNL/ none = skin intact- Skip to section:

Is client at risk for developing pressure ulcers?

Does the client currently have 1 or more unhealed pressure ulcer? Yes No

Comment
Hx of healed pressure ulcer:

Other Ulcers, wounds and skin problems:

Cellulitis Diabetic foot ulcer(s) Open lesion(s)

on the foot Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer

lesion)

Surgical wound(s) Burn(s) (second or third degree) Skin tear(s)

Moisture Associated Skin Damage (e.g., incontinence-associated dermatitis, perspiration, drainage).

Skin and Ulcer treatments: **N/A**

Turning/repositioning program: How often?

Pressure reducing device for bed. Pressure reducing device for chair

Other:

Pressure ulcer care provided by: _____

Notes:

TBI Screening Tool:

Have you ever had a head injury (i.e. due to an accident, physical assault, sports injury, or fall)?	Yes	No
If the answer to the previous question is "yes," did you lose consciousness as the injury?	Yes	No
Were you ever hospitalized or treated in an emergency room following an injury to the head?	Yes	No
If so, did you undergo a CAT scan, MRI, EEG or were you seen/treated by a neurologist?	Yes	No
Did a physician ever confirm a traumatic brain injury?	Yes	No

If so, who, when, where and through what diagnostic test? _____

Mental Health screening

Behavioral: WNL TBI None noted/ unable to determine other: _____

Is there a history of Intellectual or developmental delay?

Is there any indication of suicidal ideation?

Is there a history of mental illness?

Is there any evidence of psychosis (i.e. delusions, hallucinations, paranoid ideation)?

Are you currently under psychiatric care?

If yes, provide the doctor/ clinic: _____

Notes:

Drug and Alcohol Use

Do you use tobacco? Cigarettes Vape Chewing Tobacco Other: _____

For how long?_____Amount?_____Quit? _____

Do you use alcohol?

How Often?

Do you currently use any illegal substances?

Notes:

Medication

Are you allergic to any type of medication?	If yes, what medications and type of reaction:

For Diabetics: Is BG controlled? How is it controlled?

Are you able to check/monitor your BG? Are you able to administer your insulin?

Explain any assistance that is needed, and why, with administering and taking your medication:

List all medications currently used, including OTC:

Medication	Dosage	Route	Frequency

Does the applicant understand the purpose and time for this medication? Knowledge of medication or the ability to learn if knowledge deficit is present?
Comments:

List personal physicians and specialists:

Name	Specialty:	Date last seen:

Have you had any hospitalizations in the past year?

Diagnosis	How long were you there	Approximate Dates

Hospital of Choice: _____

Current Therapies

Are you receiving any therapies?

Therapy	Frequency	

Physical		
Speech		
Occupational		

Section Notes:

Self- reported:

Ask: “In general, how would you rate your health?”

How many hours are you out of bed on a typical day?

How many times are you able to leave your home and go into the community during a typical week?

Please describe obstacles preventing you from participating in the community as you wish.

What access do you have to transportation? Consider dependability, ease of access, and how frequently transportation is available.

GOALS: What is your personal goal/ what are you hoping to achieve/ or describe why you want to be in ICWP. (***The individual needs to answer this section, not their advocate. If the advocate answers for the individual, the nurse needs to note it on the PAF).

Assessor: comment on the answer and whether it seems appropriate and realistic:

Describe your interests/ hobbies on any typical day: (Examples: watching TV, using the computer, recreation, socializing, leisure outside the home, work, volunteer activities, school, housework, yard work, going to movies, games, bingo, reading books, etc.)

In the event of an emergency, such as severe illness or fire, what would you do?

Assessor: comment on the answer and describe if the answer seems appropriate and realistic.

If you are alone and in need of general help, but it isn't medical or life threatening, who are you most likely to call? Not Asked No one Unable to respond

Family/ significant other Neighbor Friend Other:

Assessor: comment on the answer and describe if the answer seems appropriate and realistic.

Section Notes:

Cognitive Patterns:

Does the applicant/care giver indicate any problems with memory?
Should Brief Interview for Mental Status be Conducted?

Repetition:

Ask Client: “I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are sock, blue, and bed. Now tell me the three words.”

Number of words repeated after first attempt.

IF needed: repeat the words using cues ("sock, something to wear; blue, a color;

Section notes:

bed, a piece of furniture"). You may repeat the words up to two more times.

Temporal Orientation. Ask the client:

"Please tell me what year it is right now."

"Please tell me what month it is right now."

"What day of the week is today?"

Recall:

Ask resident: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock".

B. Able to recall "blue".

C. Able to recall "bed".

Memory:

Seems or appears to recall after 5 minutes?	Yes	No	N/a	Unable to determine
Seems or appears to recall long past?	Yes	No	N/a	Unable to determine

1. Inattention - Did the resident have difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said?

2. Disorganized thinking - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

3. Altered level of consciousness - Did the resident have altered level of consciousness as indicated by any of the following criteria?

Environmental Assessment:

Current Residence

Current place of residence (ie. house, apartment, etc.)? If

the client is in a facility, when was the Admit Date?

If in a facility, where did the client live before admission?

What were the reasons the client entered the facility?

Is the client in an appropriate and safe living environment?

If applicable: is the client aware of ALS homes and would they be willing to transfer to one in order to receive ICWP?
Does client feel safe in current home?

Are there stairs inside of the home?

Are there stairs to get in/out of home? Does home h

Does the home have a ramp Need a ramp

Is the client able to access the area in the home:

Living area Bathroom area Kitchen area

Any plans to move? What is the future plans for living residence?

Assessors, please comment on the response and indicate whether it seems reasonable and appropriate.

Social Contacts And Support:

Do you have someone you plan to live with or want to live with?

Do you have a strong and supportive relationship with family/ friends living in the area (less than 30 minutes away)?

Informal Helpers: None

1. Age of individual: _____

   Relationship to individual:

   Employed:
   Distance to individuals home:
   Was person present during assessment?
   Ph:_____

2. Age of individual: _____

   Relationship to individual:

   Employed:
   Distance to individuals home: _____
   Was person present during assessment?
   Ph:_____

How often will the individual receive assistance from the informal support?

Needs Identified: Health and safety Risks: Risk for Falls Risk for Wounds Risk for hospitalizations Risk for aspiration

Recommended annual Preventative Healthcare:

Did the patient receive the influenza vaccine for this year's flu season? Yes No

Is the client's Pneumococcal vaccination up to date? Yes No N/a

If eligible, has the client received shingles vaccination? Yes No N/a

Last visit to PCP?

Waiver support

Is MFP following applicant? ☐Yes ☐ No

Are you receiving supportive services (PSS) through another waiver program? ☐Yes ☐No

If yes, which waiver? ☐CCSP ☐Source ☐NOW/COMP ☐GAPP ☐Home Health ☐Hospice
☐Other (Please specify)_____

Identify agency/ company: _____

Services Provided: _____

Hours received per day_____ Number of days per week _____

Are these hours sufficient to meet your needs? ☐Yes ☐No
☐N/A

Comment:

Do you have a Case Worker/Manager/Coordinator? ☐Yes ☐No ☐N/A If yes, provide the following:

Name: _____ Phone # _____ ext. _____

Agency: _____

Have you had any problems getting the health or social services you need? ☐Yes ☐No ☐N/A

If yes, please explain: _____

The following items have been discussed by the Alliant | GMCF nurse at the assessment:

Yes	No	
☐	☐	Applicants have been advised that this is a Medicaid waiver program.
☐	☐	Applicants have been advised to visit the Department Of Family & Children Services (DFACS) in the county in which they live to apply for Medicaid if they have not already done so and to inquire with DFACS for possible cost share.
☐	☐	Information has been given on the 'Traditional Care' option of managing personal support.
☐	☐	Information has been given on the 'Consumer Directed Care' option.
☐	☐	'Home and Community Based Services Information Booklet.' Has been given to the applicant
☐	☐	Applicant has been informed that they may be placed on a waiting list before services begin. ☐ **N/A**

INTERMEDIATE LEVEL OF CARE CRITERIA

The following status is assessed to determine if the applicant meets Intermediate Level of Care Criteria. This requires a "yes" in number 1 with a "yes" in any question from 2-8 from Criteria A, plus one item from Criteria B or C. If number 5 is chosen from Criteria C, another deficit in functional status is required to meet Intermediate Level of Care Criteria.

CRITERIA A (Medical Status):
Requires a "yes" in number 1 and a "yes" in any question from 2-8.

1. This applicant has a medical condition(s) that requires monitoring and overall management of a licensed physician. Yes☐ No☐
2. This applicant requires nutritional management which may include therapeutic diets or maintenance of hydration status. Yes☐ No☐
3. The applicant requires assistance to maintain skin integrity and/or treatment of skin conditions such as cuts, abrasions, or healing decubiti. Yes☐ No☐
4. The applicant requires catheter care such as catheter change and irrigation. Yes☐ No☐
5. The applicant requires therapy services such as oxygen therapy, physical therapy, speech therapy,

occupational therapy (less than five (5) times weekly. Yes☐ No☐
6. The applicant requires restorative nursing services such as range of motion exercise and bowel/bladder training. Yes☐ No☐
7. The applicant requires vital signs and laboratory studies or weights monitored. Yes☐ No☐
8. The applicant requires monitoring of medication regime. Yes☐ No☐

CRITERIA B (Mental Status):
The mental status must be such that the cognitive loss is more than occasional forgetfulness.

1. This applicant has documented short or long-term memory deficits with etiologic diagnosis. Yes☐ No☐
2. This applicant has moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making. (See MDS/Care Plan, if presently in nursing home.) Yes☐ No☐
3. This applicant has problem behavior, i.e., wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention. Yes☐ No☐
4. This applicant has undetermined cognitive patterns which cannot be assessed by a mental exam, for example, due to aphasia. Yes☐ No☐

CRITERIA C (Functional Status):

1. This applicant requires limited/extensive physical assist from another person to transfer and/or ambulate. Yes☐ No☐
2. This applicant requires assistance with feeding. Specifically continuous stand-by supervision, constant encouragement or cueing and set up of meals. Yes☐ No☐
3. This applicant requires direct assistance of another person to maintain continence. Yes☐ No☐

4. This applicant has documented communication deficits in making self-understood or understanding others. (Deficits must be addressed in medical record with etiologic diagnosis on MDS/Care Plan if presently in nursing home.) Yes☐ No☐
. This applicant requires direct stand-by supervision or cueing with one-person physical assistance to complete dressing and personal hygiene. Yes☐ No☐
****Applicant meets Intermediate Level of Care Criteria as outlined above: Yes☐ No☐

ICWP HOSPITAL LEVEL OF CARE CRITERIA

**To qualify an individual must meet the criteria set in #1 or #2 below. **
1. This category is for those individuals who require the skilled services of
Licensed medical professionals daily but may not meet Interqual Criteria for acute care hospitalizations. These individuals must meet the criteria in A, B
and C below.

A. The individual must have a condition that requires a treatment regimen that must be monitored by licensed medical professionals to ensure adequate care; for example, on ventilator, receiving parenteral nutritional supplementation, care of stage III or IV decubitus ulcers, a minimum of 4 hours per day of behavior management (TBI) or if the person has been receiving services in an inpatient hospital setting for more than 60 consecutive days and for whom it is likely that the stay would continue without ICWP services.

B. The family/circle of support must have been educated on the treatment

regimen by medical professionals and can articulate signs/symptoms to report to medical professionals.

C. The individual must have a condition that is expected to last at least six (6) months and normally requires services in an inpatient/skilled setting but can safely receive those services in community under the ICWP.
☐Criteria Met ☐Criteria Not Met

OR
2. The individual has a chronic condition that varies in intensity and severity of needs, such that the person frequently meets InterQual Criteria for acute care (general for regular ICWP member or psychiatric for TBI member) hospitalization (three (3) or more admissions per year), and the use of ICWP services has potential to reduce or eliminate the need for hospitalization.

☐Criteria Met ☐Criteria Not Met

ASSESSOR
***If in a nursing home, attach to this assessment 3 months of nursing home records, MDS (one year and quarterly report) and PASARR data. If in hospital, attach hospital record.
I have calculated the cost of care to be approximately $ _____ per year.
Narrative Summary:

Appendix G
Personal Care Attendant Allotment Worksheet Guidelines

Member Name: _____ Review Nurse: _____

LEVELS OF
CARE DESCRIPTION Enter
(□)
Level I Cognition and/or behavioral issues that require general safety oversight
Requires Medication Reminders
Moderate to total assistance with ADLs such as feeding, bathing, bowel care, grooming; and general housekeeping
Moderate to total transfer assistance to maintain continence and hygiene
Need assistance with feeding and meal prep
Needs assistance with elimination such as catheter/colostomy/urostomy care
Care of stage I or II decubitus ulcer
Tube feeding oversight and/ or administration of tube-feeding
Level II Requires a minimum of four hours a day of behavior management due to TBI
Unstable medical condition requiring three or more hospitalizations per year
Complex skilled needs such as trach care, ventilator care, or suctioning
Care of stage III, or IV decubitus ulcer
Receiving parenteral nutritional supplementation
Scoring Grid:

Basic needs: 4 hours/day¬¬____: body/mouth hygiene; dressing/undressing; simple transfers; light housekeeping; Grocery shopping; light meal preparation; basic range of motion; basic skin care; medication reminders.

System needs: Dependent on specific need +1 to +4 hours depending on clinical assessment (i.e., decreased Cognitive, respiratory, or cardiac functioning or decreased ability to communicate)

Elimination needs: Straight cath/Foley = 0 Bowel/Bladder training =1
Bowel/Bladder Program =1 hour
Intermittent catheterization qid =1 hour Transfer to maintain continence =+1
Incontinence care= +1

Nutrition: Complete dependence/Tube feeding =1 hour

Living Situation: Lives alone; single parent or limited assistance primary caregiver=1 hour

Skilled Nursing Needs as outlined in Level II: 4-8 hours depending on clinical assessment

Miscellaneous needs No. of hours Hours Allotted: Level I Level II

Total Hours Allotted:

Nurse's Additional Comments:

Appendix H
Independent Care Participant Application

Note: Please read all information concerning the Independent Care Waiver Program (ICWP), prior to completing this application. It is important that you become familiar with the ICWP rules and regulations that pertain to your Plan of Care. If you have any questions, please call Alliant Health Solutions at 1-888-669-7195. Please return application Alliant Health Solutions, P. O. Box 105406, Atlanta, Georgia 30348; or fax to 678-527-3001; or email HCBSWaivers@AlliantHealth.org

PERSONAL INFORMATION

Name: _____ Medicare# _____

Medicaid#_____

_____ Address: __

Private Insurance _____Y ___N

Social Security#_____

_____ Male _____

Female __

_____

County City State Zip

Phone#: (____) _____ Date of Birth: _____ Age: _____

Email: _____ @ _____ Income: $_____ (per. month)

Contact Person: _____ Phone#: (____) _____

Referral source and contact number/email:

_____

Primary Language: _____ Interpreter services needed _____Yes

_____No

DISABILITY INFORMATION

(Check all that best describes the reason for your disability)

	Spinal Cord Injury: Paraplegic			Amputation			Cerebral Palsy
	Level of injury:			Of what?			Muscular Dystrophy
	Spinal Cord Injury: Quadriplegic						Multiple Sclerosis
	Level of injury:			Parkinson's Disease			
	Head Injury			Spina Bifida			
	Stroke			CHF/ heart failure			
	Aneurysm			COPD/ Emphysema			
	Tumor			Diabetes			
	Arthritis or Rheumatism			Non- verbal			

Additional Diagnosis

_____

_____

Date of onset of disability: _____

How would you describe your general health?

Poor	Fair	Good	Excellent

(Check One)

1. If you had a choice, where would you choose to live? Is there a specific person(s) you would like to live with, or would you choose to live alone? Please explain.

_____

_____

2. What is your present living arrangement? Check one of the following:

House: is the home: owned rented

House Apartment

Nursing Home Hospital Group Home ALS/ PCH Other: _____

3. The ICWP does not allow members to live in Group Model Personal Care Homes. Would you be willing to move into an Alternative Living Services (ALS) Family Model Home? N/a Yes no

Nursing Home/ALS/ PCH Name:

_____

Address:

_____

_____

Phone number: _____

Social Worker: Phone: (_____) _____

Email: _____ @ _____

Date admitted: _____ Date discharged: _____

If application is being submitted and the applicant is in a Nursing home:

Is the applicant currently receiving: P Page **157** of **262** Speech Wound Care?

Please submit _____ history and physical ____ current medications ____ current progress notes

4. Transfer Method (please check one item that BEST describes how you transfer)

__ Two people assist with adaptive equipment

_____
Specify

__ Two people assist without adaptive equipment

__ One person assists with adaptive equipment

_____
Specify

__ One person assists without adaptive equipment

___ Can transfer without human assistance but with adaptive equipment

_____
Specify

__ Can transfer without assistance

__ Other: _____

5. ACTIVITIES OF DAILY LIVING NEED

Please indicate how much assistance you need:

	TOTAL	PARTIAL	MINIMAL	NONE
Bathing				
Dressing				
Eating				
Bowel/ Bladder Care				
Reposition to Prevent sores				
Other:				

6. EQUIPMENT YOU USE DAILY

	Use	Needed/Requested
Ventilator or Respirator		
Modified Power Wheelchair		
Regular Power Wheelchair		
Modified Manual Wheelchair		
Regular Manual Wheelchair		
Hoyer Lift		
Transfer Board		

Mouth stick		
Walker		
Brace(s)		
Prosthesis		
Crutches		
Cane		
Hospital Bed		
Hospital Bed w. Special Mattress		
Reacher		
Shower/Commode Chair		
Splints		

7. Do you require any of the following interventions?

Tracheostomy requiring suctioning		**BG checks/ insulin injections**	
Ventilator		**Wound Care**	
Tube Feeding		**Colostomy**	
Urinary Catheter		**Medication administration assistance**	

8. RELATIONSHIPS: Do you have regular visitors? Yes _____NO Who visits? (Check ALL that apply)

(Frequency)

_____ spouse _____

_____ parents _____

_____ friends _____

_____ pastor or Rabbi _____Other: _____

Do you live with someone or plan to live with someone? _____ If "YES", with whom? _____

Does that person provide any care? _____

9. Help needed at the following times (Check all that apply)

	Night	10:00 p.m. to 6:00 a.m.
	Morning	9:00 a.m. to Noon
	Afternoon	Noon to 4:00 p.m.
	Early Evening	4:00 p.m. to 7:00 p.m.
	Evening	7:00 p.m. to 10 p.m.

Total hours requested _____

Comments if needed:

---

10. Please identify caregivers who will commit to providing care on a daily basis.

Name	Relationship	Phone #
		( )
		( )
		( )

11. List all the medications you are currently taking:

Name of Medication	Dose Strength	How is it given? Oral/ inhaler/ injection	How often is it given?

12. List your current doctors you routinely see:

Doctors name:	Specialty:	City/ Location:	When did you last see the doctor?

13. How many times have you needed hospital care in the past year _____?

Diagnosis for your hospital admission?	How long were you there?	Approximate dates?

14. Are you currently receiving services from another wavier program? __Yes _____No

a. If so, from which program do you receive services? _____

b. How many hours per day or per week do you receive? _____

c. Do these services sufficiently meet your needs? ___Yes ___No

Why or Why not? _____

Please provide any additional information that would be helpful in identifying your needs.

_____

_____

_____

ATTESTATION STATEMENT

The information I have provided in this ICWP application is true and complete to the best of my knowledge.

_____ _____

Client / Client Representative Signature **Date**

Appendix I
Potential ICWP Medicaid Financial Application Worksheet

Client's Name _____ **Date of Birth** _____

Section I **INCOME**		**AMOUNT**
Social Security	$	_____
VA Benefits	$	_____
Retirement / Pension	$	_____
Interest / Dividends	$	_____
Other (specify)	$	_____
TOTAL INCOME	**$**	_____

Note: If monthly income exceeds the limit, stop here.

Section II **RESOURCES**	**ESTIMATED VALUE**	
Cash	$	_____
Checking	$	_____
Savings Account	$	_____
Credit Union Account	$	
Certificate of Deposit or IRA	$	
Stocks or Bonds	$	
Patient Fund Account (held by nursing home)	$	
House or Property other than home	$	

Appendix J
Renewal Participant Assessment Form

Care plan due date:	

Identifying Information

Member Name _____
Last First Middle Initial Suffix

Address: _____
Apartment#

_____
City State Zip County

Phone #: _____ Cell# _____

Date of Birth _____ Age: _____ ___Male ___Female

Have you moved in the past year? ___Yes ___No

If yes; when did you notify DFCS? _____

Living Arrangements at the time of the Renewal Assessment:
___Lives Alone ___With Other Family Member ___With Paid Help (not ICWP PSS)

___With Spouse/Significant other ___With a Friend ___ALS (Alternative Living Services)

As compared to 1 year ago, Member now lives with other persons (e.g. moved in with another or other person moved in with member). ___Yes ___No

Comments:

Member Name: _____

Medical Information

Current Diagnosis:

Medication List:

Skilled care duties required:

	Tracheostomy Care		Suctioning		Medication administration		Catheter Care
	Vent		Wound Care		Tube feeding set up/ administration		Accucheck/ injections
	Other:						

EVALUATION

What is the Member's condition compared to the last annual plan care year?

___Stable ___Improved ___Declining

Functional Potential:

___Member believes he/she is capable of increased functional independence

___Caregivers believe Member is capable increased functional independence

___Good prospects of recovery for current disease of conditions, improved health status expected

___None of the above

Member Name_____

Significant Changes in Last Year as reported by the ICWP member:

____Hospitalizations _____Functional Decline
____Caregiver Status change
_____New Diagnosis ____Loss of Loved One ____Any critical incident

Comments:

Member Name: _____

STATUS:

1. What was the date of the last physician visit? _____
2. Were any new physician's orders received this annual period? ___ yes ___ no
   If yes, please describe:

   _____

   _____
3. Were there any emergency room visits or hospitalizations during this annual period? ___ yes ___ no
   If yes, please provide the dates and diagnosis: _____

   _____
   a. Did you, the Case manager, submit a variance? ___ yes ___ no
4. Is the individual in jeopardy of moving from their home to a facility to get the care they need? ___ yes ___ no

Risk factors:

1. Does member have a history of nursing facility placement in the past year?	Yes	no
If yes, what were the reasons?		
2. Does the member have a progressive disease?	Yes	no
If so, state the disease:		
3. Has the member fell 2 or more times in the past year?	Yes	no
If so, has a fall safety program been implemented?	Yes	no
If the member has fallen, what were the contributing factors?		
4. Does the member have urinary incontinence?	Yes	no
5. Does the member have bowel incontinence?	Yes	no
6. Ventilator Care Prescribed to Participant?	Yes	no
If yes, What is the back-up plan in the event the ventilator is not functioning?		

Member Name: _____

If Incontinent, what devices does member use?

☐ Diaper/ pull-up/ brief	☐ In-dwelling cath	☐ Bowel program
☐ Chux	☐ Supra pubic cath	☐ Ostomy
☐ Urinal	☐ Self-cath	☐ Dialysis
☐ Condom cath	☐ Ileostomy/ ileoconduit	☐ Other: _____

Comments:

SKIN:

Does member have a wound? yes no

If yes, where is it located and what stage is it? _____

_____

_____

If yes, where is the wound being treated

☐	Home Health	☐	Wound Clinic
☐	Doctor's office	☐	Informal Caregiver
☐	Other:		

Please attach wound care notes. The notes should include location, stage of wound, current treatment plan, progress being made with treatment. If skilled PSS care for wounds has been approved, submit notes from the PSS provider detailing the additional care aides are providing.

Have you included these notes in a separate attachment? _____ *Yes* _____ *No*

Comments:

Member Name: _____

Primary Modes of Locomotion:

	No assistive device		Wheelchair
	Cane		activity does not occur
	walker/crutch scooter		Other:

Comments:

Memory Issues:

Based on your personal knowledge, does the member appear to have difficulties in remembering things?

- ☐ No issues
- ☐ No personal knowledge
- ☐ Yes, there are issues
- ☐ Member is non-verbal

If yes, would you classify memory difficulty as (choose one):

- ☐ Short-term memory problems that, with occasional reminders, do no cause difficulty in the person performing self-care tasks.
- ☐ Memory lapses that result in the person frequently not performing self-care tasks without reminders?
- ☐ Memory lapses resulting in the inability to perform routine tasks on a daily basis?
- ☐ Comments: _____

Member Name: _____

Behavior Issues:

Are there any behavior issues that may impact their ability to continue living in the community?		Yes	No
If yes, describe:			
Is the member:			
Smoking without supervision?	Yes	No	
If yes, interventions:			
Suspected alcohol abuse?	Yes	No	
If yes, interventions:			
Suspected drug abuse?	Yes	No	
If yes, interventions:			

Comments:

Personal Assistance Services Needed:

	Meal prep		Bathing		Routine hair care		exercise
	Feeding/eating		shaving		Routine skin care		laundry
	Oral care		grooming		shopping		Community outings
	transfers		dressing		cleaning		
	Assist with self-administered medication				Other:		

Comments:

ENVIRONMENTAL:

SAFETY Hazards:			**None**		
	Inadequate floor/ roof/ windows		Unsafe gas/electric appliance		lack of safety devices
	inadequate heating		inadequate cooling		Unsafe floor coverings
	inadequate stair railings		Other:		
Comments:					

Sanitation Hazards:			**None**		
	No running water		inadequate sewage disposal		no schedule trash pick-up
	Contaminated water		inadequate/improper food storage		cluttered/soiled living area
	No toileting facility		no cooking facility		insects/ rodents present
	Other:				
Comments:					

Social functioning:

In the past year has there been a decline in the member's level of participation in social, religious, occupational or other preferred activities?

	No		Decline, but individual is not distressed		Decline, and individual is distressed
	Other:				

Isolation:

How often is the member alone during the day?

☐ Never or Seldom ☐ About 1 hour ☐ Long periods of time ☐ All the time

Is the member involved in community activities (ex: church, shopping, social activities)?

☐ yes ☐ no

Comments:

Informal Caregiver:

Does the member have an informal support system?	☐	yes	☐	no
If yes, was the informal support person present for your renewal visit?	☐	yes	☐	no
no	☐	yes	☐	

If you answered "no" to any of the above questions, please explain:

Informal Caregiver Status (check all that apply):

☐ Caregiver is unable to continue in caring activities (e.g. decline in health of care giver makes it difficult to continue).

☐ Primary caregiver is not satisfied with support received from family and friends (e.g. other children of individual).

☐ Primary caregiver expresses feelings of distress, anger or depression.

☐ Caregiver expresses feelings of frustration with current PSS staffing

☐ No issues

☐ Other: _____

How often does the Member receive assistance from the Primary Informal caregiver?

☐	Several time during the day and night	☐	once daily	☐	1-2 times per week
☐	Several times during the day	☐	3 or more times per week	☐	less often than weekly

LIST MEMBER'S INFORMAL SUPPORT:

1. _____
   a. Lives with Member? ___Yes ___No
   b. Relationship to Member: ___child ___ spouse ___friend/neighbor ___parent
      Other: _____

2. _____
   c. Lives with Member? ___Yes ___ No
   d. Relationship to Member: ___child ___spouse ___friend/neighbor ___parent
      Other: _____

Member Name: _____

By signing below, I agree that I will continue to follow the Independent Care Waiver program's policies and procedures. I agree that if I have concerns or questions about the program, I will seek clarification from my case manager. If I am utilizing the Consumer Directed Care Option (CDC), I agree to follow the CDC's policy and procedures as well as maintain my budget as approved.

_____ _____

Client/Representative Signature Date

Member Name: _____

Case Manager Narrative

_____

_____ _____

1. Case Manager Signature Date

Appendix K
Independent Care Waiver Address Status Form
Complete With Annual Review and/or Change of Address

Member's Name:				**Medicaid ID:**			
Date Completed:							
Current Street Address:							
Apt. No:							
City:		**State:**		**Zip:**		**County:**	
Previous Street Address:							
Apt. No.							
City:		**State:**		**Zip**		**County**	

Member's Phone No.: _____ **Date Member Moved:** _____

Living Setting:

Private Home: ☐
Assisted Living: ☐
Licensed PCH: ☐
Other: ☐
ALS: ☐
Group Home: ☐

Member's support system, emergency contact or responsible party information:

Name:		**Relationship to Member:**	
Phone:		**Alternate Phone:**	
Street address:			
City:		**Zip:**	
County:			

Appendix L
Physicians Recommendation Concerning Nursing Facility Care or Intermediate Care for the Intellectually Disabled

Section A – Identifying Information

1. Applicant's Name/Address:

County_____

2. Medicaid Number:

3. Social Security Number

4. Sex | Age | 4A. Birthdate

7. Patient' s Na m e (Last, first, middle initial)

5. Type of Facility (Check One)
1. Nursing Facility
2. ICF/ID

6. Type of Recommendation
1. Nursing Facility
2. ICF/ID
3. Continued Placement

8. Date of Nursing Facility Admission
/ /

9. Patient Transferring From (Check One): Hospital Home Another Nursing home Private Pay Medicare

Recipient's Home Address:

Recipient's Telephone Number:

Date of Medicaid Application
/ /

9A. State Authority (MH & ID Screening)
Level I/II

This is to certify that the facility of attending physician is hereby authorized to provider the Department of Community Health, Division of Medical Assistance and the Division of Family and Children Services, Department of Human Resources with necessary information including Medical Data.

10. Signature _____ 11. Date _____

(Patient, Spouse, Parent or other Relative or Legal Representative)

Restricted Auth Code Date

9B. This is not a re-admission for OBRA purposes

Restricted Auth Code Date

Section B – Physician's Report and Recommendation

	1. ICD-10	2. ICD-10	3. ICD-10
12. Diagnosis on admission to the facility (hospital transfer report may be attached) 1. Primary_____2. Secondary_____3. Other _____			
12A. Diagnosis on admission to the facility (hospital transfer report may be attached) 1. Primary_____2. Secondary_____3. Other _____			

13. Treatment Plan (Attach copy of order sheet if more convenient) Hospital Dates:_____to _____

Hospital Diagnosis 1. Primary_____2. Secondary_____3. Other _____

Medications				16. Diagnostic and Treatment Procedures	
Name	Dosage	Route	Frequency	Type	Frequency

14. Recommendation Regarding Level of Care Considered Necessary
1. Skilled 2. Intermediate
3. Intermediate Care for the Intellectually Disabled

15. Length of Time Care Needed Months
1. Permanent 2. Temporary_____estimated

16. Is Patient free of communicable diseases?
1. Yes 2. No

17. This patient's condition could not be managed by provisions of community care or home health services.

18. I certify that the patient requires the level of care provide by a nursing facility or an Intermediate care facility for the intellectually disabled.

Physician's Signature

19. Physician's Name (Print)

Physician's Address (Print)

20. Date Signed by Physician / /

21. Physician's License Number

Physician's Phone Number ( )

Section C– Evaluation of Nursing Care Needed (check appropriate box only)

22. Diet	23. Bowel	24. Overall Condition	25. Restorative Potential	26. Mental & Behavioral Status
Regular Diabetic F o r m u l a L ow Sodium Tube feeding Other	Continent Occas. Incontinent Colostomy	Improving Stable Fluctuating Deteriorating Critical Terminal	Good Fair Poor Questionable None	Agitated Noisy Dependent Confused Nonresponsive Independent Cooperative Vacillating Anxious Depressed Violent Well Adjusted Forgetful Wanders Disoriented Alert Withdrawn Inappropriate Reaction

27. Decubitus	28. Bladder	30. Indicate Frequency Per Week							
Yes Surgery	Continent		Physical Therapy	Occupational Therapy	Remotive Therapy	Reality Orientation	Speech Therapy	Bowel and Bladder Retrain	Activities Program

No Date: Infected On Admission	Occas. Incontinent Catheter	Received							
29. Hours Out of Bed Per Day_____ Intake IV Output Bedrest	Catheter Care Colostomy Care Sterile Dressing Suctioning	Needed							

31. Record Appropriate Legend

IMPAIRMENTS	ACTIVITIES OF DAILY LIVING
1. Severe 2. Moderate 3. Mild 4. None	1. Dependent 2. Needs Asst. 3. Independent 4. Not App
Sight Hear Speech Ltd. Motion Paralysis	Eats Wheelchair Transfer Bath Ambulation Dressing

32. Remarks

33. Pre-Admission Certification Number	34. Signed	35. Date Signed / /

DO NOT WRITE BELOW THIS LINE

Continued Stay Review Date:_____ Payment Date_____ Approved for_____ Days_____

36. Level of Care Recommended by GMCF	LOS	37. Signature (GMCF)	Date: / /	38. Attachments (GMCF) 1. Yes 2. No

DMA-6 (Revised 08/11/2021)

Appendix M
Authorization for Release of Information (Submit annually with CarePlan)

I hereby request and authorize: _____
(Name of Person or Agency Requesting Information)

_____
(Address)

to obtain from: _____
(Name of Person or Agency Holding the Information)

_____
(Address)

the following type(s) of information from my records (and any specific portion thereof):

_____

_____

for the purpose of: _____

_____

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

☐ ***Ninety (90) days unless I specify an earlier expiration date here: _____.***
(Date)

☐ ***One (1) year.***

☐ ***The period necessary to complete all transactions on accounts related to services provided to me.***

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent. I may withdraw this consent at any time.

_____ _____
(Date) **(Signature of Member/Parent/Applicant)**

_____ _____ _____
(Signature of Witness) **(Title or Relationship to Member)** **(Signature of Parent or Authorized Representative, where applicable)** **(Date)**

USE THIS SPACE ONLY IF MEMBER WITHDRAWS CONSENT

_____

_____ _____
(Date this consent is withdrawn by member) **(Signature of Member)**

Form 5450 (Rev. 2-80)

Appendix N
Informed Consent (To be completed at all in-person case management visits)

Client Name: _____ ID: _____

Initial all that apply:

_____1. This is to certify that the ICWP is hereby authorized to release necessary information including medical data to the agencies which will provide services to me as outlined in the care plan. ***The level of care medical review team may request and/or retrieve additional medical information for the purpose of determining eligibility. Information may include hospitalization information, medical equipment needs, previous treatment, and medical history.**

_____2. This is to certify that I choose to participate in the ICWP-Traditional/Enhanced Services and participation is based on annual renewal/approval of level of care.

_____3. This is to certify that I received information about the Consumer-Direction Option for Personal Support Services

_____4. This is to certify that I received educational/referral information about Abuse, Neglect and Exploitation.

_____5. This is to certify that I choose placement in the community instead of nursing home placement.

_____6. Discharge plan / Emergency Preparedness plan discussed with client/representative.

_____7. This is to certify that I participated in the development of my Care Plan, including determining which services will be provided to me and which providers I choose through the Traditional/Enhanced Services.

_____8. This is to certify that I have been advised to contact my Case Manager with any service issues/problems.

_____9. I acknowledge the responsibility for the completion of the ICWP Medicaid application and submission of required documents to determine eligibility.

_____10. ALL OF THE MEDICAL, SOCIAL AND FINANCIAL INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

11. _____
SIGNATURE OF CLIENT OR CLIENT'S REPRESENTATIVE DATE

12._____
SIGNATURE OF ICWP CASE MANAGER DATE

Appendix O
Independent Care Waiver Communicator

The purpose of this form is to establish the Independent Care 30 day length of stay requirement for individuals whose Medicaid eligibility is based on Independent Care Waiver participation. Case Managers are to complete Section I of this form and forward to the appropriate DFCS caseworker.

Member Name	County	Medicaid Number
Member Name	County	Medicaid Number

SECTION I - COMPLETED BY CASE MANAGER

I. The above member has elected to accept Independent Care Waiver Program services. Case Management began effective _____, and the member was placed in an ICWP slot effective _____.

[ ] The member is currently receiving Medicaid. Please determine cost share.
[ ] The member has been referred for Medicaid eligibility and cost share determination.

Signature _____ Date _____

SECTION II - COMPLETED BY DFCS CASEWORKER

II. [ ] The member has been determined Medicaid eligible effective_____.
[ ] The member is receiving Independent Care Waiver services and is responsible for contributing $_____ monthly toward the cost effective _____.
[ ] The member has a change in cost share.

$_____ Effective _____
$_____ Effective _____
$_____ Effective _____

[ ] The above named member has been determined ineligible for Medicaid effective _____

Reason:_____

_____

[ ] Other_____

_____

Signature _____ Date _____

SECTION III - COMPLETED BY CASE MANAGER

III. [ ] The above named member is being released from the Independent Care Waiver Program effective _____. Reason:_____

_____

Signature _____ Date _____

Independent Care Waiver Program
Community Carepath Signature Sheet

Member Name:_____ DOB:_____ Medicaid No.:_____

Case Manager Name:_____
Print

_____
Signature

DMA-6 Date:_____
Plan of Care Dates:_____

By signing and initialing the lines below I am acknowledging that my plan of care and goals have been discussed between the member/caregiver and case manager conducted during the quarterly visits per ICWP policy and we are in agreement.

First Quarter/Renewal:_____ Date:_____
CM Initials:_____

Second Quarter:_____ Date:_____
CM Initials:_____

Third Quarter:_____ Date:_____
CM Initials:_____

Fourth Quarter:_____ Date:_____
CM Initials:_____

Obtain signatures every quarter and forward to Alliant Health with Annual Renewal. Enter the Carepath and Quarterly information in the web portal. The ICWP 'Community Care Path Signature Page' must have four signatures when it is uploaded with renewal care plan documents.

Rev. 8/1/2022

GOAL	PLAN	REVIEWS
1. ICWP participant will maintain maximum control over daily schedule and decisions. **PARTICIPANT INDICATORS:** **A. Participant contributes to successful design and implementation of community-based plan.** Key participant responsibilities: • Accept and participate in services planned with case manager • Provide accurate information on health status and care received • Maintain scheduled contact with case manager **B. ICWP participant anticipates needs and plans accordingly.** Indicators of inadequate planning include: • Recurrent depletion of supplies • Failure to develop or use back-up PSS plan. • Failure to promptly report faulty equipment to vendor. **C. ICWP participant communicates with PCA in a clear, positive and proactive manner.** Indicators of desirable patterns of communication include: • Clear communication directly with PSS attendant. • Problem solving around PSS issues prior to crisis level. • Establishing balance between critical job functions and desirable personality traits.	**CASE MANAGER:** _____ **EDUCATION** by case manager on service plan and provider roles. **LIVING ARRANGEMENTS:** _alone __roommate: with her son. __spouse and/or family: __paid companion_____ **X REVIEW/EDUCATION** by case manager in key areas (supply inventory, back up PSS plan, equipment repair, etc.), upon enrollment and as indicated. **EDUCATION** for ICWP participant on skills for clear, positive and proactive communication. _case manager counseling __role playing __peer counseling __assertiveness training NOTES: ___ Case _____	Baseline/Annual Review: (__/__/__) A. ___ met __not met B. ___ met __not met C. ___ met __not met Second Review (__/__/__): A. __met __not met B. __met __not met C. __met __not met Third Review (__/__/__): A. __met __not met B. __met __not met C. __met __not met Fourth Review (__/__/__): A. __met __not met B. __met __not met C. __met __not met

Participant Name: _____ Medicaid No. _____

Participant Name. _____ Medicaid No. _____

GOAL	PLAN	REVIEWS
Cont'd from Page 1 PROVIDER INDICATORS: **A. ICWP support services are delivered in a manner satisfactory to the participant and case manager.** Key provider performance areas: • Reliability of service • Responsiveness to participant concerns • Coordination with participant and case manager • Competence and compatibility of staffing **B. PSS staffing will be consistent, without excessive turnover.** **C. Supplies will be provided in a timely manner, in the correct amount and of the specific type ordered.** **D. Primary medical care will be characterized by:** • Availability of prompt appointments • Timely response to participant/case manager calls • PCP staff cooperation on issues related to meeting carepath goals • Appropriate specialist referrals	**PSS Provider: _____** **Primary Care Provider:_ _____** **Supplies Provider:** **Other Providers:** **MONITOR PROVIDER PERFORMANCE:** ICWP participant and case manager; routine conferencing and other communication as needed to meet carepath goals. NOTES_____ _____ _____ _____ _____ _____ _____ _____	Baseline/Annual Review (__/__/__) A. _-met—not met B. __met—not met C. __ met----not met D. __ met-----not met Second Review (__/__/__) A. met-----not met B. met------not met C. _met--------not met D. _met--------not met Third Review(__/__/__) A. Met---not met B. Met---not met C. Met----not met D. Met-----not met Fourth Quarter (__/__/__) A. Met----not met B. Met----not met C. Met-----not met D. Met---not met

Participant Name. _____ Medicaid No._____

GOAL	PLAN	REVIEWS
2. ICWP participant will be socially connected and involved in community activities of their choosing. **INDICATORS:** **A. Transportation is adequate and available.** **B. Participant is out of bed on a regular basis.** **C. PSS is adequate and appropriate for social and community involvement.** **D. Physical and/or mental health do not interfere with community or social activities.** **E. Opportunities are offered for community and social activities.**	**Main Community Activities*:** __education _____ _____ __work/training_____ _____ __volunteering_____ _____ __religious _____ _____ __leisure _____ _____ __other_____ _Senior Center _____ When_____ (*Indicate accompaniment by PSS aide) **Social/Emotional Support:** _ _____ **Transportation/Phone No.** Provided by:. NOTES: _____ _____ _____ _____	Baseline/Annual Review (date): (__/__/__) A. __met __not met B. __met __not met C. __met __not met D. __met __not met E. ___met __not met Second Review (__/__/__): A. __met __not met B. __met __not met C. __met __not met D. __met __not met E. __met __not met Third Review (__/__/__): A. __met __not met B. __met __not met C. __met __not met D. __met __not met E. __met __not met Fourth Quarter (__/__/__): A. __met __not met B. __met __not met C. __met __not met D. __met __not met E. __met __not met

Participant Name _____ Medicaid No. _____

GOAL	PLAN	REVIEWS
3. *ICWP participant assumes responsibility for cost effective use of medical services and supplies.* **INDICATORS:** **A. Participant seeks/accepts medical treatment as indicated for optimal health status.** **B. Participant utilizes emergency room appropriately.** **C. Participant identifies only essential personal care needs for performance by PSS attendant.** **D. Participant maintains inventory of medical supplies proportionate to need.** **E. Participant receives services according to the type, scope, amount, duration, and frequency as specified in the service plan.**	**EDUCATION** by case manager on criteria for accessing specific medical services: __Review criteria for medical services; discuss individual medical issues with participant as indicated. __Review with participant adaptive equipment available that may reduce reliance on human assistance. **IDENTIFICATION** of local/regional resources preferred for specific medical services. _ __hospital inpatient or outpatient:_ _ primary care physician: __specialists: __other_____ _____ **EDUCATION** NOTES_____ _____ _____ _____ _____	Baseline/Annual Review (date): A. __met __not met B. __met __not met C. __met __not met D. __met __not met E. ___met ___ not met Second Quarter (__/__/__): A. __met __not met B. __met __not met C. __met __not met D. __met __not met E. ___met ___not met Third Quarter (__/__/__): A. __met __not met B. __met __not met C. __met __not met D. __met __not met E. ___met ___not met Fourth Quarter (__/__/__): A. __met __not met B. __met __not met C. __met __not met D. __met __not met E. ___met __not met

Participant Name. _____ Medicaid No._____

GOAL	PLAN	REVIEWS
4. Problem or symptomatic behavior will not place the ICWP participant at risk of social isolation, neglect or physical injury to themselves or others. **INDICATORS:** **A. Living arrangements remain stable.** **B. Behavior will be managed by ICWP participant, informal caregiver and/or PSS attendant.** Signs of inadequately managed behavior include: • Hospitalization for behavioral issues • Increased level of caregiver stress (informal or paid) • Potential physical danger to self or others posed by behavior • Discharge from a program or service due to behavior. • High level of complaints/refusals-to-serve from PCAs.	**IDENTIFICATION** - with the ICWP participant and other parties involved - of the precise behavior(s) potentially putting participant at risk. **DEVELOPMENT OF A PLAN OF ACTION** to specifically address problem or symptomatic behavior (see attached as applicable).* **MEMORANDUM OF UNDERSTANDING** detailing plan of action, roles/ responsibilities, etc., signed by all parties.* NOTES_ (*attach to carepath as developed)	Baseline/Annual Review (date): A. __met __not met B. __met __not met Second Review (__/__/__): A. __met __not met B. __met __not met Third Review (__/__/__): A. __met __not met B. __met __not met Fourth Review (__/__/__): A. __met __not met B. __met __not met

Participant Name _____ Medicaid No._____

GOAL	PLAN	REVIEWS
5. *ICWP participant's diet will be balanced and appropriate for* **INDICATORS:** **Diet does not contribute to any of the following:** • **Related new diagnosis or exacerbation of existing diagnosis** • **Decreased function** • **Change in size of equipment** • **Skin problems**	**EDUCATION** on dietary/weight issues related to disability and overall health status: __primary care physician: __dietitian_____ __other_ **MEAL PREPARATION:** __self care (no assistance required) __informal/PSS caregiver(s)_____ _____ __home delivered meals_____ __PSS attendant (include G-tube) provider: _____ **MEAL PREP. SCHEDULE -** indicate SELF, INF, PSS or OTHER (optional): Mon_PSS/INFS_____B_PSS/NFL_____L_INF/PSS_____S Thurs_PSS/INF_____B_PSS_____LINF/PSS- S Tues_PSS/INF_____B__PSS/INF_____L_PSS/INF_____S Fri_PSS/INF_____B_PSS/INF_____L_PSS/INF_____S Wed_PSS/INF_____B_PSS/INF_____L__PSS/INF_____S Sat_PSS/INF_____B__PSS/INF____L__PSS/INF____S Sunday_PSS/INF_____B__PSS/INF_____L__PSS/INF_____S __gastrostomy tube informal caregivers:_____ skilled nurse/provider:_____ NOTES_____ _____ _____ _____	Baseline/Annual Review (date): ___met __not met Second Review (__/__/__): __met __not met Third Review (__/__/__): __met __not met Fourth Review (__/__/__): __met __not met

Participant Name: _____ Medicaid No._____

GOAL	PLAN	REVIEW
6. *Participant's skin will be maintained in healthy condition, avoiding breakdowns and pressure sores.*	**EDUCATION for participant or caregiver:** __physician_ __other_____ **MONITOR skin for integrity:** __self care __physician __informal/PSS support_____ __specialist_____ __PSS attendant/nursing supervisory visit: provider_____ __**ASSISTANCE REQUIRED:** ___turning/repositioning (see below) ___incontinence (see below) ___nutrition (see above) ___wound care/skilled nursing provider: Amicus Home Care_____ schedule:_____ ___specialized equipment: Hoyer lift_____ _____ Seating clinic:_____ _____ NOTES_____ _____ _____	Baseline/Annual Review (date): __met __not met Second Review (__/__/__): __met __not met Third Review (__/__/__): __met __not met Fourth Review (__/__/__): __met __not met

Participant Name. _____ Medicaid No._____

GOAL	PLAN	REVIEWS
7. *ICWP participant understands and observes medication regimen.*	**PHARMACY**_ **EDUCATION** for participant or caregiver: __physician: other_____ _____ **COORDINATION** between participant and physician(s) for efficient and effective medication management: __participant __ICWP case manager **ADMINISTRATION/MANAGEMENT:** __self-care __informal caregiver(s): __PSS attendant (cueing or as directed by participant) provider: schedule: _____ **OBTAINING MEDICATIONS:** __self care __informal caregiver: __pharmacy __PSS attendant NOTES_____ _____ _____ _____	Baseline/Annual Review (date): _met __not met Second Review (__/__/__): __met __not met Third Review (__/__/__): __met __not met Fourth Review (__/__/__): __met __not met

Participant Name: _____ Medicaid No._____

GOAL	PLAN	REVIEWS
8. *Activities of daily living are not interrupted due to cognitive or physical impairments.* **INDICATORS:** **Reports from participant, informal caregiver, case manager or provider of:** • **Problems with IADLs or ADLs (inadequate assistance, etc.)** • **Equipment repairs needed**	Indicate SELF; INF=informal support; or PSS=PSS aide (may be combination): ___PSS/INF_____bathing __PSS/INF_____dressing __SELF/PSS/INF transferring SELF/PSS/INF:turning/repositioning PSS/INF_toileting __SELF:bowel program __PSS/INF_____errands __PSS/INF_____chores __SELF/INF_____financial mgt. _PSS/INF_____meal preparation Informal caregiver(s)/role: assistance with adl's,errands,_____ _____ PSS provider: Amicus Home Care___ Total hours/week:_56 **PSS Schedule** (optional): __ERS provider:_ Responder(s):_ _____ NOTES_____ _____ _____ _____	Baseline/Annual Review (date): _met __not met Second Review (__/__/__): __met __not met Third Review (__/__/__): __met __not met Fourth Review (__/__/__): __met __not met

Participant Name _____ Medicaid No._____

GOAL	PLAN	REVIEWS
9. *Bowel and bladder care will promote cleanliness and positive health status.* **INDICATORS:** **A. Participant maintains acceptable personal hygiene (self or caregiver report, provider/PCP report, case management observation, etc.).** **B. Participant is free of excessive episodes of incontinence.** **C. Participant has no urinary tract infections or complications.**	**EDUCATION** for ICWP participant (and caregiver as applicable): __physician's office __other_____ **__catheter** ___intermittent catheter (IC) ___indwelling ___external ___self care ___assistance by informal caregiver:_____ __assistance by provider: Physician_____ schedule: _____ **__ostomy** ___self-care ___assistance by informal caregiver:_____ ___assistance by provider:_____ schedule:_____ **__bowel program** ___in bed ___raised toilet seat ___commode chair ___Digital stimulation ___suppository ___assistance by informal caregiver:_ son _____ ___assistance by provider: _____ schedule:_____ **SEE ATTACHED SUPPLIES.** NOTES_____ _____ _____ _____ _____ _____	Baseline/Annual Review (5/1/17): A. __met __not met B. __met __not met C. _met __not met Second Review (__/__/__): A. __met __not met B. __met __not met C. __met __not met Third Review (__/__/__): A. __met __not met B. __met __not met C. __met __not met Fourth Review (__/__/__): A. __met __not met B. __met __not met C. __met __not met

Participant Name: _____ Medicaid No._____

GOAL	PLAN	REVIEW
10. Transfers and mobility will occur safely and when needed. **INDICATORS:** **A. ICWP participant has no falls due to unsuccessful attempts to transfer.** **B. Participant is not restricted in activity due to inability to transfer or self-mobilize (self-report or caregiver report, etc.).**	**Physical Assistance:** __PSS/Informal caregiver(s): _____ __PSS provider: **Home Modifications:** RAMP: __has __needs (date obtained :) WIDER DOORWAYS: __needs (date obtained :) BATHROOM MODIFICATIONS: _has __needs (date obtained: AUTOMATIC DOOR OPENER: __has __needs (date obtained: _____) Other:_____ _____ _____ NOTES: _____ _____ _____ _____	Baseline/Annual Review (date): A. __met __not met B. __met __not met Second Review (__/__/__): A. __met __not met B. __met __not met Third Review (__/__/___): A. __met __not met B. __met __not met Fourth Review (__/__/__): A. __met __not met B. __met __not met

11. Ventilator care will continue in the event of an electrical interruption or natural disaster or equipment malfunction. **INDICATORS:** **A. ICWP Member has no interruption of Ventilator care.** **B. Ventilator Care Prescribed to Participant** **C. Emergency back-up plan in the event of an electrical interruption or natural disaster or equipment** (1)	Ventilator Care Prescribed to Participant? _____Yes _____No Emergency back-up plan in the event of an electrical outage, natural disaster, or equipment malfunction: _____ _____	Baseline/Annual Review (__/__/__): A. __met ___not met B. __met ___not met C. __met ___ not met Second Review (__/__/__): A. __met ___not met B. __met ___not met C. __met ___not met Third Review (__/__/____): A. __met ___not met B. __met ___not met C. __met ___not met Fourth Review (__/__/__): A. __met ___not met B. __met ___ not met C. __met ___not met

GOAL	PLAN	REVIEW
12. Physical and Wellness exam will occur annually and when needed. **A. Annual physical exam completed** **B. ICWP participant will receive recommended seasonal and preventative vaccines as needed**	**Approximate date of annual exam _____** **Seasonal vaccine received:** **A. Flu vaccine** **Preventive Vaccines received:** **B. Pneumococcal Vaccine – up to date** **C. COVID vaccine** **D. Shingles vaccine**	**Baseline/Annual Review (__/__/__):** **A. __met __not met** **B. __met __not met** **C. N/A** **Second Review (__/__/__):** **A. __met __not met** **B. __met __not met** **C. N/A** **Third Review (__/__/___):** **A. __met __not met** **B. __met __not met** **Fourth Review (__/__/__):** **A. __met __not met** **B. __met __not met**

NAME_____Medicaid No._____

GOAL	PLAN	REVIEW
		Baseline/Annual Review (__/__/__): Second Review (__/__/__): Third Review (__/__/___): Fourth Review (__/__/__):

EQUIPMENT SHEET

Equipment LIST FOR: _____ DATE: _____

Wheelchair Accessories		**Respiratory Equipment**		**Assistive Devices for Increased Function:**		**Miscellaneous:**	
Manual Wheelchair		ventilator		Specialty Phone		Electrical stimulation unit	
Power Wheelchair		Insufflator (cough assist)		Mouth stick		Portable Ramps	
Tilt in space wheelchair		Suction machine		Plate Guard		Augmented communication devices	
Wheelchair Cushion		Ambu- bag		Specialty Utensils		Reacher	
Wheelchair Lap Tray		other		Over the Stove Mirror		Shoe horn	
Lift Chair						sponge	
Mobility Assistance Devices		**Bathroom Equipment**		**Beds/ mattresses**		Dressing stick	
Quad cane		Tub grab bars		Hospital Bed		Sock aid	
standard Cane		Raised toilet seat		Specialty mattress			
Side Walker/ hemi walker		Bedside commode chair		Safety bed rails			
Lofstrand/ forearm crutches		Drop arm commode		Other:			
Regular Crutches		Upright shower chair		Over the bed table			
Rolling walker		Shower stool		**Transfer Devices**			
Walker without wheels		Reclining shower chair		Sliding board			
Walker platform attachment		Bath transfer bench		Hoyer lift			
scooter		Bathtub safety rail		Gait belt			

ICWP SUPPLY LIST FOR: _____ DATE: _____

SUPPLY ITEM	PER MONTH	PER	COST PER	TOTAL COST PER YEAR
Bowel and Bladder				
Gloves			$	$
Adult Briefs/ pullups			$	$
Bladder control pads cs			$	$
Chux			$	$
Wipes- disposable			$	$
Skin Cream:			$	$
Reusable under pads			$	$
Urinal			$	$
Bisacodyl box of 10			$	$
Glycerin box of 4			$	$
Magic bullets box 100			$	$
Fleet enema			$	$
Lubricant *M pays 4ea/mo.			$	$
Urinary leg bag			$	$
Other:			$	$
			$	$
			$	$
Feeding			$	$
TF formula case:			$	$
Glycerin swabs			$	$
Toothettes- bx 250			$	$
Sip and puff straws bx 100			$	$
Bibs- disposable cs500			$	$
Bibs- reusable			$	$
			$	$
			$	$
Trach Supplies			$	$
Inner cannula bx10			$	$
Trach care kit			$	$
Trach collar tie bx12			$	$
Drain sponge pk50			$	$
Multidose saline bx100			$	$
			$	$
Barrier spray			$	$
Peri wash			$	$
Heel protector			$	$
Elbow protectors			$	$
Skin barrier wipes bx50			$	$
Geomat			$	$
Reacher			$	$
			$	$
Grand Total:			$	$

Name: _____

Date: _____

Service Description	Frequency Intensity	Responsible Provider	Per Unit Cost	Yearly Cost
		Grand Total:		

Reference Sheet

Name: _____ Plan of Care Date: _____

This reference sheet will assist you and your provider in addressing your needs.

Your ICWP case manager is: _____
Phone number: _____

Your Emergency Contact Name: _____
Phone Number: _____

Personal Support Provider: _____
Phone Number: _____

Your Primary Care Physician: _____
Phone number _____

Supplies and Equipment
Supplies Provider _____
Phone number _____
Equipment Provider: _____
Phone number _____

Hospital for Emergencies: _____
Phone number: _____
Address: _____

Behavior Management: Yes ____ No _____
(if yes, see specific plan)

Notes:

Appendix Q
Quarterly Review Tool

Participant Name _____
QTR/Date _____

Answer Sheet (column A)	Notes (column B)
1.1 Control A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met	
1.2 Control A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met D. ___ met ___ not met	
2. Connect A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met D. ___ met ___ not met E. ___ met ___ not met	
3. Cost A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met D. ___ met ___ not met E. ___met ___ not met	
4. Behavior A. ___ met ___ not met B. ___ met ___ not met	
5. Diet A. ___ met ___ not met	
6. Skin A. ___ met ___ not met	
7. Meds A. ___ met ___ not met	
8. ADLs A. ___ met ___ not met	

9. B/B A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met	
10. Trans A. ___ met ___ not met B. ___ met ___ not met	
11. Vent care A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met	
12. Annual exams A. ___ met ___ not met B. ___ met ___ not met	

Participant Signature _____ Date_____ CM Signature _____

At the end of the quarter, complete column A and document compliance, progress, and continued appropriateness of the plan in column B.

This form is a paper copy of the electronic version and is not to be used for reporting purposes.

Case Managers must enter the quarterly reviews electronically in the Alliant Health Solutions Long Term Care System.

Case Manager Packet Submission Checklist

- ☐ DMA – 6
  - Member's signature & date
  - DOB
  - Last 4 of SSN
  - Diagnosis
  - MD's signature & Date (within 90 days of start/renewal of plan of care)
  - Case Manager's signature & date
- ☐ RPAF (Renewal Participant Assessment form) – Required for Annual Renewal and new admissions if it has been more than 6 months since the initial assessment.
- ☐ Narrative Summary – A detailed narrative is required annually OR if it has been more than 6 months since the initial assessment, OR if member has had any significant changes since the initial assessment was completed and may require additional services. Please address any health, safety, environmental, etc concerns in the narrative. The *Review Nurse will use information from the RPAF and/or Narrative to make a determination when processing any Change Requests.*
- ☐ Reference Sheet
- ☐ Equipment / Supply List
- ☐ Release of Information Form
- ☐ Care Path Goals(12 items/questions to address for Initial & Renewal) – Quarterly and Annual Carepath Goal Indicators must be entered electronically.
- ☐ Community Care Path Signature Page – This form must be included in the Annual POC Packet. Signatures must be obtained in chronological order on the day of the case manager's required quarterly visit. The Carepath Signature Sheet should never be pre-dated or pre-signed by the Case Manager or member.
- ☐ Financial Summary – must include accurate PSS hours and supplies.
- ☐ Address Status Form- Should be submitted with each renewal and *any time* the member's location of services changes.
- ☐ Memorandum of Understanding (MOU)
- ☐ Freedom of Choice
- ☐ Member Rights and Responsibilities
- ☐ CDC Option:
  - CDC Memorandum of Understanding (MOU)
  -

**It is the responsibility of the case manager to review the FI statements monthly with the member. Monthly, case managers should review the budget to ensure that members are still within CDC budget and will remain so for the remaining care plan year.

Appendix R
Freedom of Choice Form

It is the policy of the State of Georgia that participants have the option to receive appropriate services in the setting of choice. Further, it is the policy of the State to recognize the participant's individual dignity, providing safeguards to protect rights, health, and the welfare of recipients.

Based on these beliefs the State of Georgia assures that potential participants and their authorized representative(s) will be afforded an opportunity to make an informed choice concerning services. Once an individual is determined to be likely to require the level of care provided in a nursing facility or hospital the individual or his/her authorized representative will be (1) informed of any feasible alternative available under the waiver, and (2) given the choice of either institutional or home and community-based services, and (3) that the substance of the information provided will make one reasonable familiar with service options, their alternatives, and possible benefits and hazards, and (4) the disclosure of said information is designed to be fully understood and appears to be fully understood.

Verification
I have verified that the participant or his/her authorized representative have been informed about their choices in the manner outlined above.

_____ _____
Case Manager Date

Acceptance

I and/or my authorized representative have been informed of my choices and have chosen to participate in the Home and Community Based Services Program.

_____ _____ _____ _____
Participant Date Authorized Representative Date

_____ _____
Witness Date

Refusal

I and/or my authorized representative have been informed of my choices and have chosen to refuse waiver services.

_____ _____ _____ _____
Participant Date Authorized Representative Date

_____ _____
Witness Date

Independent Care Program
FREEDOM OF CHOICE FORM INSTRUCTIONS

Purpose

The intent of this form is to assure that the participants and their representatives will be:

(1) informed of this form is to assure that the participants and their representatives will be:
(2) given the choice of either institutional or home and community-based services.

The process ensures that participants and their representatives can make an informed choice concerning services option(s). The presumption of the law is that a person may consent for him/herself. This presumption should be abandoned only when it is evident that the individual is not capable of doing so. The Independent Care Program has chosen to involve and recognize the rights of all participants while at the same time protecting the rights of participants through the request of concurrent consent by participants' authorized representatives.

Whomever is selected as authorized representative must meet the three tests to effect consent; that is, he/she must be competent, adequately informed about the factors involved in the decision and be knowledgeable about the person for whom consent is sought, and voluntary (free from coercion or conflict of interest). The authorized representative must act based on the best interest of the person for whom his or her consent is sought. A suggested list of potential candidates for authorized representatives includes but is not limited to the following: guardian or conservator, parent, participant's spouse, adult child, adult next-of-kin, any responsible relative, and attorney(s). In the absence of an available, suitable candidate, an advocate appointed by the Georgia Advocacy Office may serve as the designated representative.

Process

Step (1) Provide an overview of service options, noting pros and cons related to each option; this includes inherent and potential risks, benefits and stigmas.

A) The content of the overview should make one reasonable familiar with service options
B) The presentation of information should be designed to match the participants' and/or his/her representative's level of comprehension.
C) Evidence of participant/representative understanding of information should be evidenced by discussion of same.

Step (2) Once information has been provided and appears to be understood, the provider should verify that information has been provided appropriately and is understood. Once verified, the form should be signed at the designated sign-off under verification statement.

1004.1. Step (3) Informed participant/representative chooses a service option. The informed participant/representative should sign under the appropriate statement that reflects their choice. In cases where the individual participant is a minor, and/or unable due to physical and/or mental causes to sign his/her name, and/or unable to legibly write his/her name, the participant's name should be printed, above signature or mark, if any, and initialed by the participant's authorized representative. Across and within all HCBS Waiver Programs, a non-family representative cannot represent more than three (3) waiver participants.

Step (4) Once form is completed (signatures under appropriate statements), it should be attached to the Plan of Care.

Appendix S
Discharge Notice

DISCHARGE NOTICE

DISCHARGE/TRANSFER NOTICE
INDEPENDENT CARE WAIVER PROGRAM

PROVIDER NAME: _____
PROVIDER NUMBER: _____
If transferring to new provider, new provider Medicaid number: :_____
PROVIDER ADDRESS: _____
_____
_____

MEMBER NAME: _____
MEDICAID NUMBER: _____

STATUS: □ Discharge □ Transfer Last Date of Service: _____

REASON FOR DISCHARGE:

□ Member or member's caregiver/legal guardian requests member be discharged or transferred (please check appropriate status). If transfer is indicated, please specify reason:

_____
_____
_____

□ Member no longer requires services.
□ Member expired.
□ Member no longer Medicaid eligible.
□ Utilization & Compliance Team recommends discharge.
□ Member has entered a Long Term Care Facility
□ Agency issues. Please provide explanation:

_____
_____
_____

□ Member, member's caregiver/legal guardian engages in/or allows illegal activities in the home or member, member's caregiver or others living in the home have inflicted or threatened bodily harm to another person within past 30 calendar days. (Must provide completed Incident Report).
□ Member or representative fails to adhere to the conditions of the "Member Rights and Responsibilities."
□ Member or representative refuses to comply with "Memorandum of Understanding."
□ Provider is no longer able to provide appropriate staff to render services to the member.
□ The enrolled member has not received ICWP Personal Support Services, Behavioral Management, and/or Case Management for sixty (60) consecutive days.
□ Transfer to new Case Manager or Service provider

REASON FOR TRANSFER

□ The member is transitioning to another waiver program.
□ CCSP □ SOURCE □ NOW/COMP □ ICWP Provider change

PROVIDER SIGNATURE: _____DATE:_____

Appendix T
Prior Authorization Request

PRIOR AUTHORIZATION REQUEST*

FOR DMA USE ONLY

PRIOR AUTHORIZATION NO.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
ATLANTA, GEORGIA 30334

Include This Number On All Claim Forms → 807725

1. Recipient Name (Last, First, Init.)			2. Medicaid ID No.
3. Birthdate	4. Sex	5. Address	Nursing Home ☐ Yes ☐ No / 6. Telephone (Area Code/Number)

7. Prescribing Physician/Practitioner Name And Address		10. Provider Of Service(s) Name And Address	
8. Medicaid Provider Number	9. Telephone (Area Code/Number)	11. Medicaid Provider Number	12. Telephone (Area Code/Number)

☐ HOME HEALTH ☐ PODIATRIST ☐ OPTOMETRIST ☐ PHYSICIAN ☐ PSYCHOLOGIST ☐ DME/OP ☐ DDS ☐ PHARMACY

13. Authorization Period: From / Through	14. Description Of Service(s) Requested	DEPT. USE ONLY 15. Rec. Type	16. Ctgy. Of Svc.

17. Primary Diagnosis Requiring Service(s)	18. ICD-9-CM
19. Justification And Circumstances For Required Service(s) (Use separate page if necessary)	

STATEMENT OF SERVICE(S)

LINE NO. 20	21. Description Of Procedures, Drugs, Equipment, Or Other Services	22. Procedure/ Drug Code	23. Requested Or Estimated Price Per Unit	24. Bill. Units	25. Months or Units Of Service	26. Units Per Claim Max.	26. Units Per Claim Min.	27. Max. Units Per Month
1								
2								
3								
4								
5								
6								
7								
8								

28. PROVIDER'S SIGNATURE

29. DATE SUBMITTED

30. REQUEST: ☐ APPROVED ☐ DENIED ☐ PENDING/ADDITIONAL INFORMATION ☐ APPROVED AS AMENDED	31. DMA SIGNATURE	32. DATE APPROVED
33. Explanation to Provider		

*Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program.

DMA-80 (6-00) **COPIES: WHITE: DMA; PINK: SERVICING PROVIDER; GREEN: RECIPIENT'S FILE; YELLOW: REQUESTING PROVIDER**

INSTRUCTIONS FOR COMPLETING THE PRIOR APPROVAL AUTHORIZATION REQUEST FORM - DMA 80

The prior authorization request form must be completed electronically in the web portal.

1. Participant Name - Enter the participant's complete name, last name first.

2. Medicaid ID Number - Enter the participant's complete Medicaid number exactly as it appears on the Medicaid card including alpha characters.

3. Birthdate - Enter participant's complete birthdate including the year of birth.

4. Sex - Enter M for male or F for female.

5. Address - Enter participant's complete address including city, state and zip code.

   In the area titled nursing home please indicate yes or no.

6. Telephone - Enter participant's complete telephone number including the area code.

7. Prescribing Physician/Practitioner Name and Address - Enter name and address of attending physician in this space. This should be the name of the physician who has written the orders for Waivered Home Care Services.

8. Medicaid Provider Number - Enter the provider number of the physician listed in number seven (7). If the physician is not enrolled in the Medicaid program, enter his/her state license number.

9. Telephone - Enter the telephone number of the provider listed in number seven (7).

10. Provider of Service(s) Name and Address - Enter the complete name and address of agency providing services. If form should be mailed to a different address please indicate mailing address.

11. Medicaid Provider Number - Enter the provider number of the agency providing the service(s).

12. Telephone - Enter the telephone number including the area code of the agency providing the services.

13. Authorization Period - Enter the beginning and ending dates of services to be provided. These dates must not exceed twelve (12) months. These dates must correspond with the number of months indicated in item number twenty-one (21).

14. Description of Services - Enter description of services requested.

15. For Division use only.

16. For Division use only.

17. Primary Diagnosis Requiring Services - Enter diagnosis and briefly describe condition.

18. ICD-10 CM – Optional

19. Justification and Circumstances for Required Service(s) - Enter the rationale for requested services including clear and concise explanation of overall condition and needs.

20. Line Number - Enter each service on a separate line. Each line represents one (1) year.

21. Description of Services - Enter the description of services being requested. Enter only one (1) service per line.

22. Procedure/Drug Code - Enter only procedure codes from current rate sheet in the appendixes of this manual.

23. Price Per Unit - Enter charge per unit.

24. Bill Units - Enter charge per units for service requested.

25. Months or Units of Service - Enter the exact number of months of service requested. This number must not exceed twelve (12) months and must correspond with the number of months requested in item number thirteen (13).

26. Units Per Claim - For Division use only.

27. Maximum Units Per Month - Enter the maximum number of units to be billed for the total twelve (12) month period.

28. Provider's Signature - Enter signature of person completing this form. The provider of service must sign the form.

29. Date Submitted - Enter the date completed.
    30, 31, 32, and For Division Use Only - Do not write in these spaces. Read spaces carefully when form is returned to determine the Division's decision.

Appendix U
Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

A. Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

For information on the Georgia Families, Georgia Families 360, or Non-Emergency Medical Transportation program, please access the overview document at the following link:

i. Policy Fee Schedule(s): https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Fee%20Schedules/tabId/20/Default.aspx
ii. Georgia Families Overview: https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx
iii. Georga Families 360 Overview: https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx
iv. Non-Emergency Medical Transportation Overview: https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

Appendix V
Georgia Advance Directive

Georgia Advance Directive for Health Care

By: _____ Date of Birth: _____
(Print Name) (Month/Day/Year)

This advance directive for health care has four parts:

PART ONE—Health Care Agent. This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.

PART TWO—Treatment Preferences. This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.

PART THREE—Guardianship. This part allows you to nominate a person to be your guardian should one ever be needed.

PART FOUR—Effectiveness and Signatures. This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care may be used in Georgia.

You may revoke this completed form at any time. This completed form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.

PART ONE—Health Care Agent

PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your health care agent. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your health care agent. If you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.

1. Health Care Agent

I select the following person as my health care agent to make health care decisions for me:

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

2. Back-Up Health Care Agent

This section is optional. PART ONE will be effective even if this section is left blank.

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

3. General Powers of Health Care Agent

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent´s authority includes, for example, the power to:

- **Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;**
- **Request, consent to, withhold, or withdraw any type of health care; and**
- **Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).**

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that under Georgia law:

- **My health care agent may refuse to act as my health care agent;**
- **A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and**
- **My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.**

4. Guidance for Health Care Agent

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

5. Powers of Health Care Agent After Death

(A) AUTOPSY

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent´s power by initialing below.

_____ (Initials) **My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).**

(B) ORGAN DONATION AND DONATION OF BODY

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my health care agent´s power by initialing below.

Initial each statement that you want to apply.

_____ (Initials) **My health care agent will not have the power to make a disposition of my body for use in a medical study program.**

_____ (Initials) **My health care agent will not have the power to donate any of my organs.**

(C) FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

_____ (Initials) **I want the following person to make decisions about the final disposition of my body:**

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

I wish for my body to be:

_____ (Initials) **Buried**

OR

_____ (Initials) **Cremated**

PART TWO—Treatment Preferences

PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART

ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.

6. Conditions

PART TWO will be effective if I am in any of the following conditions:

Initial each condition in which you want PART TWO to be effective.

_____ (Initials) **A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.**

_____ (Initials) **A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.**

My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

7. Treatment Preferences

State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) _____ (Initials) **Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.**

OR

(B) _____ (Initials) **Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.**

OR

(C) _____ (Initials) **I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:**

Initial each statement that you want to apply to option (C).

_____ (Initials) **If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.**

_____ (Initials) **If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.**

_____ (Initials) **If I need assistance to breathe, I want to have a ventilator used.**

_____ (Initials) **If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.**

8. Additional Statements

This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional

treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.

_____

_____

_____

9. In Case of Pregnancy

PART TWO will be effective even if this section is left blank.

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_____ (Initials) **I want PART TWO to be carried out if my fetus is not viable.**

PART THREE—Guardianship

10. Guardianship

PART THREE is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.

State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.

(A) _____ (Initials) **I nominate the person serving as my health care agent under PART ONE to serve as my guardian.**

OR

(B) _____ (Initials) **I nominate the following person to serve as my guardian:**

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

PART FOUR—Effectiveness and Signatures

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy,

or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

_____ (Initials) **This advance directive for health care will become effective on or upon _____ and will terminate on or upon _____.**

You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:

- Cannot be a person who was selected to be your health care agent or back-up health care agent in PART ONE;
- Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or
- Cannot be a person who is directly involved in your health care.

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

_____ _____
(Signature of Declarant) (Date)

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

_____ _____
(Signature of First Witness) (Date)

Print Name: _____

Address: _____

_____ _____
(Signature of Second Witness) (Date)

Print Name: _____

Address: _____

This form does not need to be notarized.

Appendix W
Procedure Codes and Reimbursement Rates

The appropriate invoice for reimbursement is the CMS-1500. The following procedure codes are for use in the Independent Care program.

Description	HIPAA Codes	Modifier	Description	Rates
Case Management	T1016		Case management, each 15 minutes	Max units 48 a month. $14.45 per unit (eff 7/1/2024)
Case Management	T1016	U1	Case management, each 15 minutes	Max units 48 a month. $14.45 per unit (eff 7/1/2024)
Enhanced Case Management	T2022		Case Management per month	Max units = 1 month $515.58 per month (eff 7/1/2024)
Enhanced Case Management	T2022	U1	Case Management per month	Max units = 1 month $515.58 per month (eff 7/1/2024)
Counseling	96152		Health and behavior intervention, each 15 minutes, individual	Max 2 units per day not to exceed 40 units per month $28.41 per unit (eff 7/1/2024)
Counseling	96152	U1	Health and behavior intervention, each 15 minutes, individual	Max 2 units per day not to exceed 40 units per month $28.41 per unit (eff 7/1/2024)
Environmental Modification	S5165		Home modification; per service	$20,000. per member per lifetime (eff 7/1/2024)
Environmental Modification	S5165	U1	Home modification; per service	$20,000. per member per lifetime (eff 7/1/2024)
Personal Emergency Response Installation	S5160		Emergency response system; installation and testing	max unit =1 $121.11 per resident (eff 7/1/2024)
Personal Emergency Response Installation	S5160	U1	Emergency response system; installation and testing	max unit =1 $121.11 per resident (eff 7/1/2024)
Personal Emergency Response – Monitoring	S5161		Emergency response system service fee, per month (excludes installation and	Max unit = 1 $40.36/month (eff 7/1/2024)

			testing)	
Personal Emergency Response - Monitoring	S5161	U1	Emergency response system service fee, per month (excludes installation and testing)	Max unit = 1 $40.36/month (eff 7/1/2024)
Skilled Nursing	T1030		Nursing care, in the home, by registered nurse, per diem	Max units per month = 31 $95.34/per day (eff 7/1/2024) * If an LPN was approved but an RN provided the service, the claim must be paid at the LPN rate.
Skilled Nursing	T1030	U1	Nursing care, in the home, by registered nurse, per diem	Max units per month = 31 $95.34/per day (eff 7/1/2024) * If an LPN was approved but an RN provided the service, the claim must be paid at the LPN rate.
Skilled Nursing	S9123	TD	Nursing care, in the home, by registered nurse, hourly	$23.84 per 15 minute unit (eff 7/1/2024) * If an LPN was approved but an RN provided the service, the claim must be paid at the LPN rate.
Skilled Nursing	S9123	U1 TD	Nursing Care in the home, by registered nurse, hourly	$23.84 per 15 minute unit (eff 7/1/2024) * If an LPN was approved but an RN provided the service, the claim must be paid at the LPN rate.
LPN Nursing	S9124	TE	Nursing Care in the home, by licensed practical nurse, hourly	$15.85 per 15 minute unit (eff 7/1/2024)
LPN Nursing	S9124	U1 TE	Nursing care, in the home, by licensed practical nurse, hourly	$15.85 per 15 minute unit (eff 7/1/2024)
Personal Support Level I	T2025	U5 TF	*Attendant care services per hour	Max = 24 hours a day and 744 hours a month $25.53 per hour (eff 7/1/2024)

Personal Support Level II	T2025	U5 TG	*Attendant care services per hour	Max = 24 hours a day and 744 hours a month $27.54 per hour (eff 7/1/2024)
TBI Personal Support Level I	T2025	U5 U1/TF	*Attendant care services per hour	Max = 24 hours a day and 744 hours a month $25.53 per hour (eff 7/1/2024)
TBI Personal Support Level II	T2025	U5 U1/TG	*Attendant care services per hour	Max = 24 hours a day and 744 hours a month $27.54 per hour (eff 7/1/2024)
Respite Care Services Level 1	S5150		Unskilled respite care, not hospice; per 15 mins	1 unit =15 minutes. max units 240/calendar month and/or 1440/year $6.38/unit (eff 7/1/2024)
Respite Care Services Level 1	S5150	U1	Unskilled respite care, not hospice; per 15 minutes	1 unit =15 minutes. max units 240/calendar month and/or 1440/year $6.38/unit (eff 7/1/2024)
Respite Care Services Level II	S5150	TF	Unskilled respite care, not hospice; per 15 minutes	1 unit =15 minutes. Max units=240 per month and 1440/year $6.89/unit (eff 7/1/2024)
Respite Care Services Level II	S5150	U1/TF	Unskilled respite care, not hospice; per 15 minutes	1 unit =15 minutes. Max units=240 per month and 1440/year $6.89/unit (eff 7/1/2024)
Respite Care Level III	S5150	TG	Unskilled respite care, not hospice; per 15 minutes	1 unit =15 minutes. Max units=240 per month and 1440 per year $7.39 per unit (eff 7/1/2024)
Respite Care Level III	S5150	U1/TG	Unskilled respite care, not hospice; per 15 minutes	1 unit =15 minutes. Max units=240 per month and 1440 per year $7.39 per unit (eff 7/1/2024)
Respite Service_ Full Day Level 1	S5151		Unskilled respite care, not hospice; per diem	Max = 14 days per year $105.01/day (eff 7/1/2024)
Respite Services Full Day Level I	S5151	U1	Unskilled respite care, not hospice; per diem	Max = 14 days per year $105.01/day (eff 7/1/2024)
Respite Services Level II full day	S5151	TF	Unskilled respite care, not hospice; per diem	Max = 14 days per year $121.09 per day (eff 7/1/2024)
Respite Services Level II full day	S5151	TF/U1	Unskilled respite care, not hospice; per diem	Max = 14 days per year $121.09 per day (eff 7/1/2024)

Respite Services full day Level III	S5151	TG	Unskilled respite care, not hospice; per diem	Max = 14 days per year $133.96 per day (eff 7/1/2024)
Respite Services full day Level III	S5151	TG/U1	Unskilled respite care, not hospice; per diem	Max = 14 days per year $133.96 per day (eff 7/1/2024)
TBI Specialized Medical Equipment and Supplies	T2029	U1	Specialized medical equipment; not otherwise specified waiver	$1134.24 max per month (eff 8/11/2023) No change eff 7/1/2024
Specialized Medical Equipment and Supplies	T2029		Specialized medical equipment; not otherwise specified waiver	$1134.24 max per month (eff 8/11/2023) No change eff 7/1/2024
Behavior Management	H2019		Therapeutic behavioral services; per 15 minutes	Max units=16 per day, 368 per month, and 80/week $22.34/unit (eff 7/1/2024)
Behavior Management	H2019	U1	Therapeutic behavioral services; per 15 minutes	Max units=16 per day, 368 per month, and 80/week $22.34/unit (eff 7/1/2024)
Adult Day Services	S5102		Day care services, adult; per diem	Max days = 31 $100.72 per day (eff 7/1/2024)
Adult Day Services	S5102	U1	Day care services, adult; per diem	Max days = 31 $100.72 per day (eff 7/1/2024)
Adult Day Services	S5101		Day care services, adult; per half day	Max units = 31 per month $61.53 per half day (eff 7/1/2024)
Adult Day Services	S5101	U1	Day care services, adult; per half day	Max units = 31 per month $61.53 per half day (eff 7/1/2024)
Vehicle Adaptation	T2039		Vehicle modification, waiver; per service	$15,000. per year (eff 7/1/2024)
Vehicle Adaptation	T2039	U1	Vehicle modification, waiver; per service	$15,000. per year (eff 7/1/2024)
Fiscal Intermediary	T2040	UC	Financial Management services	$95.00 per member per month (eff 7/1/2024)
Personal Support Services - Consumer Directed Services	T2025	U5 UC	Consumer Directed Care Personal Support services attendant care	$27.54 per hour (eff 7/1/2024) *See PSS rates above for Levels I &II

Alternative Living Services -Family Model	T1020		Personal Care Services, per diem, not for an inpatient or resident of hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant	$91.48 per day – (eff 7/1/2024) (payment to the individual model home must be no less than $54.89 per day)
Alternative Living Services -Family Model	T1020	U1		$91.48 per day – (eff 7/1/2024) (payment to the individual model home must be no less than $54.89 per day)

ICWP modifiers are as follows:

U1_____Traumatic Brain Injury
TF_____Intermediate Care (Level II)
TG_____High Complexity Care (Level III)
UC_____Consumer Directed Care
U5_____ Represent an hourly code
***A claim will not pay if a provider fails to use the correct modifier.

NOTE: Personal Support codes were identified as S9122 with the modifiers for one month in November 2005.

Appendix X
Consumer Directed Care Policy Guideline and Agreement

The Georgia Department of Community Health, Independent Care Waiver Program, Home and Community Based Medicaid Waiver program has implemented Consumer Directed Care (CDC) into the 1915 C waiver. The goal of this program is to offer Independent Care Wavier Program (ICWP) members the opportunity to direct their personal support services.

The member and/or representative may direct their personal support services through Consumer Directed Care. The member must be able and willing to be the employer to be considered for CDC. If the member is not able or willing to be the employer, (i.e., TBI) a member's representative may act on the member's behalf. Members must be trained in the roles and responsibilities of the employer and must have the capacity to perform the CDC employer function, e.g. Make hiring decisions; set schedules; and track and report hours of work time and perform other employer related functions.

The Case Manager is responsible for training all prospective EMPLOYERS (member/ representative). Once trained, the EMPLOYER agrees to perform all Employer related responsibilities including, but not limited to, hiring, training, and supervising personal care attendants. The policies listed below will assist CDC employers to understand the CDC program requirements. .

Eligibility Requirements for Consumer Directed Care

To be eligible for Consumer Directed Care, an individual must meet all the requirements below and any additional eligibility requirements located in Chapter 700 of the ICWP Manual Part II:

1. Meet all ICWP eligibility criteria
2. Be motivated and possess the skills to self-direct care
3. Be willing to assume responsibility for cost effective use of Personal Support Services.
4. Does not have a history of behavior that places self or others at risk
5. Must fulfill the training requirements of Consumer Directed Care by successful review and demonstration of understanding of the training content.
6. Is able to maintain maximum control over daily schedule and decisions.
7. Must be able to manage and stay within the established budget to remain eligible for Consumer Directed Care.
8. Is able to make an informed choice to accept Medicaid Waiver services in a Plan of Care.
9. Must be willing to sign the Consumer Directed Care Memorandum of Understanding (MOU).

Program Limitations

Consumer Directed Care is an alternative to Traditional PSS. Being an EMPLOYER is an important responsibility and should not be taken lightly.

The Medicaid Waiver program has the following limitations under the consumer/representative directed option:

1. The member or their representative will not be paid by Medicaid to direct and manage services.
2. A waiver participant's legal guardian (appointed by a probate court) may not be paid to provide services under the Consumer Directed Care Option.
3. A member's representative may not serve as a paid care giver employee.
4. A representative is not permitted to manage employer duties for multiple clients in the consumer direct option for ICWP or other waivers including EDWP, NOW, and COMP. The representative many not serve as direct care employees, nor can employees service as employer representatives.

5. An employee working for other employers in ICWP or other waivers including EDWP, NOW, and COMP will be evaluated by ICWP case management regarding daily hours worked for the ICWP member based on total hours worked across all waiver members, per employee.
6. The ICWP only provides services and care for the individual who have been found eligible for the Consumer Directed Care. Therefore, services are restricted to the benefit of the member.
7. Persons with a history of abuse, neglect, or exploitation may not be paid to provide any services under the Medicaid Waiver Program.
8. A participant's spouse or Domestic Partner may not be paid to provide services under the Consumer Directed Care.
9. Paid caregivers, family and others, are limited to reimbursement for 40 hours per 7-day work period. Inadvertent overtime must be paid following Department of Labor Rules and Regulations.
10. Employees are not paid to provide services while the member is admitted to a hospital or nursing facility.
11. Members may remain eligible for the ICWP up to 60 days while in the hospital. However, if any member has not received personal support service for 60 days they will be discharged from Consumer Directed Services.
12. A member's representative employer may only manage one ICWP Consumer.
13. Consumer Directed Care PSS cannot be duplicative of any other services.
14. An Employer may not pay an employee for vacation time or any other services not rendered according to ICWP policies.
15. An Employer may not exceed 12 hours of personal support services in a day per one employee. The work schedule must provide for relief of the employee and adequate rest and recuperation between scheduled work hours. Fatigue is an unacceptable risk to the member and work safety.

Note: Georgia Medicaid will not reimburse for personal care services when provided to recipients by legally responsible relatives, i.e., spouses, parents of minor children, or legal guardians, when the services are those that these persons are already legally obligated to provide, or the family normally would provide.

Services provided by relatives or friends, may be covered only if the member is geographically isolated and no one else is available to provide care, for example, in rural areas where the member may not have routine access to employees. All efforts must be made to identify staff to provide personal support services prior to utilizing family. If family or friends are approved to provide care:
* The relatives or friends meet the qualifications and training standards for providers of care;
* All training and qualifications of an employee must be met prior to rendering services to the member;
* Payment is made to the relative or friend as providers only in return for specific services rendered.

Employer Eligibility Requirements

Employer Responsibilities

Prior to enrolling in Consumer Directed Care the EMPLOYER must understand and follow the program requirements. The Employer must also agree to perform the following ongoing tasks:

1) Sign the Consumer Directed Care Option Memorandum of Understanding
2) Notify the case manager of the chosen Fiscal Intermediary (FI) and complete the Fiscal Intermediary Communication form (P2)

3) Coordinate services to transition into CDC. When it is determined that the member is approved to transition into CDC, a thirty (30) days written notice must be given to the personal support provider. The member may not move into CDC until the first (1st) of the month.
4) Submit required documents to AHS thirty days prior to the month when CDC services will start.
5) Must submit all required documents to the chosen FI by the 15th of the month prior to when services will begin. The documents will include employees social security numbers, CPR Card, First Aid training and all other documents requested by the FI. The chosen FI will communicate to the Employer and case manager the potential start date for CDC services to begin.
6) Must agree to stay with chosen FI for one year. If an Employer wants to change FI after one year he/she must give the FI a 30 day notice prior to the anniversary date of change request
7) Recruit and select employee(s) as outlined under "Program Limitation" section.
8) Arrange for substitute or back-up employees as needed.
9) Ensure that employees meets the following eligibility requirements:
    a) CPR
    b) First Aid
    c) Basic skills necessary to provide member's care
    d) Confidentiality regarding the services of the member's care
    e) Environmental and Fire safety
    f) Document all training sessions and maintenance of the employee file
    g) Have a 1-9 on the employee completed and maintain on file
    h) Complete an initial physical that includes TB screening (documentation of TB screening in the past 3 months will be accepted) and symptoms screening yearly per CDC guidelines, verified by the employer.

    (all required documents must be on file before a staff person can be paid under ICWP)

10) Notify selected employee(s) of their responsibilities
11) Assure that employment forms are completed and submitted to the Fiscal Intermediary
12) Develop a work schedule based on the approved Care Path
13) Train employee(s) to perform specific tasks as needed
14) Maintain updated copies of approved waiver Care Path
15) Develop and maintain a list of tasks for the employee(s) to perform
16) Must document tasks employees perform daily and keep a record of this in a
17) Approve employee time worked in the FI EVV system.
18) Complete an evaluation on employee(s) at least every thirty 30 days to assure that tasks are performed correctly and completely
19) Evaluate employee(s) performance in written document
20) Provide ongoing performance feedback to employee(s) verbal/writing
21) Terminate employee(s) employment when necessary and complete termination and give to the employee
22) Notify the FI provider of any necessary changes
23) Participate in the assessment and reassessment of ICWP eligibility
24) Communicate with the ICWP case manager on a regular basis
25) Track use of personal support hours, so as not to exceed the approved dollars and hours per plan year. Member is required to meet with their case manager at least monthly to review their budget reports
26) Must remain within a budget not to exceed 10% of their approved Plan of Care for one month, without a medical reason or approval from the contracting agency. If the member exceeds 10% above their budget for one month the member will be at risk of returning to the traditional option of the

Independent Care Waiver Program. If a member exceed 10% of their budget for two consecutive months the case manager, Alliant Health Solutions and DCH will assist the member with returning to the traditional option.

27) A member may not approve for one employee to work 24 hours a day. (Medicaid will not reimburse over 40 hours per week or more than 12 hours per day to one employee.
28) Avoid conflict of interest with employees, participant and/or other participating agencies.
29) Employer must not authorize or approve services provided while the member is inpatient in hospitals and other medical facilities. Funds paid to the employee by the FI that are later recouped by DCH must be repaid to the FI by the employer. A second occurrence of employee reimbursement during an inpatient stay will result in the member being removed from the CD option. The case manager, Alliant Health Solutions, and DCH will assist the member with returning to the traditional option.

NOTE: EMPLOYERS must obtain workman compensation insurance for the employees. The Fiscal Agent will assist the Employer (Member) with this task.

Representative employers must be available to perform the above employer responsibilities on an ongoing basis. The Employer must maintain a file of all the required documents of the employees. If requested, these documents must be made available to the Department of Community Health, Independent Care Waiver Program.

Once an applicant has met the general eligibility criteria and approved to be in ICWP by Alliant Health Solutions (AHS) An ICWP CDC Certified Case manager will assess their needs and provide consumer directed care training to the Employer. The following outlines the steps involved with certifying and enrolling EMPLOYERS, and their EMPLOYEES.

Employer Training

During the training process, the case manager completes a skills check list which documents that the Employer (Member) has been trained and has demonstrated the ability to direct and manage care. By signing the Memorandum of Understanding (MOU) and Plan of Care, the EMPLOYER agrees to perform the required duties. The Member and or Representative must assume the responsibility of an EMPLOYER. The case manager will monitor the EMPLOYER's ability to manage their personal support service as well as the member's condition during monthly contact, annual reassessments and as needed. All documents must be forwarded to AHS and the FI prior to member's participation in this option.

If the case manager and AHS determine that the Employer is out of compliance with the CDC policies the Member will be returned to traditional care services. However, if a member is not in compliance with ICWP policies, he or she may be discharged from the ICWP program.

All CDC Employers must be trained by an ICWP case manager. The case manager will certify that the Employer is as able and willing to direct CDC personal support services.

Once trained, all ICWP members and representatives must choose and enroll with a FI.

1. The member must contact an FI to obtain the necessary forms to become enrolled in the Consumer Directed Option.
2. The following forms must be completed by the EMPLOYER and submitted to the FI in order to enroll in the Consumer Directed Option.

Enrolling Employers

- Form 2678 Employer Appointment of Agent Form (IRS # 2678)
- Consumer/Representative Directed Employer Agreement Form
- Authorization Form
- Durable Power of Attorney Form (if applicable)
- Consumer Information Form
- Consumer Directed Care Memorandum of Understanding
- Employer Agreement
- FI Communication Form

After the case manager has provided training to the EMPLOYER, the Employer must demonstrate the ability to maintain CDC documentation requirements and manage their PSS staffing needs and schedules.

Enrolling Employees

Employees Eligibility

All EMPLOYEES must be legally eligible for employment under state and federal laws. In addition, for the Medicaid Waiver program, eligible EMPLOYEES must:

- Be 18 years or over
- Must possess basic reading, writing and math skills
- Must be a U.S. Citizen or legally authorized to work in the United states
- Must have completed and passed the CPR and Basic First Aid training. The employee is responsible for keeping their CPR and Basic First Aid training current
- Must have a valid social security number
- The FI must complete a fingerprint based criminal background check, prior to employment, to ensure the employee has no history of a felony conviction
- Understands and agree to comply with the Consumer Directed Option requirements as outlined in the ICWP manual, located at www.AlliantHealth.georgia.gov
- Must have basic skills necessary to provide the member's care
- Must not discuss the member's personal health or care with any other person
- Must receive training in environmental and fire safety.

In the case of self-directed care, the following criteria must be met:

- The Employee must meet the qualifications and training standards specified for personal support services;
- The Employee must meet the training qualifications prior to rendering services to an ICWP member;
- An agreement must be in place between the member and employee before services are rendered;
- The Employer must not pay the caregiver at a rate that exceeds that which would otherwise be paid to a provider of a similar service
- An Employee providing care may not provide more than 40 hours of paid personal support services in a seven day period.
- The Employee must use the FI EVV system to sign in and sign out. Both Employee and Employer must approve the time captured by the EVV system.

Once the EMPLOYER locates a personal support attendant (EMPLOYEE), the EMPLOYEE must complete the following forms and return to the FI. This applies to all employees who have not been employed by the consumer in the current calendar year:

- Form W-4 Employee's Withholding Allowance Certificate
- Form I-9 Employment Eligibility Verification Form
- Record Check Release Form
- Consent for Release of Information Adult Protective Services
- Background Check Release Form
- Optional: Direct Deposit Form
- Employee information form

Important: Claims cannot be processed, nor can payments to workers be made, until all of these forms (not including optional forms) have been received and processed by the FI

Employee Restrictions

The following restrictions apply to all EMPLOYEES:

- Persons with a history of abuse, neglect, or exploitation may not be paid to provide any services under the Medicaid Waiver Program.
- The spouse or domestic partner of the consumer may not be paid to provide any services through Medicaid Waiver funds for care of the consumer.

An employee with the following history may not be employed by a member in the ICWP:

Murder or Felony Murder;
Attempted Murder;
Kidnapping; Rape;
Armed Robbery;
Robbery;
Cruelty to Children;
Sexual Offenses;
Aggravated Assault;
Aggravated Battery; Arson;

Theft by taking (O.C.G.A. 16-8-2), by deception (O.C.G.A. 16-8-3) or by conversion (O.C.G.A. 16-8-4); and

Forgery (in the first or second degree).

Also, DCH prohibits **an employer** from hiring into direct care any employees who have been convicted of child, client, or patient abuse, neglect or mistreatment, regardless of the date.

- A waiver member's legal guardian (appointed by a probate court) may not be paid to provide services under the Medicaid Waiver Program.

- A member's Representative EMPLOYER may not be a paid EMPLOYEE for any services under the Medicaid Waiver Program.

Personal support Service Description

Consumer Directed Personal Support Services includes help with the following:

- Dressing
- Bathing
- Grooming (brushing teeth, shaving, hair and skin care)
- Bed mobility (turning and repositioning)
- Toileting
- Personal hygiene or incontinence care
- Assistance with and care of adaptive equipment
- Transferring (getting to and from chair into bed; bed to wheelchair, etc.).
- Mobility assistance
- Help using the telephone
- Preparing meals and feeding assistance
- General housekeeping (mopping floors and taking out garbage, changing the bed, dusting, vacuuming and doing laundry
- Shopping
- Travel assistance necessary for the person's health and welfare

Payroll Policies and Procedures

Financial Support Services

All Consumer Directed Care employers must select a Fiscal Intermediary to manage their financial personal support funds. There are no exceptions to the policy.

The Financial Intermediary (FI) Services are provided to assure that consumer directed funds outlined in the individual plan of care are managed and distributed as intended. See Addendum P1 for further FI responsibilities.

The annual budget for a member's personal support dollars and hours must be in accordance with the ICWP policy. All services provided under ICWP must have prior approval.

Payroll services are provided by the Medicaid Waiver program, through an enrolled Medicaid provider. The FI will process time worked, paychecks, taxes and maintain individual employment tax records for employees and complete criminal fingerprint background checks. The FI will conduct up to five background checks for no additional charged to the consumer. Any background checks beyond five, the Employer (member) will be personally required to pay the cost.

The Fiscal Intermediary will provide employers and employees with:

- all of the necessary employment forms
- approved fingerprint based background checks (employee only) up to 5
- an electronic visit verification system
- The FI will provide instructions, training, and technical assistance on using their EVV system
- annual W-2 tax statements to employees
- instructions and technical assistance in completing forms
- The FI will provide an orientation packet to each member that chooses to self-direct
- The FI will provide each member with a budget report monthly

The FI will assure that the account statement will be available on the web to be reviewed by the Employer and Case manager. The FI will be responsible for maintaining ~~the above~~ account records. If the employer changes to a different FI, it is the responsibility of the current FI to forward a copy of the ~~entire~~ member's account record to the new FI.

The FI will collect and track the First Aid and CPR certifications of employees. The FI will provide a monthly report to the case manager regarding upcoming expirations of First Aid and CPR. The case manager will communicate with the employer regarding the need to have the employee's certifications updated timely.

Submitting Time

- Employees must sign in and out using the FI EVV system.
- Both the Employer and the Employee must use the FI EVV system to approve the time worked.

All employees must complete the employment enrollment process prior to receiving a paycheck. **There are no exceptions to this policy.**

Termination of Employment

The Employer is responsible for termination of employees. The employer must notify the case manager of all changes in the employment status of EMPLOYEES. The EMPLOYER must notify the FI of any changes in employment by using the FI Communication Form.

Approved Plan of Care

The total number of dollars and hours for *all employees combined* must not exceed the authorized number of hours for any service as shown on the individual's approved Plan of Care per year.

Changes in Hours

The EMPLOYER (member) should contact the case manager directly to review the need for changes in approved services. A written change of care must be submitted by the case manager and approved by AHS before any increased service hours will be paid.

Reasons an Employee may not get paid

1. Failure to sign in and out using the FI EVV system.
2. Lack of or incomplete Employer enrollment forms.
3. Lack of or incomplete Employee enrollment forms.

EMPLOYERS and EMPLOYEES should first attempt to resolve payroll problems by directly contacting the FI. If problems persist, the EMPLOYER or EMPLOYEE may contact the case manager for assistance.

Pay Schedule/Rate

FI will generate paychecks twice monthly according to the pay schedule provided by the FI. -

EMPLOYEES who are paid through Consumer Directed Care will be paid an hourly rate as set by the

employer. The total amount billed to Medicaid may not exceed the hourly rate in current rate sheet located in the part II, Policies and Procedures for Independent Care Waiver Services, manual. The total annual cost of employment related expenses may not exceed the approved dollar amount approved in the member's Plan of Care.

Workman Compensation Insurance

All Employers must provide Workman Compensation insurance. The FI will process the deduction from the member's budget.

Unemployment Benefits

Every employee is eligible for unemployment benefits. If the employer has questions about unemployment compensation coverage, or about submitting a claim, contact the FI.

Health Insurance

Employees may purchase health insurance at their own expense. The employer is not responsible for this expense. The employee may contact the FI for further information on obtaining the optional health insurance.

Taxes

Payments made to every EMPLOYEE are treated as earned income, and are taxed as earned income. The FI provider processes payroll taxes, withholds taxes from wages and prepares annual W-2 tax withholding statements.

Budgetary Reports

The FI will provide account statements online and mailed monthly (if requested).

Medicaid Fraud

Medicaid fraud is committed when an EMPLOYER (member) or EMPLOYEE is untruthful regarding services provided to Medicaid participants in order to obtain improper payment. The Medicaid Fraud and Abuse Unit of Georgia investigates and prosecutes individuals who commit fraud against the Medicaid program. Medicaid fraud is a felony and conviction may lead to substantial penalties (including but are not limited to, imprisonment up to ten years, or a fine up to $1,000 or an amount equal up to twice the amount of the assistance or benefits wrongfully obtained, or both). Additionally, individuals convicted of Medicaid fraud will be prohibited from any employment with a program or facility receiving Medicaid funding for a minimum of five years.

Examples of Medicaid fraud include but are not limited to:

- Billing for services not actually provided (e.g. signing or approving time for services which were not actually provided)
- Billing for services provided by a different person (e.g. signing or approving time for services provided by a different person)
- Billing twice for the same service (e.g. signing or approving time for services which were reimbursed by another source or submitting duplicate time for reimbursement from the same source)

Suspected cases of fraud will be referred to the State of Georgia Attorney General's Medicaid Fraud Control Unit and may be referred to local police authorities for further investigation and possible prosecution.

Case Management Services

The case manager is responsible for training EMPLOYERS and monitoring services and the health and welfare of individuals participating on the Medicaid Waiver program. Case Management services are provided to all Medicaid Waiver participants.

To provide case management services under the Consumer Directed Care Option, the case manager must pass the Consumer Directed Care Option test given by DCH through its contractor AHS. A case manager must pass with a score of 85 or better. All case managers will be given two opportunities to become An ICWP Certified Case Manager.

If an ICWP Case Manager is not certified and serves a member that wants to direct his or her PSS hours, the ICWP Case Manager must provide the member with a list of ICWP Certified Case Managers that can serve the member.

Case Manager Responsibilities:

The case manager must contact the member on a regular basis including a face-to-face visit monthly).
Case managers are responsible for**:**

- Providing training to each ICWP member or member's representative that is capable and willing to participate in the Consumer Directed Care option
- Monitoring the services reported in the FI EVV system, monitoring the notes from employees in the FI EVV system, and monitoring budget reports at least monthly
- Must inform the member when his or her budget exceeds 10% of the monthly budget amount set by the member and the case manager
- Will train the member on documentation requirements
- The case manager and the EMPLOYER must sign the Memorandum of Understanding
- Must review the number of paid hours the member approves for the employee each month
- Notifying AHS if the member is no longer able to demonstrate that he or she can manage the Consumer Directed option
- Answering questions about the Medicaid Waiver Program
- Assisting individuals in gaining access to needed services
- Notifying AHS if a change is identified in the consumer's health status.
- Assisting the consumer in developing a Plan of Care
- Timely submitting the DMA 80 and the DMA 6 to AHS for approval (all members starting services in the CDC option must submit required documents into AHS by the 1st of the month prior to a member services to begin)
- Monitoring the services included in an individual's plan of care
- Assessing the adequacy of care being provided
- Evaluating the ability of a consumer or representative to manage services as an employer under the Medicaid Waiver program
- Reporting suspected cases of abuse, neglect, exploitation to Adult Protective Services
- Reporting suspected cases of Medicaid Fraud to the ICWP Program Specialist
- Monthly audits of training file
- Must convey to the Member and or Member's Representative information concerning the enrolled FI. This will give the Member the opportunity to select a FI from the list of enrolled Medicaid Fiscal Intermediaries.

2. Case Manager Limitations

Case Managers are not responsible for:

- completing or processing payroll forms,
- payroll documentation and submission
- hiring, firing and training employees

An individual's case manager can provide some *advisory* assistance with these activities, but the EMPLOYER is ultimately responsible for all employment issues concerning the EMPLOYEES.

Abuse, Neglect, and Exploitation

The State of Georgia requires, by law that all health professionals report cases of suspected adult abuse, neglect, and exploitation. Those who are "mandated" to report such cases include, but are not limited to:

- Medicaid Waiver Case Managers,
- Personal Care Attendants,
- Home Health Agency Employees,
- Adult Day Employees,
- Hospital Employees,
- Social Workers,
- Physicians, and
- Enrolled Medicaid Providers

Other concerned individuals may also report suspected adult abuse, neglect, or exploitation. In most cases, the identity of the individual making the report shall remain confidential. Reports are made by contacting the Fraud and Abuse Unit at 1-800-533-0686 (toll free).

Appeal Rights

Appeal rights are available upon the denial of an applicant seeking entry into the Consumer Directed Care Option. If a member or member's representative is found to be ineligible to act as the EMPLOYER, and is not certified by the case manager, the application will be denied. This decision may be appealed. Alliant Health Solutions (AHS) will send the member a written notice explaining the basis of the denial/adverse action. This notice will also include information regarding the member's appeal rights.

Appendix Y
Fiscal Intermediary Provider Enrollment

ADDENDUM	PROVIDER ENROLLMENT APPLICATION
Service Title	Financial Support Services/Fiscal Intermediary (FI)
Service Definition	Financial Support Services are provided to assure that consumer-directed funds outlined in the individual plan of care are managed and distributed as intended. The Financial Support Services Provider (FI) will file claims through the MMIS for consumer-directed goods and services. Additionally, the FI will deduct all required federal, state and local taxes. The FI will also calculate and pay as appropriate, applicable unemployment insurance taxes and worker compensation on earned income. The FI will be responsible for maintaining separate accounts on each Member's consumer-directed service funds and producing expenditure reports as required by the State Medicaid agency. The FI will conduct fingerprint based criminal background checks and age verification on service support workers.
Provider Requirements	• Must understand the laws and rules that regulate the expenditure of public resources. • Utilize accounting systems that operate effectively on a large scale as well as track individual budgets. • Adhere to the timelines for payment that meet the individual's needs within DOL standards. • Develop, implement and maintain an effective payroll system that adheres all related tax obligations, both payment and reporting. • Conduct and pay for fingerprint based criminal background checks (national) and age verification on service support workers up to a maximum of five (5) background checks per calendar year per member. Additional background checks will be performed at the expense of the member. • Collect and track First Aid and CPR documentation on service support workers. Report to case management on a monthly basis those employees whose First Aid and CPR documentation is set to expire in the coming month. • Generate service management, and statistical information and reports during each payroll cycle. • Provide startup training and technical assistance to members, their representatives, and others as required. • Process and maintain all unemployment records. • Provider must use the DCH Electronic Visit Verification (EVV) system or ensure that their EVV system is compatible for use for the purposes of member scheduling, employee signing in and out and claims submission. • Have at least two years of basic accounting and payroll experience. • Must have a surety bond issued by a company authorized to do business in the State of Georgia in an amount equal to or greater than the monetary value of the members business accounts managed but not less than $250,000. • Must not be enrolled to provide any other Medicaid services in the State of Georgia.

State License	Georgia Business License
Certification	Must be approved by the IRS (under IRS Revenue Procedure 70-6) and meet requirements and functions as established by the IRS Code, Section 3504.
Other Requirements or Standards	• Must be able to act in a fiduciary capacity, file claims accurately on behalf of the member, process payroll and other reimbursement services in a timely manner. • Must have successfully completed a Readiness Review by the Department of Community Health (DCH), demonstrating ability to perform all required functions and services, prior to enrollment. • Provide at a minimum an electronic visit verification system for time submission.
Describe Service Delivery Method	Consumer-Directed
Service Requirements:	In general, the Financial Support Services (FSS) provider will: • Act as a "fiscal employer agent" receiving and disbursing public funds in accordance with the members' direction, approved budgets, and applicable rules, regulations, and policies. • Monitor a member's spending of public funds for any underage and overage in accordance with the member's approved budget, review the same with the member, and report to the DCH. • Facilitate and process the payment for health insurance and workman compensation benefits for the service provider. • Electronically collect service worker's time worked. • The FI EVV system must submit time worked to the DCH EVV system which will submit claims to MMIS. • Pay invoices for goods and services authorized in the member's budget. • Manage payroll for support service workers hired by the member/representative including federal, state and local employment taxes. • Process and pay invoices for goods and services included in individual budgets on the 15th and last day of each month. • Provide skills training to members and/or member's representatives related to employer-related tasks (e.g., recruiting, hiring, training, managing and discharging support service workers and managing payroll and paying bills). • Provide member utilization reports after each payroll cycle. • Provide web access to review member's expenditure activity.
Service Rate	• Per enrolled member will be $95.00 per month billed on the CMS-1500. • This rate will be reviewed annually for adjustments as needed.

Appendix Z
Fiscal Intermediary Communication Form

Fiscal Intermediary (FI) Communication Form
Consumer Directed Care (PSS)

Name of FI _____

ICWP Member Name _____

ICWP Member Address _____

_____

Member's telephone number _____

ICWP Case Manager Name _____

Case manager's telephone number _____

TRANSACTION TYPE

↑ I authorize your agency to provide FI service to me.

I _____authorized_____ to be my Fiscal Intermediary for the ICWP Consumer Directed Option, Personal Support Service. I understand that I must remain with the chosen FI for one year. I also understand that if I decide to change to another FI at the end of one year, I must give the FI a 30 day notice at the end of this agreement.

Consumer's signature _____ Date __/__/_____

Hospital Stay

I understand that I or my representative is to notify my case manager and the FI when I am admitted to the hospital. I also agree that I will not authorize work time to the FI for any employee while hospitalized.

□ I was in the hospital from _____ to _____.

□ My employees are as follows:

Name_____

Address_____ss#_____

Name_____

Address_____ss#_____

Name_____

Address_____ss#_____

Name_____

Address_____ss#_____

↑ Other:_____

Terminating an FI

↑ I am terminating services from your agency effective_____
Member must stay with chosen FI for one year. A 30-day notice must be provided to the FI before changing to another FI.

_____ _____
ICWP Member/Date ICWP Case Manager/Date

Appendix AA

Adult Protective Services Brochure on Recognizing and Reporting Abuse, Neglect, and Exploitation

TO REPORT SUSPECTED ABUSE OF DISABLED ADULTS & ELDER PERSONS

In a community setting
Call the Adult Protective Services Central Intake line at 866-552-4464 and choose Option 3.

In a long-term care facility or residence
Call Healthcare Facility Regulation at 404-657-5728 or toll-free at 800-878-6442.

In any setting
For immediate, serious risk, call 911.
For nonemergencies, report suspected abuse to your local law enforcement agency.

For residents of a facility who need an advocate
Call the Long-Term Care Ombudsman at 866-552-4464. Choose Option 5.

OTHER HELPFUL SERVICES

Free of charge regardless of income

GeorgiaCares
866-552-4464, Option 4 | mygeorgiacares.org
Provides free health insurance counseling about Medicare, Medicaid, Prescription Assistance Program, and planning for long-term care needs. Also reports suspected fraud in Medicare and Medicaid.

Senior Legal Hotline
404-657-9915
Outside Metro Atlanta: 888-257-9519
georgialegalaid.org/organization/georgia-senior-legal-hotline
Provides legal assistance over the telephone for Georgians 60 and older.

Elderly Legal Assistance Program
866-552-4464, Option 7
aging.georgia.gov/elderly-legal-assistance-program
Provides legal assistance for civil matters for people 60 and older.

Georgia Department of Behavioral Health and Developmental Disabilities
800-715-4225 | mygcal.com
Provides 24/7 mental health, substance abuse and emergency services. For nonemergency mental health and addictive diseases services and nonemergency developmental disability services, call 888-785-6954.

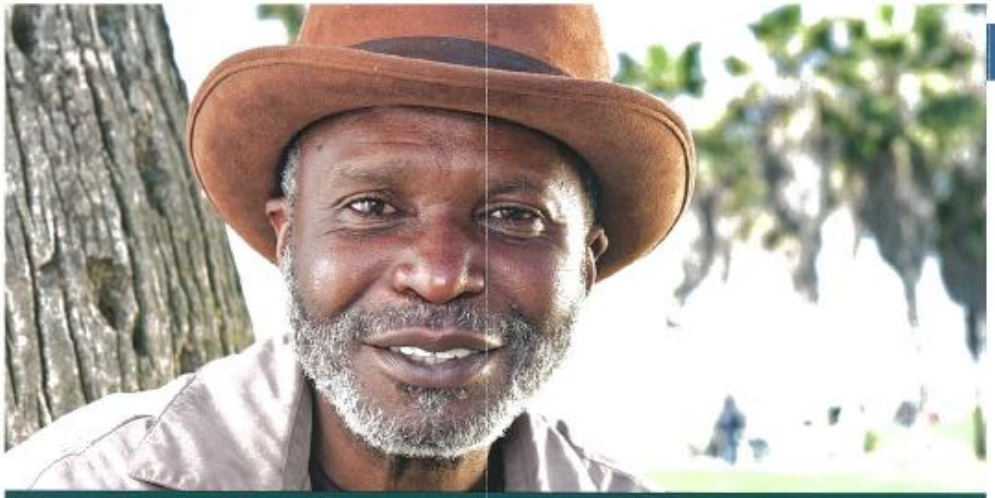
Georgia Department of Law's Consumer Protection Unit
404-651-8600
Outside Metro Atlanta 800-869-1123
ocp.ga.gov
Enforces the Fair Business Practices Act and other consumer protection laws. The unit works to prosecute crimes related to telemarketing, home-construction and home-repair fraud, identity theft, and internet fraud.

Georgia Department of Human Services
Division of Aging Services

ADULT PROTECTIVE SERVICES

Learn how to recognize the signs of abuse, neglect and exploitation of Georgia's vulnerable adults, and how to report it

aging.ga.gov



FORMS OF ABUSE

Physical abuse

Physical abuse is using physical force to coerce or to inflict bodily harm. It often, but not always, causes physical discomfort, pain or injury. It may include the willful deprivation of essential needs, such as medical care, food or water.

Sexual abuse

Sexual abuse refers to any kind of sexual behavior directed toward an at-risk adult without the person's full knowledge and consent. A spouse, partner, family member or other trusted person can perpetrate sexual abuse.

Emotional abuse

Emotional abuse includes using tactics such as harassment, insults, intimidation, isolation or threats that cause mental or emotional anguish. It diminishes the person's sense of identity, dignity and self-worth.

Visit **aging.ga.gov** for more information or to report suspected abuse, neglect or exploitation.

Financial abuse or exploitation

Financial abuse or exploitation is described as improperly or illegally using a person's resources for the benefit of another person. Examples include using power of attorney to gain access to an adult's assets for personal gain, or using undue influence, false representation and other means to gain access to an adult's government checks.

Neglect

Neglect occurs when a caregiver refuses or fails to provide essential needs (food, water, shelter, medical care, etc.) to the degree that it harms or threatens to harm an older and/or disabled adult.

Self-neglect

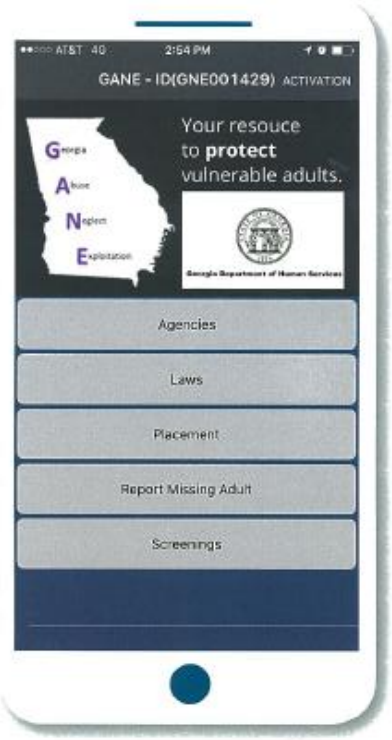
Self-neglect is defined as failing to perform essential self-care such as depriving oneself of necessities such as food, water, or medication. Consciously putting oneself in harm's way or being unable to handle needs of day-to-day living because of medical, mental health or other disabilities is self-neglect, but it is not a crime.

DOWNLOAD THE GANE APP

Download the free Georgia Abuse, Neglect and Exploitation (GANE) app for additional information and resources related to vulnerable adult abuse.

Access resources, find placement options, use easy screening tools and report abuse straight from your phone.

The app is available on all platforms. Simply go to your app store and search "eyeon GANE."



Appendix BB
Waiver Transfer Form

1.**Prior Authorization Number:** _____ **Expiration Date:** _____

2. Member Name: _____ DOB:_____

Social Security Number: _____ Medicaid #: _____

3.Other Contact Information: _____

4. Transfer Type:

ICWP to ICWP ☐ ICWP to SOURCE ☐ ICWP to CCSP ☐

5. Member transfer from: Agency Name _____

Provider ID _____

County _____ Care Coordination/Contact Person _____

Email _____Telephone _____

Last Service Date _____

Member current waiver type (circle one) CCSP SOURCE ICWP

Member street address _____

City _____ County_____ State _____

Zip Code _____ Member Phone Number _____

6. **Member transfer to**: Agency Name _____

Provider ID _____

Care Coordination/Contact Person _____

Email_____ Telephone _____

New waiver type (circle one) CCSP SOURCE ICWP

Member new street address _____

City _____ County _____ State _____

Zip Code _____ Member Phone Number _____

WAIVER TRANSFER FORM

Instructions

Independent Care Waiver Program

Purpose: The waiver transfer form is used to transfer case records from one waiver to another and also to notify Alliant of the transfer.

Who Completes/When Completed: The ICWP case manager completes the member transfer form for a member that is being discharged from her agency to another waiver such as Source or CCSP. It accompanies the original case record of the last year of service to the receiving agency. Original agency is also responsible for notifying Alliant by attaching this form and supporting documentation of reason for transfer and client agreement of such. This is attached to the "Contact Us".

Instructions:

1. Enter the Member's Prior Authorization number and expiration date.

2. Enter the Member's name (last name, first, and middle initial), DOB, SS# and Mdcd ID #

3. Enter other contact information

4. Enter the type of transfer.

5. Enter Member transfer from information (Agency, provider ID, Email contact, telephone, last service date, current waiver type, member street address and phone information)

6. Enter Member transfer to information (Agency, provider ID, Email contact, telephone, new waiver type, member address and phone number information)

Distribution: The original form accompanies the original client case record to the receiving agency. A copy is filed in the duplicate case record maintained at the transferring agency.

Appendix CC
Reportable Incident Types: Definitions

	Definition
Injury Severity Ratings:	1 - No injury (no treatment required) 2 - Injury requiring first aid (small adhesive bandages, cleaning of abrasion, application of ice packs, over the counter medications as physician ordered) 3. Injury requiring treatment beyond first aid (medical treatment required by a licensed practitioner - MD, NP, PA, etc. that is not serious enough to warrant hospitalization, such as sutures, broken bones, prescriptions etc.) 4. Injury requiring hospitalization (medical intervention and treatment at a hospital, including stays for observation only) 5. Death 6. Refused treatment
Death - Expected	Cause of death is attributed to a terminal diagnosis or diagnosed disease process identified more than 30 days before the date of death, where the reasonable expectation of outcome is death, there is no indication that the individual was not receiving appropriate care.
Death - Unexpected	Death due to any cause where the cause of death is not attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation or outcome is death, does not meet the definition of an expected death. Examples include but not limited to death from suicide, homicide, medication errors, undiagnosed condition, criminal activity, an accident, or possible abuse or neglect.
Suicide Attempt resulting in injury	Self-inflicted harm due to failed suicide attempt. Injury severity scale 2, 3, and 4.
Alleged Abuse - Physical	The willful use of physical force to coerce or to inflict bodily harm, pain or mental anguish. Indicators of physical abuse may include, but are not limited to, rough handling, improper use of restraints, injuries not consistent with medical diagnosis or explanation, or unreasonable confinement.

Alleged Abuse - Sexual	Any kind of sexual behavior directed towards an individual without their full knowledge and consent. A spouse, partner, family member or other trusted person can perpetrate sexual abuse. Indicators of sexual abuse include, but are not limited to, any nonconsensual sexual contact, inappropriate touching, forced viewing of sexually explicit materials, sexual harassment or sexual assault.
Alleged Abuse - Psychological	Using tactics, such as harassment, insults, intimidation, isolation or threats that cause mental or emotional anguish. It diminishes the person's sense of identity, dignity, and self-worth.
Alleged Abuse - Verbal	Verbal abuse is any use of oral, written or gestured language that may be threatening, demeaning, discriminatory, or insulting regardless of their age, ability to comprehend, or disability.
Alleged Neglect	Failure to provide essential services (food, water, shelter, medical, etc.) that cause actual or potential physical or medical harm, mental anguish, or mental illness.
Alleged Self-Neglect	Failing to perform essential self-care such as depriving oneself of necessities such as food, water, or medication. Consciously putting oneself in harm's way or being unable to handle needs of day-to-day living because of medical, mental health or other disabilities.
Alleged Exploitation	Evidence of deliberate intent to manipulate an individual for personal benefit or self-advancement.
Alleged Financial Exploitation	Evidence of deliberate intent to misuse funds or assets of an individual for personal benefit or benefit of another. Examples include, but are not limited to, theft, forgeries, unauthorized check-writing, unexplained disappearance of cash or valuable objects, misuse of an insurance policy, or identity theft.
Accidental Injury	Injuries to individuals with a known cause that were not a result of aggressive acts to self or others.
Fall - Accidental	Uncontrolled, unintentional, downward displacement of the body to the ground or other object.

Fall - Purposeful	Willful intent of an individual to cause downward displacement of the body to the ground or other object.
Fall - Medical condition	Uncontrolled, unintentional, downward displacement of the body to the ground or other object due to a medical condition.
Choking with intervention	An incident of choking that required intervention to clear the airway. Choking is defined as any episode of airway obstruction by food or foreign object as evidenced by one or more of the following: a) inability to speak when asked if choking (if individual is verbal); b) inability to breath or difficulty taking in adequate breaths; c) movements indicating distress such as grasping for neck or throat; d) turning blue.
Medication Error with Adverse Consequences	A failure in the medication process that results in a significant adverse reaction requiring medical attention in an emergency room, urgent care center, or hospital. Errors include but are not limited to: omission of a medication, wrong dose, wrong time, wrong person, wrong medication, wrong route, and/or wrong position.
Medication Error without Adverse Consequences	A failure in the medication process that does not result in harm. Errors include but are not limited to: omission of a medication, wrong dose, wrong time, wrong person, wrong medication, wrong route, and/or wrong position.
Hospitalization - Medical	Any admission to a hospital, either directly or through a facility's emergency room.
Hospitalization - Psychiatric	An unplanned, involuntary admission of an individual to a psychiatric treatment facility.
ER Admission	Any admission to an emergency room.
Aggressive Act for all three types (member against member, member against non-member, staff against member)	Aggressive act resulting in injury of severity ranking 3, 4, and 5.
Seclusion or Restraint	The use of physical holding and mechanical restraints and/or solitary confinement of member, which are prohibited per waiver policy.

Elopement - Greater than 30 minutes	A cognitively impaired person who successfully leaves unsupervised and undetected from a residential location or day program.
Alleged Criminal Act by a Member	Conduct that could result in criminal proceedings.
Violation of Individual Rights	A denial of an individual's rights without good cause regardless of age, race, sex, nationality, ethnicity, sexual orientation, language or religion. Examples include but are not limited to: a denial of individual's rights without the benefit of due process, breaching an individual's confidentiality, purposely allowing an individual's privacy to be invaded or breached, denial of access to the Patients' Rights Advocate, and denial of legal representation.
Environmental Threat	An event with direct impact on member health and safety occurring within or around a residential location or day program. These events can result in but are not limited to mortality, illness and/or injury, and disrupts living arrangements requiring intervention or relocation.
Media Alert	An incident that may have significant impact upon, or significant relevance to, issues of DCH public concern and/or are likely to be reported in the media.

Appendix DD
Authorization For Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Georgia and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Member Name: _____

Member Identification Number: _____

Health Plan Name: _____

Persons/Organizations authorized to *use or disclose* the information:[i] _____

_____

Persons/Organizations authorized to *receive* the information: _____

_____

Purpose of requested use or disclosure:[ii] _____

_____

This Authorization applies to the following information (select ***only one*** of the following):[iii]

- ❑ All health information pertaining to any medical history, mental or physical condition and treatment received.

  [Optional] **Except:**_____

- ❑ **Only** the following records or types of health information (including any dates). This may consist of psychotherapy notes, if specifically authorized:

  _____

  _____

EXPIRATION

This Authorization expires [insert date or event]:[iv] _____

_____

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: _____

_____.

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or

others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.[v]

Neither treatment, payment, enrollment or eligibility for benefits, will be conditioned on my providing or refusing to provide this authorization.[vi]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).

_____

Signature of Member or Authorized Representative Date

_____

If Signed by Representative, State the Relationship or Basis of Authority

[i] If the Authorization is being requested by the entity holding the information, this entity is the Requestor.

ii The statement “at the request of the individual” is a sufficient description of the purpose when

the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

[iii] This form may not be used to release both psychotherapy notes and other types of health information *(see 45 CFR § 164.508(b)(3)(ii)).* **If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.**

[iv] If authorization is for use or disclosure of PHI for research, including the creation and maintenance of a research database or repository, the statement "end of research study," "none" or similar language is sufficient.

[v] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures *(see 45 CFR § 164.508(d)(1), (e)(2)).*

[vi] If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. **Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.**

Appendix EE
Member Acknowledgment of Receipt of Forms

Completion of this form is for the Member to acknowledge receipt of the forms and information provided by ICWP Case Managers. The following forms must be provided to all ICWP Members. After receipt of the forms listed below, the member must sign and date this acknowledgement. The Case Manager must retain this form in the members record. Form templates are located in the appendixes.

All Members must receive forms in Section 1. Consumer Direct Members must receive forms in both Section 1 and Section 2 and must sign both sections.

Section 1

1. Individual Plan of Care
2. List of available Service Providers
3. Freedom of Choice Form
4. Member Rights and Responsibilities
5. Memorandum of Understanding
6. Advance Directive
7. NEMT –
8. Informed Consent Additional forms provided:

Member's Signature verifies receipt of the above forms:
Print Name: _____
Signature: _____ Date: _____

Section 2

Additional Forms Provided to ICWP Consumer Direct Members

1. Consumer Directed Care
2. Memorandum of Understanding for Consumer Direct Member **Member's Signature verifies receipt of the above forms:**

Print Name: _____
Signature: _____ Date: _____

Appendix FF
HCBS Person Centered Service Plan

Authorization Period: Date Issued:

Name:		Date of Birth:	
Address:			
Phone Number:		Preferred Language:	
Email Address:			

If you have a question or a problem regarding your services, call your Care/Case Manager:
_____[Care/Case Manager name]_____ at (xxx) xxx-xxxx_____

Preferences:

Ask the person about the things they like and dislike. Input their responses here as well as any other known preferences of the person. Include any preferences they may have for the delivery of their services.

Strengths:

Ask the person about the things they're good at. Input their responses here as well as any other known strengths of the person.

Goals/Desired Outcomes:

Use the space below to identify the person's health care and social goals/desired outcomes. Goals may be long-term or short-term with measurable outcomes. Where applicable, indicate which unmet service need the goal ties into. Include strategies to achieve desired outcome. [Add boxes for additional outcomes as needed].	
Goal/Desired	

Outcome	
Goal/Desired Outcome	
Goal/Desired Outcome	

Description of Services:

Identify services the person is currently receiving. [Duplicate boxes below as needed].

Name of Service:			
Scope/Description of Service			
Unit and Frequency of Service		Provider:	
Duration/Authorization Period		Contact Information:	
Assessment Identifying Need		Authorizing Entity:	
Desired Outcome/Goals			

Name of Service:			
Scope/Description of Service			
Unit and Frequency of Service		Provider:	
Duration/Authorization Period		Contact Information:	
Assessment Identifying Need		Authorizing Entity:	
Desired Outcome/Goals			
Name of Service:			
Scope/Description of Service			
Unit and Frequency of Service		Provider:	
Duration/Authorization Period		Contact Information:	
Assessment Identifying Need		Authorizing Entity:	
Desired Outcome/Goals			

Unmet Service Needs:

Identify any services the person needs but does not have. [Duplicate boxes below as needed].

Service Need		Assessment/Date	

		Identified:	
Justification for Service			
Reason Need is Unmet			
Plan to Address Need			
Service Need		Assessment/Date Identified:	
Justification for Service			
Reason Need is Unmet			
Plan to Address Need			

Informal Supports:

Identify unpaid supports and their relationship to the person. [Duplicate boxes below as needed.]

Name:			
Relationship/Title:		Contact Information:	
Service(s) Provider/Support Role:			
Unit and Frequency of Service:			

Name:			
Relationship/Title:		Contact Information:	
Service(s) Provider/Support Role:			
Unit and Frequency of Service:			

Name:			
Relationship/Title:		Contact Information:	
Service(s) Provider/Support Role:			
Unit and Frequency of Service:			

The person's information			
Primary Care Manager:		Secondary Care Manager:	
Organization:		Organization:	
Primary Care Provider (PCP)			
PCP Contact Information			

Medicaid/CIN#:			
Primary Insurance Agency		Secondary Insurance Agency	
Enrollee ID		Enrollee ID	

Residential Setting and Supports:
Use this section to confirm that the individual's residential setting meets the HCBS Settings Rule.

Is the residence integrated in and does it support full access to the greater community?	Yes ☐ No ☐
Was the residence selected from among options by the person?	Yes ☐ No ☐
Does the residence ensure the person's rights of privacy, dignity and respect, and freedom from coercion and restraint?	Yes ☐ No ☐
Does the resident optimize the person's autonomy and independence in making life choices?	Yes ☐ No ☐
Does the residence facilitate the person's choice about services and who provides them?	Yes ☐ No ☐
Is the residence physically accessible to the person?	Yes ☐ No ☐
Can the person control personal resources?	Yes ☐ No ☐
Did the person participate in the person-centered planning process, leading the process whenever possible?	Yes ☐ No ☐
Did the person choose where they live now?	Yes ☐ No ☐
Can the person easily move around their home and other places where services are received?	Yes ☐ No ☐
Can the person participate in the activities such as work, volunteer, attending school, etc., when they like inside and outside of their home? If not, is there a modification noted properly below? (See Residential and Non-Residential Modifications Section below)? (Note: modifications are only applicable for provider-owned or controlled residential or non-residential settings, not private homes) Yes ☐ No ☐	Yes ☐ No ☐
Can the person visit friends and family if/when they want? If not, is there a modification noted properly below? Yes ☐ No ☐	Yes ☐ No ☐
For provider-owned or controlled residential settings, is there a lease/occupancy agreement in place that gives the person the same rights and protections afforded to anyone in that jurisdiction, i.e., no rules are in the written agreement that would not be in a common lease, including the ability to furnish and decorate sleeping or living	Yes ☐ No ☐

unit? If not, is there a modification noted properly below? Yes ☐ No ☐	
Use the space provided below for additional comments if the answer to any of the questions above is "No".	

Assessment Information:
Include all applicable assessments. [Duplicate boxes below as needed].

[Insert Assessment Name]	Date of Initial Assessment	XX/XX/XXXX	Most Recent Assessment Date	XX/XX/XXXX
	Anticipated Reassessment Date	(Month/Year)		
[Insert Assessment Name]	Date of Initial Assessment	XX/XX/XXXX	Most Recent Assessment Date	XX/XX/XXXX
	Anticipated Reassessment Date	(Month/Year)		
[Insert Assessment Name]	Date of Initial Assessment	XX/XX/XXXX	Most Recent Assessment Date	XX/XX/XXXX
	Anticipated Reassessment Date	(Month/Year)		
Diagnosis				

Risk Management and Safeguards:
Identify risks to the person's health/wellbeing, potential triggers, the person's previous responses to triggers, measures in place to minimize risks, and safeguards. Safeguards detail the support needed to keep the person safe from harm and actions to be taken when their health and welfare is at risk (please refer to guidance for more information).

RISK	
Trigger(s):	
Known Response(s):	
Measure(s) in place:	
Safeguard(s):	
RISK	
Trigger(s):	
Known Response(s):	
Measure(s) in place:	
Safeguard(s):	
RISK	
Trigger(s):	
Known Response(s):	
Measure(s) in place:	
Safeguard(s):	

Backup Plan:
A plan in place to ensure that needed assistance will be provided if the regular services and supports in the person's person-centered service plan are temporarily unavailable. The backup care plan may include electronic devices, relief care, providers, other individuals, services, or settings. Individuals available to provide temporary assistance include informal caregivers such as a family member, friend or another responsible adult. Include contact information as appropriate.

Self-Directed Services:

Fill out this box for a person self-directing their services under a 1915(c) or 1915(k) authority such as the Consumer Directed Personal Assistance Program (CDPAP) through the Community First Choice Option or under the state plan but as a waiver enrollee. If this information is documented in another place, place attestation to this PCSP. [Duplicate service description portion for each self-directed service].
☐ I, _____, choose to self-direct some or all of my services. ☐ _____, may also act on my behalf to self-direct some or all of my services. This means that I have the right to recruit, hire, fire, supervise, and manage my own staff. Alone, or with the help of my supports, I can choose the duties, schedules, and training requirements of my staff. This also includes the right to evaluate staff, decide their rate of pay, and review/approve payment

requests. I will follow all laws and regulations when exercising these rights and responsibilities. The services I choose to self-direct are as follows:
Service:
Method of Self-Direction (self or designated representative):
Risk Management Techniques:
Process for Transitioning out of Self-Direction:

Residential and Non-Residential Modifications (applies when HCBS provider owns or controls the Residential or Non-Residential setting):

Fill out these boxes for special populations receiving HCB services under 42 CFR 441 Subparts G, K, or self-directed 1905(a) state plan services, including the Consumer Directed Personal Assistance Program (CDPAP). Such residential modifications described here may relate to a change in status of written, legal agreements to live in the current setting; privacy; sleeping/living unit having lockable entrance doors with the only the person and appropriate staff keeping keys; choice of roommate(s); freedom to furnish/decorate within legal agreements; and for both residential and non-residential settings, control of schedules, activities, and access to food at all times; or the ability to receive visitors of the person's choosing at any time. [Duplicate modifications box if needed for multiple modifications].
☐ **I, _____, understand the information below and agree to the use of the modification(s) required to address my assessed risks and needs. I know that I can change my mind and will tell my Care/Case Manager if I do.**
Modification:
Specific Individualized Assessed Need (Note: a diagnosed disability is not a specific assessed need):
Positive Interventions and Supports used Before this Modification:
Diagnosis/Condition Related to the Modification:
Method for Collection and Review of Data for Effectiveness:

Timeframes/Limits for Review and Determination of Need for Modification:
Assurance that the Modification will Cause no Harm:

Person-Centered Service Planning Process Information:

Complete the table below with meeting information as appropriate. Include signatures and information indicated in boxes below for all persons responsible for writing and implementing this plan. Acceptable methods of agreement with the PCSP from the person or designated representative are: (1) wet signature on the PCSP, either in person or mailed or (2) wet signature on a separate page with language indicating agreement with the current PCSP, either in person or mailed. All attempts to obtain signature should be documented on the PCSP by the Care/Case Manager.

Meeting Date:		Meeting Time:	
Meeting Location:			
Was this meeting held at a place and time of the person's choosing?			Yes ☐ No ☐
Did the person lead the meeting to the best of their ability?			Yes ☐ No ☐
Did the person choose who was invited to/in attendance at the meeting?			Yes ☐ No ☐
Name	Title/Relationship	Agency	Date
	[e.g. Care/Case Manager]		
	[e.g. Provider]		
	[e.g. Provider		
	[e.g. Informal Support]		
	[e.g. Informal Support]		

Acknowledgement:

I have been a part of the Person-Centered Planning process to the best of my ability. I agree with what is written in my plan. I understand my rights and/or I have someone I trust who can help me with them. I understand that my plan will be reviewed regularly and that I can ask for it to be reviewed sooner. I agree to this plan being shared with the people that need it to provide my services. I was given a choice of my service providers. I know who to talk to if I want to change my services or my Person-Centered Service Plan.

_____ _____

Enrollee/Recipient or Designated Representative Signature Date

Attachments to Person-Centered Service Plan: [Name(s) of Attachment(s)].

Appendix GG
HCBS Settings Rule Member Questionnaire

Instructions:
Each provider and their case managers must help each member complete this questionnaire for every service location. Members should answer the questions freely and without any pressure. When completed and executed a copy should be kept in each member's case file attached to their Person Centered Care Plan. The questionnaire must be signed by the member and, if needed, their legal guardian or a family member. For each question, check the box that matches the member's honest and independent answer.

Section 1: General Information
• Member Name: _____
• Service Location: _____
• Case Manager Name: _____
• Date of Completion: _____

Section 2: Access to the Community
• Do you feel this place lets you take part in community activities, like working, going to events, or using community services, just like people who don't get Medicaid services? □ Yes □ No □ I'm Not Sure o If no, please explain: _____

• Do you have chances to work in a regular job with people who don't have disabilities? □ Yes □ No □ Not Applicable
• Can you do things outside of this place that you enjoy? □ Yes □ No □ I'm Not Sure

Section 3: Choosing Your Setting
• Did you choose this place from different options? □ Yes □ No □ I'm Not Sure
• Were you told about places that aren't just for people with disabilities or about private rooms if this is a residential place? □ Yes □ No □ I'm Not Sure
• Is this place listed in your personal care plan? □ Yes □ No □ I'm Not Sure

Section 4: Independence and Freedom
• Can you make your own choices about what you do every day, like meals, routines, or activities? □ Yes □ No □ I'm Not Sure
• Do you feel like you have control over your surroundings? □ Yes □ No □ I'm Not Sure
Can you choose who you spend your time with? □ Yes □ No □ I'm Not Sure

Section 5: Choices About Services and Support

• Do you get to decide what services and help you receive? □ Yes □ No □ I'm Not Sure

• Can you choose who provides your services? □ Yes □ No □ I'm Not Sure

Section 6: Residential Settings *(If Applicable)*

• If you share a room, can you choose your roommate? □ Yes □ No □ Not Applicable

• Can you make your own schedule and pick the activities you want to do? □ Yes □ No □ I'm Not Sure

Acknowledgment and Signature I confirm that I have completed this form freely and honestly. I understand that my answers will help make sure this place follows the HCBS Settings Rule and provides quality services.

Member Signature: _____ Date: _____

Legal Guardian/Family Member Signature (if applicable): _____ Date: _____

Case Manager Signature: _____ Date: _____

Important Notice to Providers and Case Managers: DCH requires that signed copies of these questionnaires, along with each member's person-centered care plan, are placed within the member's record for further review by the medical management agency or DCH. Time designated by DCH.

Appendix HH
HCBS STP Community Integration Plan (CIP) Template

Instructions: CIP to be completed at admission and annually by the ALS, ADH, or Out of Home Respite Service Provider.

Individual's Name:
Date of Plan Development:
Medicaid ID:
Waiver Program:
Case Manager:
Service Provider:

==========1.
Individual's Profile

a) **Current Living Situation:** (e.g., nursing home, hospital, intermediate care facility)
b) **Desired Community Setting:** (e.g., independent living, assisted living, family home) If a change is indicated, review available options and document the change.

c) **Primary Support System:** (e.g., family, friends, legal guardian)
d) **Current Medical/Behavioral Health Needs:**
e) **Goals for Community Integration:**

==========2.

Person-Centered Goals & Services

Housing & Living Arrangements

a) Preferred housing type:
b) Housing assistance needed? (Yes/No)
    a. If yes, specify: Rental assistance, home modifications, accessibility support, etc.
    b. Steps taken to meet goal:
    c. Outcome/Results:
c) Projected Move-in Date if alternate housing acquired:

Healthcare & Behavioral Support

a) Current medical services provided: (e.g., primary care, specialists, in-home care)
b) Additional medical services needed? If yes, specify the service and actions taken by provider to ensure medical care.
c) Current Behavioral health services provided:
    a. If yes, specify: Therapy, case management, crisis intervention, etc.
d) Additional behavioral health services needed? If yes, specify the service and actions taken by provider to ensure behavioral health services.
e) Outcome/Results:

Daily Living & Support Services

a) Personal Care Assistance provided? (Yes/No)
b) Change to personal care assistance needed? (yes/no)
c) Actions taken to modify personal care assistance.
d) Outcomes/Results:

Transportation Support

a) Transportation support currently provided:
b) Change to transportation support requested: (Yes/No)
c) Actions taken to obtain requested transportation support:
d) Outcomes/Results:

Meals/Nutrition Support

a) Meals/Nutrition support provided? (Yes/No)
b) Dietary restrictions? (yes/no)
c) Change to meals/nutrition support requested? (yes/no)
d) Actions taken to address and change meals/nutrition support requested:
e) Outcomes/Results:

Employment and Community Engagement

a) Goals: (e.g. employment, volunteering, and extracurricular activities, etc.)
b) Support needed for goals: (Yes/No) If yes, specify: Job coaching, skills training, workplace accommodations
c) Service provider actions taken to assist with employment and community engagement:
d) Outcomes/Results:

Facility social and recreational activities of interest

a) Social & recreational activities of interest:
b) Actions taken by service provider to provide requested activity:
c) Outcomes/Results:

==========**3. Transition Plan & Responsibilities**

Task	Responsible Party	Deadline	Status
Identify housing resources	Care team	MM/DD/YYYY	Pending/In Progress/Completed
Apply for rental assistance	Individual/informal support	MM/DD/YYYY	Pending/In Progress/Completed
Arrange transportation services	Care team	MM/DD/YYYY	Pending/In Progress/Completed
Set up medical appointments	Individual/informal support	MM/DD/YYYY	Pending/In Progress/Completed
Secure employment opportunities	Individual/informal support	MM/DD/YYYY	Pending/In Progress/Completed

==========**4. Monitoring & Follow-Up**

a) Check-in Schedule: (e.g., weekly, biweekly, monthly)
b) Care Team Contacts:

- Case Manager:
- Service Provider:
- Medical Provider:
- Family/Guardian/informal supports:
- Other Key Contacts:

c) Review & Update Plan Date: (minimum annual revision)

==========