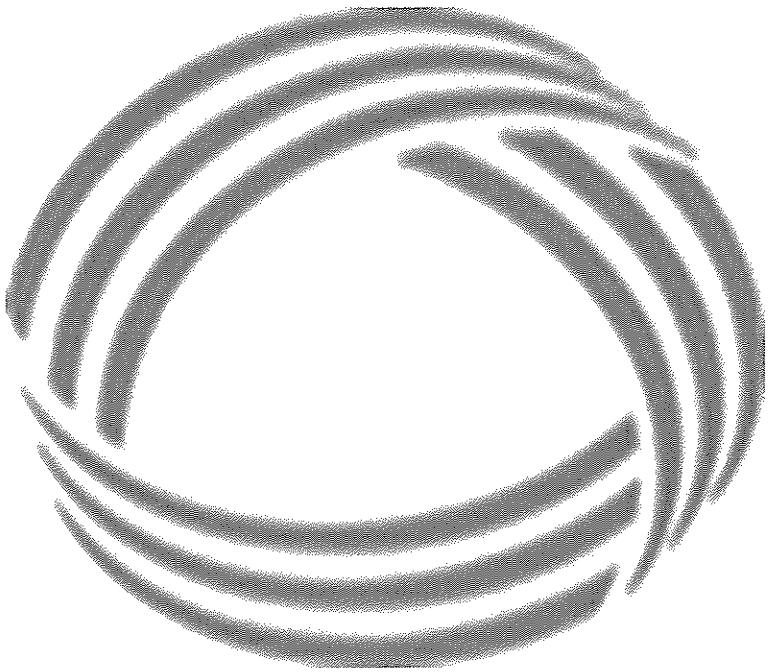
Elderly and Disabled Waiver Program/CCSP Documents Manual



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: January 1, 2022

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EDWP Traditional + Enhanced Waiver Information

THE ELDERLY AND DISABLED WAIVER PROGRAM (EDWP)

What is the EDWP Program?

SOURCE + CCSP (Traditional/Enhanced) are part of the EDWP. Both SOURCE and CCSP assists individuals who are elderly and/or functionally impaired to remain in their homes and/or communities. For eligible consumers, EDWP offers community-based services as an alternative to nursing facility placement. The Department of Community Health administers and operates the EDWP.

What services are available through this program?

Adult Day Health
- Daytime care and supervision in an adult day center
- Nursing and medical social services
- Planned therapeutic activities
- Physical, speech, and occupational therapy
- Meals, including prescribed diets

Alternative Living Services
- Alternative residence for persons unable to remain independent in their own homes
- Meals, personal care, and supervision

Emergency Response Services
- In-home electronic support system providing two-way communication between isolated persons and a medical control center
- Service available 24 hours a day, seven days a week

Home-Delivered Services
- Skilled nursing services
- Physical, speech and occupational therapy
- Medical social services and home health aide assistance
- Personal care and assistance with meals

Personal Support Services
- Assistance with meal preparation, hygiene and nutrition
- Light housekeeping, necessary errands, and other support services
- In-home respite care provided by an aide

Consumer-Directed Personal Support Services option
Same as Personal Support Services, except:
- Consumer hires and supervises worker(s) of choice
- Clients enrolled in the option are required to choose a Financial Management Services provider that will issue paychecks and adhere to federal and state tax laws on behalf of the client

Structured Family Caregiver
- Provides support, education and oversight on behalf of waiver members whose family caregiver lives in the home with the member.
- Live-in family member works with SFC provider's health coach while supporting the member to maximize the highest level of independence for the member by providing necessary care and support.

Out-of-Home Respite Care
- Out-of-home overnight respite care in an approved facility with 24-hour supervision

Home Delivered Meals
- Prepared outside the home and delivered to the client

Case Management (Enhanced and Traditional)
- Process which includes assessing, implementing, coordinating, monitoring, evaluating options and services required to meet individual needs and making referrals as needed

Who is eligible for EDWP?
The eligibility criteria for EDWP include the following:
- Functional impairment caused by physical limitations NOTE: Alzheimer's and dementia are physical conditions.
- Unmet need for care
- Approval of an intermediate level of care (LOC) certification for nursing home placement
- Approval of care plan by client's physician
- Medicaid eligible or potentially eligible after admission to EDWP
- Client chooses community-based, rather than institutional services
- Services fall within the average annual cost of Medicaid reimbursed care provided in a nursing facility. Health and safety needs can be met by EDWP
- Participation in one waiver program at a time
- Medicare home health services or hospice (Medicare or Medicaid) does not meet consumer need for services
- Home Delivered Meals is not the only service need
- The home environment is free of illegal behavior and threats of bodily harm to other persons.

A client is not required to be homebound to receive EDWP services.

How does an individual obtain EDWP Services?

Step 1: The individual contacts the Area Agency on Aging for an EDWP assessment for Traditional/Enhanced care. The individual with active full Medicaid can contact the AAA or a SOURCE site for assessment.

Step 2: If the individual is eligible for EDWP, the care coordinator and the member/representative collaborate to determine which services the applicant needs.

How are services arranged?

Step 1: The case management arranges for EDWP service agencies to provide the needed services. Service agencies are approved Medicaid providers who bill the Department of Community Health directly for services rendered to EDWP clients. Care coordinators also arrange for client services through other service agencies and fund sources.

Step 2: If the individual is not a Medicaid recipient, she/he applies for Medicaid at the local county office of the Division of Family and Children Services.

Step 3: The case management maintains regular contact with EDWP clients to assure that services are appropriate and that individuals' needs are met. Client /family representative participates in the development of the client care plan.

What are the financial eligibility requirements?

The following information summarizes the financial eligibility criteria for the EDWP.

- SSI category: Persons who receive Supplemental Security Income (SSI) and are eligible for medical assistance. The Social Security Administration takes applications for SSI.

- Medical Assistance Only (MAO) category: Persons who do not receive cash benefits under the SSI program may qualify for medical assistance under another Medicaid category. The county Departments of Family and Children Services take applications for MAO. MAO participants may have to pay toward the cost of services.

	SSI Income Limits:*	**Waiver Medicaid/ MAO Income Limits:**	**SSI and Waiver Medicaid Resource Limits:**
Individual	Below $841/ Month	$2,523/month	$2,000 or less
Couple (both in EDWP)	Below $1,261/ Month	$2,523/month per individual	$3,000 or less
Individual in EDWP, But married	Below $1,261/Month	$2,523/month	$2,000 or less for SSI $130,380 (combined) or less for EDWP Medicaid**

* These limits change when the Social Security Administration increases Social Security and SSI.

** If the EDWP Medicaid applicant has a spouse who is neither in EDWP nor in an institution, the assets of the spouse MUST be considered in the eligibility determination. The combined total of **countable** assets of the individual and the spouse must be $130,380 or less. The EDWP client must transfer assets in his/her name in excess of $2,000 to the community spouse within one year from the month Medicaid eligibility begins. A waiver Medicaid eligible person may divert up to $3259.50 per month of income to a legal spouse who is neither in the EDWP nor an institution. The legal spouse's income is deducted from the $3259.50 limit before determining the amount of income to divert.

Elderly and Disabled Waiver
Aging and Disability Resource Connection and Geographic Service Areas

Listed below are Georgia's 12 Planning & Service Areas. Each agency, called Area Agency on Aging (AAA), coordinates a variety of services and resource information for the elderly and disabled, including assessment and referral to programs including EDWP (Traditional/Enhanced + Source). The AAA serves as the EDWP's entry point, determines both consumer eligibility and the type of services needed.

ATLANTA REGIONAL COMMISSION
EDWP Information- (404) 463-3333 (Atlanta)
Area Agency on Aging- (404) 463-3100 (Atlanta)
Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Rockdale, and Henry.

CENTRAL SAVANNAH RIVER
EDWP Information- 1-888-922-4464 or (706) 210-2018
Area Agency on Aging (706) 210-2018 (Augusta)
Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington and Wilkes.

COASTAL GEORGIA
EDWP Information - 1-800-580-6860
Area Agency on Aging- (912) 437-0800
Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long and McIntosh.

HEART OF GEORGIA /ALTAMAHA
EDWP Information - 1-888-367-9913 or (912) 367-3648
Area Agency on Aging - (912) 367-3648 (Baxley)
Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler and Wilcox.

LEGACY LINK
EDWP Information- 1-800-845-LINK or (770) 538-2650
Area Agency on Aging - (770) 538-2650 (Oakwood)
Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union and White.

MIDDLE GEORGIA
EDWP Information- (478) 751-6466
Area Agency on Aging (478) 751-6466 or 1-888-548-1456
Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs and Wilkinson.

NORTHEAST GEORGIA
EDWP Information-1-800-474-7540 or (706) 583-2546
Area Agency on Agency - (706) 583-2546 (Athens)
Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe and Walton.

NORTHWEST GEORGIA
EDWP Information - 1-800-759-2963 or (706) 802-5506
Area Agency on Aging- (706) 295-6485
Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker and Whitfield.

RIVER VALLEY REGIONAL COMMISSION
EDWP Information- (706) 256-2900 or 1-800-615-4379
Area Agency on Aging- (706) 256-2900 (Columbus)
Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor and Webster.

SOUTHERN GEORGIA
EDWP Information- (912) 287-5888 or 1-888-732-4464
Area Agency on Aging - (912) 285-6097(Waycross)
Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner and Ware.

SOUTHWEST GEORGIA (SOWEGA)
EDWP Information- (229) 432-1124 (Albany)
Area Agency on Aging- 1-800-282-6612 or (229) 432-1124 (Albany)
Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas and Worth.

THREE RIVERS REGIONAL COMMISSION
EDWP Information/Area Agency on Aging – 1-866-854-5652 or 678-552-2838 (Franklin)
Butts, Carroll, Coweta, Heard, Lamar, Meriwether, Pike, Spalding, Troup and Upson.

EDWP는 어떤 프로그램입니까?

SOURCE + CCSP (전통적/강화된 프로그램) 는 노인과 장애인을 위한 면제 프로그램의 일환입니다. SOURCE와 CCSP는 모두 노인 또는 장애인들이 자신의 집이나 지역사회에 머무를 수 있도록 지원합니다. EDWP는 자격이 되는 사람에게 요양시설을 알선하는 대신 지역사회 기반 서비스를 제공합니다. 지역보건부(Department of Community Health)가 EDWP를 관리하고 운영합니다.

이 프로그램을 통해 어떤 서비스가 제공됩니까?

주간 노인 건강 서비스
- 주간 시간 동안 돌봄 및 감독 서비스 제공
- 간호 및 의료 사회 서비스
- 계획된 치료에 도움이 되는 활동들
- 신체적, 언어적 및 작업적 치료법
- 규정식을 포함한 식사

대체 생활 서비스
- 자신의 집에서 독립적으로 거주할 수 없는 사람들을 위한 대체 거주지
- 식사, 개인 간병 및 감독

응급 대응 서비스
- 격리된 사람과 의료통제센터 간의 양방향 커뮤니케이션을 제공하는 가정용 전자 지원 시스템
- 24시간 연중 무휴 서비스 제공

가정 배송 서비스
- 숙련된 간호 서비스
- 신체적, 언어적 및 작업적 치료법
- 의료 사회 서비스 및 가정 건강 보조 지원 서비스
- 개인 간병 및 식사 지원

개인 지원 서비스
- 식사 준비, 위생 및 영양 지원
- 가벼운 청소, 필요한 심부름 및 기타 지원 서비스
- 도우미가 제공하는 자택 위탁 간병

소비자 중심 개인 지원 서비스 옵션
다음을 제외하고 개인 지원 서비스와 동일합니다.
- 소비자가 선택한 근로자를 고용하고 감독합니다.
- 이 옵션에 등록된 고객은 급료를 지급하고 자신을 대신해서 연방 및 주 세법을 준수할 재무 관리 서비스 제공자를 선택해야 합니다

시설에서의 위탁 간병
- 24시간 감독하에 승인된 시설에서 위탁 간병

가정 급식 배송
- 외부 시설에서 준비하여 고객에게 전달

(강화된 및 전통적) 사례 관리
- 개별 요구사항을 충족시키는데 필요한 옵션과 서비스의 할당, 구현, 조정, 모니터링, 평가 및 필요한 경우 위탁을 포함한 절차

누가 EDWP 자격이 됩니까?

EDWP의 자격 기준은 다음과 같습니다.
- 신체적 제약으로 인한 기능 손상
  참조: 알츠하이머 및 치매는 신체적 상태입니다.
- 간병 필요 조건을 충족하지 않음
- 중급 간병 (LOC) 승인
  요양원 알선을 위한 증명
- 고객측 의사의 간병 계획 승인
- EDWP 승인 후 메디케이드 자격이 되거나 잠재적으로 자격이 가능한 경우
- 고객이 기관 서비스가 아닌 지역 기반 서비스를 선택한 경우
- 요양 시설에서 제공되는 서비스는 메디케이드가 지급하는 평균 연간 비용 내에서 이뤄집니다. EDWP는 보건 및 안전 요구 사항을 준수합니다.
- 한 번에 한 개의 면제 프로그램에 참여
- 메디케어 가정 건강 서비스 또는 호스피스(메디케어 또는 메디케이드)가 소비자의 서비스 요구를 충족시키지 못하는 경우
- 가정 급식 배송 외에 다른 서비스도 필요한 경우
- 가정 환경이 불법적인 행동과 타인에게 신체적 신체적 상해를 가할 위험이 없는 경우

고객은 EDWP 서비스를 받기 위해 자택에 머무를 필요가 없습니다.

개인이 EDWP 서비스를 받으려면 어떻게 해야 합니까?

1단계: 전통적/강화된 간병을 위한 EDWP 평가를 받기 위해 해당 지역의 노인 서비스 제공 기관에 연락합니다. 메디케이드에 가입되어 유효한 경우, AAA 또는 SOURCE에 연락하여 평가를 받을 수 있습니다.

2단계: EDWP 자격이 되는 경우, 간병 코디네이터와 회원/대리인이 함께 상의하여 신청자에게 필요한 서비스를 결정합니다.

서비스는 어떻게 준비됩니까?

1단계: 사례 관리 기관은 필요한 서비스를 제공하기 위해 EDWP 서비스 기관과 조율합니다. 서비스 기관은 EDWP 고객에게 제공한 서비스에 대해 지역사회 보건부에 직접 청구할 수 있는 메디케이드 제공자로 승인을 받았습니다. 간병 코디네이터는 다른 서비스 기관 및 펀드 출처를 통해서도 고객 서비스를 제공합니다.

2단계: 메디케이드 수혜자가 아닌 사람의 경우, 메디케이드 신청서를 가족 및 아동 서비스부(Division of Family and Children Services)의 지역 카운티 사무실에 신청합니다.

3단계: 사례 관리 기관은 EDWP 고객과 정기적인 연락을 통해 개인별 요구 사항이 충족되고 적절한 서비스가 이뤄지고 있는지 확인합니다. 고객/가족 대리인은 고객 간병 계획 개발에 참여합니다.

재정적 자격 요건은 무엇입니까?

다음 정보는 EDWP에 대한 재정적 자격 요건을 요약한 것입니다.

- 생활보조금 (SSI) 카테고리: 생활보조금 (Supplemental Security Income) 를 받고 있으면서 의료 지원을 받을 자격이 있는 사람. 사회보장국 (Social Security Administration) 이 SSI 신청서를 접수합니다.

- 의료 지원 전용 (MAO) 카테고리: SSI 프로그램에 따른 현금 혜택을 받지 못한 사람은 다른 메디케이드 카테고리에 따라 의료 지원을 받을 수도 있습니다. 카운티 아동 및 가족 서비스부가 MAO 신청서를 접수합니다. MAO 참가자가 서비스 비용을 지불해야 할 수도 있습니다.

	SSI 소득 한도: *	면제 메디케이드/ MAO 소득 한도:	SSI 및 면제 메디케이드 자원 한도:
개인	$841/월 미만	$2,523/월	$2,000 이하
부부 (두 사람 모두 EDWP에 해당되는 경우)	$1,261/월 미만	$2,523/월 개인당	$3,000 이하
EDWP에 해당되는 개인으로 기혼인 경우	$1,261/월 미만	$2,523/월	생활보조금(SSI)의 경우 $2,000 이하 EDWP 메디케이드의 경우 $130,380(합계) 이하**

* 사회 보장국이 사회보장 및 생활보조금(SSI)을 증액할 경우 한도가 변경됩니다.

** EDWP 메디케이드 신청자에게 EDWP 또는 기관에 속하지 않는 배우자가 있는 경우, 자격 결정단계에서 배우자의 자산이 고려됩니다. 개인과 배우자의 **가산** 자산 합계는 $130,380 이하여야 합니다. EDWP 고객은 메디케이드 자격이 시작되는 달부터 1년 내에 자신의 이름으로 된 $ 2,000를 초과하는 자산에 대해서는 같은 지역사회 배우자에게 양도해야 합니다.

면제 메디케이드 자격이 있는 사람은 EDWP 또는 기관에 속하지 않은 법적 배우자에게 월 소득 $3259.50까지 전환할 수 있습니다. 전환할 소득 금액을 결정하기 전에 $3,259.50 한도에서 법적 배우자의 소득이 공제됩니다.

노인 및 장애인 면제

다음은 조지아에 있는 12개의 계획 및 서비스 지역입니다. 지역노인복지사무소(AAA)라고 불리는 각 기관은 EDWP (전통적/강화된 프로그램 + Source) 를 포함한 프로그램 평가 및 의뢰를 포함하여 노인 및 장애인을 위한 다양한 서비스와 자원 정보를 조율합니다. 지역노인복지사무소(AAA)는 EDWP의 창구 역할을 하는 곳으로 소비자의 자격 요건과 필요한 서비스 유형을 결정합니다.

ATLANTA REGIONAL COMMISSION
EDWP 정보 - (404) 463-3333 (Atlanta)
지역노인복지사무소 - (404) 463-3100 (Atlanta)
Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Rockdale 및 Henry.

CENTRAL SAVANNAH RIVER
EDWP 정보 - 1-888-922-4464 또는 (706) 210-2018
지역노인복지사무소 (706) 210-2018 (Augusta)
Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington 및 Wilkes.

COASTAL GEORGIA
EDWP 정보 - 1-800-580-6860
지역노인복지사무소 - (912) 437-0800
Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long 및 McIntosh.

HEART OF GEORGIA /ALTAMAHA
EDWP 정보 - 1-888-367-9913 또는 (912) 367-3648
지역노인복지사무소 - (912) 367-3648 (Baxley)
Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler 및 Wilcox.

LEGACY LINK
EDWP 정보 - 1-800-845-LINK 또는 (770) 538-2650
지역노인복지사무소 - (770) 538-2650 (Oakwood)
Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union 및 White.

MIDDLE GEORGIA
EDWP 정보 - (478) 751-6466
지역노인복지사무소 (478) 751-6466 또는1-888-548-1456
Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs 및 Wilkinson.

NORTHEAST GEORGIA
EDWP 정보 -1-800-474-7540 또는 (706) 583-2546
지역노인복지사무소 - (706) 583-2546 (Athens)
Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe 및 Walton.

NORTHWEST GEORGIA
EDWP 정보 - 1-800-759-2963 또는 (706) 802-5506
지역노인복지사무소 - (706) 295-6485
Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker 및 Whitfield.

RIVER VALLEY REGIONAL COMMISSION
EDWP 정보 - (706) 256-2900 또는 1-800-615-4379
지역노인복지사무소 - (706) 256-2900 (Columbus)
Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor 및 Webster.

SOUTHERN GEORGIA
EDWP 정보- (912) 287-5888 또는 1-888-732-4464
지역노인복지사무소 - (912) 285-6097(Waycross)
Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner 및 Ware.

SOUTHWEST GEORGIA (SOWEGA)
EDWP 정보 - (229) 432-1124 (Albany)
지역노인복지사무소 - 1-800-282-6612 또는
(229) 432-1124 (Albany)
Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas 및 Worth.

THREE RIVERS REGIONAL COMMISSION
EDWP 정보 - 1-866-854-5652
678-552-2838 (Franklin)
또는 (770) 854-6026
지역노인복지사무소 –
Butts, Carroll, Coweta, Heard, Lamar, Meriwether, Pike, Spalding, Troup 및 Upson.

¿Qué es el programa EDWP?

SOURCE y CCSP (tradicional/optimizado) forman parte del programa EDWP. SOURCE y CCSP ayudan a que las personas ancianas o discapacitadas permanezcan en sus hogares o comunidades. El programa EDWP ofrece a los clientes que cumplen los requisitos servicios en la comunidad como una alternativa a los centros de enfermería. El Departamento de Salud Comunitaria administra y opera el programa EDWP.

¿Cuáles son los servicios que se ofrecen a través de este programa?

Centros diurnos de salud para adultos
- Atención y supervisión durante el día en centros diurnos para adultos
- Servicios de enfermería y servicios médicos sociales
- Actividades terapéuticas planificadas
- Terapia física, del habla y ocupacional
- Comidas, incluso dietas prescritas

Servicios de vida alternativos
- Residencia alternativa para las personas que no pueden mantenerse a sí mismas en sus propios hogares
- Comidas, cuidado personal y supervisión

Servicios de respuesta en caso de emergencia
- Sistema electrónico de respaldo a domicilio que brinda comunicación bidireccional entre las personas aisladas y un centro de control médico
- Servicio disponible las 24 horas del día, los siete días de la semana

Servicios de salud en el hogar
- Servicios de enfermería especializada
- Terapia física, del habla y terapia ocupacional
- Servicios sociales médicos y asistente de salud en el hogar
- Cuidado personal y asistencia con las comidas

Servicios de apoyo personal
- Asistencia con la preparación de comidas, higiene y nutrición
- Limpieza de la casa, recados necesarios y otros servicios de apoyo
- Cuidado auxiliar de apoyo familiar a cargo de un asistente

Opción de servicios de apoyo personal dirigidos al consumidor
Igual que los servicios de apoyo personal, salvo que:
- El cliente contrata y supervisa al trabajador de su elección
- Los clientes que se inscriban en esta opción tienen la obligación de elegir un proveedor de servicios de administración financiera a fin de que emita cheques y cumpla con las leyes impositivas federales y estatales en nombre del cliente.

Cuidado auxiliar de apoyo familiar fuera del hogar
- Cuidado auxiliar de apoyo familiar nocturno fuera del hogar en un establecimiento aprobado con supervisión las 24 horas del día

Alimentos a domicilio
- Preparados fuera del hogar y entregados al cliente

Administración de casos (optimizado y tradicional)
- Proceso que incluye evaluación, ejecución, coordinación, supervisión y análisis de las opciones y servicios necesarios para satisfacer las necesidades individuales y realizar remisiones según sea necesario

¿Quién puede recibir los servicios del programa EDWP?

Los requisitos para recibir los servicios del programa EDWP incluyen los siguientes:
- Discapacidad funcional debido a limitaciones físicas
  NOTA: El síndrome de Alzheimer y la demencia son enfermedades físicas.
- Necesidad de atención médica no satisfecha
- Aprobación de un nivel intermedio de atención médica (LOC)
  certificación para traslado a un asilo de ancianos y convalecientes
- Aprobación del plan de atención médica por el médico del cliente
- Cumple los requisitos o puede cumplir los requisitos de Medicaid después de ser aceptado en el programa EDWP
- El cliente elige servicios comunitarios, en vez de servicios institucionales
  Los servicios están dentro del costo promedio anual de atención médica reembolsada por Medicaid que se proporciona en un centro de enfermería. Las necesidades de salud y seguridad pueden satisfacerse mediante la participación en el programa EDWP
- Participación en un programa de exención a la vez
- Los servicios de salud en el hogar de Medicare o los servicios de cuidados paliativos (Medicare o Medicaid) no satisface las necesidades del cliente
- La entrega de comidas a domicilio no es la única necesidad
- No hay conductas ilegales y amenazas de daño corporal a otras personas en el entorno del hogar.

Los clientes no necesitan estar confinados en el hogar para recibir los servicios del programa EDWP.

¿Cómo puede recibir una persona los servicios del programa EDWP?

Paso 1: La persona debe comunicarse con la Agencia Local para el Envejecimiento (Area Agency on Aging, AAA) a fin de realizar una evaluación para recibir cuidado tradicional/optimizado. La persona que tenga Medicaid completo activo puede comunicarse con la AAA o con SOURCE para recibir la evaluación.

Paso 2: Si la persona cumple los requisitos del programa EDWP, el coordinador de atención médica y el integrante/representante colaboran para determinar qué servicios necesita el solicitante.

¿Cómo se organizan los servicios?

Paso 1: La administración de casos se comunica con las agencias de servicios del programa EDWP para que proporcionen los servicios necesarios.
Las agencias de servicio son proveedores aprobados por Medicaid que les facturan directamente al Departamento de Salud Comunitaria por los servicios proporcionados a los clientes del programa EDWP. Los coordinadores de atención médica también organizan los servicios para el cliente a través de otras agencias de servicios y fuentes de fondos.

Paso 2: Si la persona no es beneficiaria de Medicaid, debe solicitar Medicaid en la oficina local del condado de la División de Servicios para Familias y Niños.

Paso 3: La administración de casos se comunica periódicamente con los clientes del programa EDWP para garantizar que los servicios sean adecuados y que se atiendan las necesidades de las personas. El representante del cliente/la familia participa al momento de desarrollar el plan de atención del cliente.

¿Cuáles son los requisitos financieros?

La información que sigue resume los requisitos financieros para recibir los servicios del programa EDWP.

- Categoría de SSI: Personas que reciben Ingresos del Seguro Suplementario (SSI) y cumplen los requisitos para recibir asistencia médica. La Administración del Seguro Social recibe solicitudes para SSI.

- Categoría de Asistencia Médica Solamente (MAO): Las personas que no reciben beneficios de dinero en efectivo mediante el programa de SSI podrían calificar para asistencia médica ofrecida por otra categoría de Medicaid. Los Departamentos de Servicios para Familias y Niños reciben solicitudes para MAO. Es posible que los participantes de MAO tengan que pagar el costo de los servicios.

	Límites de ingreso para SSI:*	**Exención de Medicaid/ Límites de ingresos para MAO:**	**SSI y Exención de Medicaid Límites de recursos:**
Una sola persona	Inferior a $841/por mes	$2,523/por mes	$2,000 o menos
Pareja (ambos en el programa EDWP)	Inferior a $1,261/por mes	$2,523/por mes por persona	$3,000 o menos
Una sola persona en el programa EDWP, pero casada	inferior a $1,261/por mes	$2,523/por mes	$2,000 o menos para SSI $130,380 (combinados) o menos para Medicaid EDWP**

* Estos límites cambian cuando la Administración del Seguro Social aumenta la cantidad de Seguro Social y de SSI

** Si el solicitante del programa EDWP de Medicaid tiene un cónyuge que no está en un programa EDWP ni en una institución, los activos del cónyuge DEBEN tomarse en cuenta al momento de determinar si cumple los requisitos. El total de activos **contables** combinados de la persona y el cónyuge debe ser $130,380 o menos. El cliente del programa EDWP debe transferir los activos en su nombre de más de $2,000 al cónyuge en la comunidad en un plazo de un año a partir del mes en el cual comienza a cumplir los requisitos de Medicaid.

La persona que cumple los requisitos para la exención de Medicaid puede desviar hasta $3,259.50 de ingreso por mes al cónyuge legal que no está en el programa EDWP ni en una institución. El ingreso del cónyuge legal se descuenta del límite de $3,259.50 antes de determinar la cantidad de ingreso que se va a desviar.

Exención para ancianos y discapacitados
Centro de recursos para ancianos y discapacitados y Áreas geográficas de servicios

A continuación aparecen las 12 áreas de planificación y servicios de Georgia. Cada una de las agencias, llamada Agencia Local para el Envejecimiento (AAA), coordina varios servicios e información de recursos para los ancianos y los discapacitados, incluso la valoración y remisión a programas que incluyen el programa EDWP
(tradicional/optimizado + Source). La AAA sirve como el punto para ingresar al programa EDWP, determina tanto si el cliente cumple los requisitos y el tipo de servicios que necesita.

COMISIÓN REGIONAL DE ATLANTA
Información del programa EDWP- (404) 463-3333 (Atlanta)
Agencia Local para el Envejecimiento - (404) 463-3100 (Atlanta)
Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Rockdale y Henry.

CENTRAL SAVANNAH RIVER
Información sobre EDWP - 1-888-922-4464 o (706) 210-2018
Agencia Local para el Envejecimiento (706) 210-2018 (Augusta)
Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington y Wilkes.

COASTAL GEORGIA
Información sobre EDWP - 1-800-580-6860
Agencia Local para el Envejecimiento - (912) 437-0800
Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long y McIntosh.

HEART OF GEORGIA /ALTAMAHA
Información sobre EDWP - 1-888-367-9913 o (912) 367-3648
Agencia Local para el Envejecimiento - (912) 367-3648 (Baxley)
Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler y Wilcox.

LEGACY LINK
Información sobre EDWP- 1-800-845-LINK o (770) 538-2650
Agencia Local para el Envejecimiento - (770) 538-2650 (Oakwood)
Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union y White.

MIDDLE GEORGIA
Información sobre EDWP- (478) 751-6466
Agencia Local para el Envejecimiento (478) 751-6466 o 1-888-548-1456
Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs y Wilkinson.

NORTHEAST GEORGIA
Información sobre EDWP -1-800-474-7540 o (706) 583-2546
Agencia Local para el Envejecimiento - (706) 583-2546 (Athens)
Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe y Walton.

NORTHWEST GEORGIA
Información sobre EDWP - 1-800-759-2963 o (706) 802-5506
Agencia Local para el Envejecimiento - (706) 295-6485
Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker y Whitfield.

COMISIÓN REGIONAL RIVER VALLEY
Información sobre EDWP -(706) 256-2900 or 1-800-615-4379
Agencia Local para el Envejecimiento - (706) 256-2900 (Columbus)
Chattahoochee, arcilla, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter Talbot, Taylor y Webster.

SOUTHERN GEORGIA
Información sobre EDWP -(912) 287-5888 o 1-888-732-4464
Agencia Local para el Envejecimiento - (912) 285-6097(Waycross)
Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner y Ware.

SOUTHWEST GEORGIA (SOWEGA)
Información sobre EDWP - (229) 432-1124 (Albany)
Agencia Local para el Envejecimiento - 1-800-282-6612 o (229) 432-1124 (Albany)
Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas y Worth.

COMISIÓN REGIONAL THREE RIVERS
Información sobre EDWP - 1-866-854-5652
678-552-2838 (Franklin)
Agencia Local para el Envejecimiento:
Butts, Carroll, Coweta, Heard, Lamar, Meriwether, Pike, Spalding, Troup y Upson.

AGENCY NAME CCSP	ADDRESS	Serving County(ies)	Email
360 Case Management LLC	Main Number: 803-226-0236 Fax: 803-226-0335 35 Varden Dr., Suite A Aiken, South Carolina 29803	Burke, Columbia, Jefferson, Lincoln, McDuffie, Richmond, Warren, Washington and Wilkes	Juanethea@360cares.org
A Step Above Case Management, Inc.	50 Hurt Plaza SE Unit 1108 Atlanta, GA 30303 404-400-2218 FAX: 404-220-9450	Clayton, Cobb, DeKalb, Douglas, Fulton, Gwinnett and Henry	mark@stepabovegeorgia.com
Action Pact Reidsville	P.O. Box 1550 111 Medical Arts Drive Reidsville, GA 30453 Main Number: 912-557-6687 Emergency Number: 833-882-8193 Fax: 912-557-3039	Appling, Bleckley, Bryan, Bulloch, Candler, Chatham, Dodge, Emanuel, Evans, Glynn, Jeff Davis, Johnson, Laurens, Liberty, Long, McIntosh, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler and Wilcox.	thendley@myactionpact.org
Action Pact Waycross	Waycross + Administration P.O. Box 1965 Waycross, GA 31502 510 Tebeau St. Waycross, GA 31501 Main Number: 912-285-6083 Emergency Number 833-882-8193 Fax: 912-285-6288	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner and Ware	lbsteedley@myactionpact.org
Andrea Monday Case Management Services	105 Troy Edwards Rd. Eatonton, Ga 31024 (706) 473-3662	Baldwin, Bibb, Cobb, Crawford, DeKalb, Fulton, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs and Wilkinson	andrea.mondaycms1@gmail.com
B & B Care Services Inc Macon	3676 Fairmont Ave Macon, GA 31204 PO Box 1040 Springfield, Ga 31329 Phone: (912) 754-0817 Fax: 888-284-6039	ARC, Ga. Mtns, Heart, Middle, River Valley, SOWEGA and Three Rivers	edwp@bandbcare.com
B & B Care Services Inc Springfield	303 S Laurel St. PO Box 1040 Springfield Ga 31329 Main Number: 912-754-0817 Fax: 888-284-6039	Coastal, CSRA and NE	edwp@bandbcare.com

Care Assurance Aging Care Management	310 Horseshoe Bend Woodstock, Ga 30189 Main Number- 770-835-4085 ext 800 Fax- 770-828-0502	Bartow, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Floyd, Fulton, Gordon, Gwinnett, Hall, Henry, Jackson, Jasper, Lumpkin, Newton, Paulding, Pickens and Rockdale	jennifer@mycareassurance.com
Care Lync Georgia, LLC	1372 Peachtree St NE Atlanta, GA 30309 Main Number- 833-333-5962 Fax- 215-904-5073	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Cherokee, Clayton, Clinch, Cobb, Coffee, Cook, Dawson, DeKalb, Douglas, Echols, Fayette, Floyd, Forsyth, Fulton, Gwinnett, Hall, Henry, Irwin, Lanier, Lowndes, Paulding, Pierce, Rockdale, Tift,	atoecus@care-lyncga.com
Creative Case Management Temp Hold	280 Beckenham Walk Dr. Dacula, Ga 30019 Ph: 678-668-0222 Fax: 678-535-2963	Barrow, Clarke, Clayton, Cobb, DeKalb, Fulton, Gwinnett, Henry, Rockdale and Walton	ccms2020@yahoo.com
Crew Consulting Services	200 Suddeth St Winterville, GA 30683 Ph: 706-338-5544 Fax: 706-995-6865	Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe and Walton	info@crewconsultingservices.org
Crossroads Community Source LLC PERRY	1211 Macon Rd STE D Perry, Ga 31069 Ph: 478-224-6677 Fax: 478-988-0093	Bibb, Bleckley, Crawford, Crisp, Dodge, Dooly, Houston, Jones, Laurens, Macon, Monroe, Peach, Pulaski, Sumter, Taylor, Telfair, Twiggs Wilcox and Wilkinson	Awoolfolk@cc-source.net
Crossroads Community Source LLC TIFTON	311 12th Street West Tifton, Ga 31794 Ph: 229-396-4272 Fax: 478-988-0093	Ben Hill, Berrien, Coffee, Colquitt, Cook, Irwin, Lee, Tift, Turner and Worth	Awoolfolk@cc-source.net
Diversified Resources Inc. Camilla	34 S Scott St. Camilla, GA 31730 Main Number: 229-522-3770 Fax: 229-522-3161 Toll Free: 888-597-3511	Baker, Calhoun, Decatur, Dougherty, Early, Miller, Mitchell, Seminole	llewis@diversifiedresources.net
Diversified Resources Inc. Tifton	1411 U.S. Highway 41N P.O. Box 7614 Tifton, GA 31793 Main Number: 229-386-9296 Fax: 229-386-9271 Emergency Number: 800-575-7004	Ben Hill, Colquitt, Irwin, Lee, Telfair, Terrell, Tift, Turner, Wilcox and Worth	jlpate@diversifiedresources.net

Diversified Resources Inc. Valdosta	2700-C N. Oak Street Valdosta, GA 31601 Main Number: 229-253-9995 Fax: 229-253-9930 Emergency Number: 800-706-9674	Berrien, Brooks, Cook, Echols, Grady, Lanier, Lowndes and Thomas	dhoffman@diversifiedresources.net
Diversified Resources Inc. Waycross	147 Knight Avenue Circle P.O. Box 1099 Waycross, GA 31502 Main Number: 912-285-3089 Fax: 912-285-0367 Emergency Number: 800-283-0041	Appling, Atkinson, Bacon, Brantley, Camden, Charlton, Clinch, Coffee, Glynn, Jeff Davis, Liberty, Long, McIntosh, Pierce, Ware and Wayne	kthrift@diversifiedresources.net
Faith Health Services of GA Inc.	770-416-1910 Fax: 770-925-1448 5325 Oakbrook Pkwy, Norcross, GA, 30093	Barrow, Carroll, Cherokee, Clarke, Cobb, Coweta, Clayton, Dekalb, Douglas, Fayette, Fulton, Forsyth, Gwinnett, Hall, Henry, Newton, Oconee, Paulding, Rockdale, Spalding and Walton	llaplace@fhsga.com
Ga Infirmary DBA St. Joseph's/Candler Health System Baxley	833-370-0857 or 912-367-6108 Fax 912-367-0392 68 North Oak St. Suite E Street, Baxley, GA 31513	Appling, Bacon, Brantley, Coffee, Dodge, Emanuel, Evans, Jeff Davis, Liberty, Long, Montgomery, Pierce, Tattnall, Telfair, Toombs, Treutlen, Ware, Wayne and Wheeler	brownji@sjchs.org
Ga Infirmary DBA St. Joseph's/Candler Health System Savannah	912-819-1520 or 866-218-2259 Fax 912-819-1548 1900 Abercorn Street, Savannah, GA 31401	Brantley, Bryan, Bulloch, Camden, Candler, Chatham, Effingham, Glynn, Liberty, McIntosh	puckettd@sjchs.org
Infinity Case Management LLC pending	478-491-2732 Fax: 7005 Becca Lane Locust Grove, GA 30248	Clayton, Cobb, DeKalb, Fayette, Fulton, Gwinnett, Henry Newton, Paulding and Rockdale	infinitycasemanagementllc@gmail.com
Legacy Link Inc	770-538-2650 or 1-800-845-5465 Fax: 770-538-2660 or 770-538-2791 4080 Mundy Mill Road Oakwood Ga 30566	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Clarke, Dade, Dawson, Elbert, Fannin, Forsyth,Floyd, Franklin, Gilmer, Gordon, Gwinnett, Hall, Habersham, Haralson, Hart, Jackson, Lumpkin, Madison, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, White and Whitfield	lgthomas@legacylink.org
Lower Chattahoochee Direct Services Americus	P.O. Box 1668 Americus, GA 31709 Main Number: (229) 928-8730 Fax: (229) 928-8732	Crisp, Dooly, Macon, Marion, Schley, Stewart, Sumter, Taylor, and Webster	kendra.coleman@directservices.org

Lower Chattahoochee Direct Services Columbus	1500 Second Avenue Columbus, GA 31901 Main Number: 706-321-9545 Fax: (706) 887-4829	Chattahoochee, Clay, Harris, Muscogee, Quitman, Randolph, and Talbot	kendra.coleman@directservices.org
McIntosh Trail Mgmt. Services- Franklin	P.O. Box 310 Franklin, GA 30217-0310 Main Number: 706-675-2985 or 706-675-6495 or 770-854-4463 Fax: 706-675-1648	Carroll, Coweta, Harris, Heard, Meriwether and Troup	cthornhill@mtmsi.org
McIntosh Trail Mgmt. Services- Griffin	246 O'Dell Rd. STE 5 Griffin, GA 30224 Main Number: 770-567-5948 Fax: 770-567-	Butts, Fayette. Lamar, Pike, Spalding, and Upson	cthornhill@mtmsi.org.
McIntosh Trail Mgmt. Services- Macon	3200 Riverside Dr. STE A 200 Macon, GA 31210 Main Number: 478-752-3260 Fax: 478-752-1058	Baldwin, Bibb, Crawford, Houston, Jones, Macon, Monroe, Pulaski, Peach, Putnam, Twiggs and Wilkinson	dshuler@mtmsi.org
On My Watch Athens	1711 Prince Avenue Athens, GA 30606 Main Number: 706-354-1621 or Toll Free 1-800-689-5123 Fax: 706-354-0837 Emergency / On-Call Number: 706-540-5934	Banks, Barrow, Clarke, DeKalb, Elbert, Franklin, Fulton, Greene, Gwinnett, Hall, Hart, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Putnam, Rockdale, and Walton	jwyrick@onmywatchcare.com
On My Watch Augusta	119 Davis Road, Suite 9A Martinez, GA 30907 Main Number: 706-707-8005 or Toll Free 1-800-689-5123 FAX: 706-869-2295 Emergency/On-Call Number: 706-540-5934	Baldwin, Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes and Wilkinson	sholloway@csraccsp.org
	Served via the Augusta office Main Number: 912-544-4699 FAX: 912-544-4698	Bryan, Bulloch, Chatham, Effingham, Evans, and Liberty,	lpeden@onmywatchcare.com
Prestige Case Management Firm, LLC (formerly D&B Case Management)	1216 Dawson Rd STE 211 Albany, GA 31707 Ph: 229.446.7332 Fax: 229.446.7435	Baker, Colquitt, Dougherty, Early, Grady, Lee, Mitchell, Terrell, Thomas and Worth	dandbcm@att.net
Pruitt Health Home First Albany	470-585-6333 Fax: 202 North Westover Boulevard Albany, Georgia 31707	Baker, Ben Hill, Bleckley, Calhoun, Chattahoochee, Clay, Crisp, Dodge, Dooly, Dougherty, Early, Irwin, Lee, Macon, Marion, Miller, Muscogee, Pulaski, Quitman, Randolph, Schley, Stewart, Sumter, Telfair, Terrell, Tift, Turner, Webster, Wilcox and Worth	sbass@pruitthealth.com

Pruitt Health Home First Athens	706-549-3315, Fax: 706-543-3841 1751 Meriweather Drive Watkinsville, Georgia 30677	Banks, Barrow, Clarke, Elbert, Franklin, Greene, Habersham, Hart, Jackson, Madison, Morgan, Oconee, Oglethorpe, Stephens, Walton	TLucas@pruitthealth.com
Pruitt Health Home First Atlanta	770-925-1143 Fax: 678 533-6488 1626 Jeurgens Court Norcross GA 30093	Carroll, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Newton, Paulding, Polk, Rockdale and Troup	chteasley@pruitthealth.com
Pruitt Health Home First Blue Ridge	706-632-9263, Fax 706-632-0028 6050 Appalachian Hwy Blue Ridge, GA 30513	Bartow, Catoosa, Cherokee, Chattooga, Dade, Dawson, Fannin, Floyd, Gilmer, Gordon, Lumpkin, Murray, Pickens, Rabun, Towns, Union, Walker, White, Whitfield	JGAddison@pruitthealth.com
Pruitt Health Home First Macon	478-474-0979 Fax: 478-474-2068 6060 Lakeside Commons Drive Macon, GA 31210	Baldwin, Bibb, Butts, Crawford, Harris, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriwether, Monroe, Montgomery, Peach, Pike, Putnam, Spalding, Talbot, Taylor, Treutlen, Twiggs, Upson, Wheeler, Wilkinson	moneal@pruitthealth.com
Pruitt Health Home First Savannah	912-925-9181 Fax: 912-925-9341 9100 White Bluff Rd STE 303 Savannah, Ga 31406	Appling, Bacon, Bryan, Bulloch, Brantley, Camden, Candler, Charlton, Chatham, Effingham, Evans, Glynn, Liberty, Long, McIntosh, Pierce, Tattnall, Toombs and Wayne	mcuff@pruitthealth.coms
Smiling Angels Case Management	1429 Stoneleigh Hill Rd. Lithonia, Ga. 30058 Main Number: 678 939 3643 Fax:	Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry and Rockdale	tamarabrown0608@yahoo.com
Smith Out Reach Family Services LLC	2453 Powder Springs Rd STE 325 C Marietta, GA 30064 Main Number: 470.264.1608 Fax:	Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry and Rockdale	Info@smithoutreachcf.com
SOURCE Care Management dba NextStep Care Columbus	2320 Double Churches Rd. STE A Columbus Ga 31909 Main Number: 888-762-2420 Fax: 706-257-1006	Chattahoochee, Clay, Harris, Marion, Meriwether, Muscogee, Quitman, Randolph, Schley, Stewart, Talbot, Troup and Webster	OHumphrey@nextstepcare.org
SOURCE Care Management dba NextStep Care Macon	2000 A Northside Crossing Macon, Ga 31210 Main Number: 888-762- 2420 Fax: 478-621-7538	Baldwin, Bibb, Bleckley, Butts, Crawford, Dodge, Houston, Jones, Lamar, Macon, Monroe, Peach, Pike, Pulaski, Putnam, Spalding, Taylor, Twiggs, Upson and Wilkinson.	OHumphrey@nextstepcare.org

Visiting Nurse Health System Atlanta	5775 Glenridge Drive, NE Suite E200 Atlanta, GA 30328 Ph: 404-581-4782; Fax: 404-527-0606	Barrow, Butts, Carroll, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Jasper, Newton, Rockdale, Spalding and Walton	Suzanne.Salak@vnhs.org
Visiting Nurse Health System Rome	109 W. 8th Ave. Rome, Ga. 30161 Ph: 706.525.6053 Fax: 404.443.1296	Bartow, Chattooga, Cherokee, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk and Whitfield	Taesha.Ward@vnhs.org

AGENCY NAME SOURCE	ADDRESS	Serving County(ies)	Email
360 Case Management LLC	Main Number: 803-226-0236 Fax: 803-226-0335 35 Varden Dr., Suite A Aiken, South Carolina 29803	Burke, Columbia, Jefferson, Lincoln, McDuffie, Richmond, Warren, Washington and Wilkes	Juanethea@360cares.org
Ace Care Management	Ph: 844-937-4223, Fax: 844-937-4223 (follow prompts) 50 Hurt Plaza SE Atlanta, Georgia 30303	Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Rockdale, Spalding and Walton	ruchelle.thomas@acecaremgmt.com
Atlanta Pro Health LLC	Office: 470-275-1046 Fax: 470-275-6812 6251 Smithpoint Dr. Norcross, GA 30092	Bartow, Cherokee, Clayton, Cobb, DeKalb, Floyd, Fulton, Gwinnett, Rockdale and Walton	Atlprohealth@outlook.com Tonyervinaph@gmail.com
Care Assurance Aging Care Management	310 Horseshoe Bend Woodstock, Ga 30189 Main Number- 770-835-4085 ext 800 Fax- 770-828-0502	Bartow, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Floyd, Fulton, Gordon, Gwinnett, Hall, Henry, Jackson, Jasper, Lumpkin, Newton, Paulding, Pickens and Rockdale	jennifer@mycareassurance.com
Care Lync Georgia, LLC	1372 Peachtree St NE Atlanta, GA 30309 Main Number- 833-333-5962 Fax- 215-904-5073	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Cherokee, Clayton, Clinch, Cobb, Coffee, Cook, Dawson, DeKalb, Douglas, Echols, Fayette, Floyd, Forsyth, Fulton, Gwinnett, Hall, Henry, Irwin, Lanier, Lowndes, Paulding, Pierce, Rockdale, Tift, Turner and Ware.	atoecus@care-lyncga.com
Crisp Care Management SOURCE	229 276-2126 Fax: 229-271-4669 910 North 5th Street, Cordele, GA 31015	Crisp, Dooly, Macon, Pulaski, Sumter, Wilcox	jsmith@crispregional.org
Crossroads Community Source LLC PERRY	1211 Macon Rd STE D Perry, Ga 31069 Ph: 478-224-6677 Fax: 478-988-0093	Bibb, Bleckley, Crawford, Crisp, Dodge, Dooly, Houston, Jones, Laurens, Macon, Monroe, Peach, Pulaski, Sumter, Taylor, Telfair, Twiggs Wilcox and Wilkinson	Awoolfolk@cc-source.net
Crossroads Community Source LLC TIFTON	311 12th Street West Tifton, Ga 31794 Ph: 229-396-4272 Fax: 478-988-0093	Ben Hill, Berrien, Coffee, Colquitt, Cook, Irwin, Lee, Tift, Turner and Worth	Awoolfolk@cc-source.net
Diversified Resources Inc. Camilla	34 S Scott St. Camilla, GA 31730 Main Number: 229-522-3770 Fax: 229-522-3161 Toll Free: 888-597-3511	Baker, Calhoun, Decatur, Dougherty, Early, Miller, Mitchell, Seminole	cmcgovern@diversifiedresources.net

Diversified Resources Inc. Tifton	1411 U.S. Highway 41N P.O. Box 7614 Tifton, GA 31793 Main Number: 229-386-9296 Fax: 229-386-9271 Emergency Number: 800-575-7004	Ben Hill, Colquitt, Irwin, Lee, Telfair, Terrell, Tift, Turner, Wilcox and Worth	Klindsey@diversifiedresources.net
Diversified Resources Inc. Valdosta	2700-C N. Oak Street Valdosta, GA 31601 Main Number: 229-253-9995 Fax: 229-253-9930 Emergency Number: 800-706-9674	Berrien, Brooks, Cook, Echols, Grady, Lanier, Lowndes and Thomas	bmday@diversifiedresources.net
Diversified Resources Inc. Waycross	147 Knight Avenue Circle P.O. Box 1099 Waycross, GA 31502 Main Number: 912-285-3089 Fax: 912-285-0367 Emergency Number: 800-283-0041	Appling, Atkinson, Bacon, Brantley, Camden, Charlton, Clinch, Coffee, Glynn, Jeff Davis, Liberty, Long, McIntosh, Pierce, Ware and Wayne	Caltman@diversifiedresources.net
Faith Health Services of GA Inc.	770-416-1910 Fax: 770-925-1448 5325 Oakbrook Pkwy, Norcross, GA, 30093	Barrow, Carroll, Cherokee, Clarke, Cobb, Coweta, Clayton, Dekalb, Douglas, Fayette, Fulton, Forsyth, Gwinnett, Hall, Henry, Newton, Oconee, Paulding, Rockdale, Spalding and Walton	llaplace@fhsga.com
Ga Infirmary DBA St. Joseph's/Candler Health System Baxley	833-370-0857 or 912-367-6108 Fax 912-367-0392 68 North Oak St. Suite E Street, Baxley, GA 31513	Appling, Bacon, Brantley, Coffee, Dodge, Emanuel, Evans, Jeff Davis, Liberty, Long, Montgomery, Pierce, Tattnall, Telfair, Toombs, Treutlen, Ware, Wayne and Wheeler	brownji@sjchs.org
Ga Infirmary DBA St. Joseph's/Candler Health System Savannah	912-819-1520 or 866-218-2259 Fax 912-819-1548 1900 Abercorn Street, Savannah, GA 31401	Brantley, Bryan, Bulloch, Camden, Candler, Chatham, Effingham, Glynn, Liberty, McIntosh	davisterr@sjchs.org
Legacy Link Inc	770-538-2650 or 1-800-845-5465 Fax: 770-538-2660 or 770-538-2791 4080 Mundy Mill Road Oakwood Ga 30566	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Clarke, Dade, Dawson, Elbert, Fannin, Forsyth, Floyd, Franklin, Gilmer, Gordon, Gwinnett, Hall, Habersham, Haralson, Hart, Jackson, Lumpkin, Madison, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, White and Whitfield	slwaren@legacylink.org

On My Watch Athens	1711 Prince Avenue Athens, GA 30606 Main Number: 706-354-1621 or Toll Free 1-800-689-5123 Fax: 706-354-0837 Emergency / On-Call Number: 706-540-5934	Banks, Barrow, Clarke, DeKalb, Elbert, Franklin, Fulton, Greene, Gwinnett, Hall, Hart, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Putnam, Rockdale, and Walton	lpeden@onmywatchcare.com
On My Watch Augusta	119 Davis Road, Suite 9A Martinez, GA 30907 Main Number: 706-707-8005 or Toll Free 1-800-689-5123 FAX: 706-869-2295 Emergency/On-Call Number: 706-540-5934	Baldwin, Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes and Wilkinson	lpeden@onmywatchcare.com
	Served via the Augusta office Main Number: 912-544-4699 FAX: 912-544-4698	Bryan, Bulloch, Chatham, Effingham, Evans, and Liberty,	lpeden@onmywatchcare.com
Piedmont Columbus Regional Healthcare System	(706) 571-1946; Fax: (706) 660-6279 1900 10th Avenue, STE 100 Columbus GA, 31901	Chattahoochee, Harris, Marion, Muscogee, Talbot, Stewart, Meriwether, Upson, Pike, Taylor, Troup	Jenny.Dowdy@piedmont.org
Prestige Case Management Firm, LLC (formerly D&B Case Management)	1216 Dawson Rd STE 211 Albany, GA 31707 Ph: 229.446.7332 Fax: 229.446.7435	Baker, Colquitt, Dougherty, Early, Grady, Lee, Mitchell, Terrell, Thomas and Worth	dandbcm@att.net
Pruitt Health Home First Albany	470-585-6333 Fax: 202 North Westover Boulevard Albany, Georgia 31707	Baker, Ben Hill, Bleckley, Calhoun, Chattahoochee, Clay, Crisp, Dodge, Dooly, Dougherty, Early, Irwin, Lee, Macon, Marion, Miller, Muscogee, Pulaski, Quitman, Randolph, Schley, Stewart, Sumter, Telfair, Terrell, Tift, Turner, Webster, Wilcox and Worth	sbass@pruitthealth.com
Pruitt Health Home First Athens	706-549-3315, Fax: 706-543-3841 1751 Meriweather Drive Watkinsville, Georgia 30677	Banks, Barrow, Clarke, Elbert, Franklin, Greene, Habersham, Hart, Jackson, Madison, Morgan, Oconee, Oglethorpe, Stephens, Walton	TLucas@pruitthealth.com
Pruitt Health Home First Atlanta	770-925-1143 Fax: 678 533-6488 1626 Jeurgens Court Norcross GA 30093	Carroll, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Newton, Paulding, Polk, Rockdale and Troup	chteasley@pruitthealth.com
Pruitt Health Home First Augusta	706-651-1535, Fax: 706 863-9401 1220 Augusta West Parkway Augusta, Georgia 30909	Burke, Columbia, Emanual, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes	tbates@pruitthealth.com

Pruitt Health Home First Blue Ridge	706-632-9263, Fax 706-632-0028 6050 Appalachian Hwy Blue Ridge, GA 30513	Bartow, Catoosa, Cherokee, Chattooga, Dade, Dawson, Fannin, Floyd, Gilmer, Gordon, Lumpkin, Murray, Pickens, Rabun, Towns, Union, Walker, White, Whitfield	JGAddison@pruitthealth.com
Pruitt Health Home First Macon	478-474-0979 Fax: 478-474-2068 6060 Lakeside Commons Drive Macon, GA 31210	Baldwin, Bibb, Butts, Crawford, Harris, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriwether, Monroe, Montgomery, Peach, Pike, Putnam, Spalding, Talbot, Taylor, Treutlen, Twiggs, Upson, Wheeler, Wilkinson	moneal@pruitthealth.com
Pruitt Health Home First Savannah	912-925-9181 Fax: 912-925-9341 9100 White Bluff Rd STE 303 Savannah, Ga 31406	Appling, Bacon, Bryan, Bulloch, Brantley, Camden, Candler, Charlton, Chatham, Effingham, Evans, Glynn, Liberty, Long, McIntosh, Pierce, Tattnall, Toombs and Wayne	mcuff@pruitthealth.coms
Pruitt Health Home First Valdosta	229-241-8750 Fax: 229-241-8940 312 Canna Drive Valdosta, Georgia 31602	Atkinson, Berrien, Brooks, Clinch, Coffee, Colquitt, Cook, Decatur, Echols, Grady, Jeff Davis, Lanier, Lowndes, Miller, Mitchell, Seminole, Thomas, Ware	Tstill@pruitthealth.com
SOURCE Care Management dba NextStep Care Albany	Ph: 888-762-2420 Fax: 229-431-0525 507 N Jefferson St, Albany, GA 31701	Ben Hill, Crisp, Dooly, Dougherty, Irwin, Lee, Sumter, Terrell, Turner, Wilcox, Worth	GBussey@nextstepcare.org
SOURCE Care Management dba NextStep Care Augusta	Ph: 888-762-2420 Fax: 706-737-0250 2100 Central Avenue Suite #5, Augusta	Burke, Columbia, Richmond	EBrooks@nextstepcare.org
SOURCE Care Management dba NextStep Care Athens	Ph: 888-762-2420 Fax: 706-543-8293 1865 W. Broad St. STE C., Athens, GA	Banks, Barrow, Clark, Elbert, Franklin, Habersham, Hart, Jackson, Madison, Oconee, Oglethorpe, Rabun, Stephens, Towns, White	MBarton@nextstepcare.org
SOURCE Care Management dba NextStep Care Butler	Ph: 888-762-2420 Fax: 478-862-4844 12 South Broad Street, P.O. Box 89 Butler, GA 31006	Crawford, Macon, Marion, Peach, Pike, Schley, Spalding, Talbot, Taylor, Upson	MBalli@nextstepcare.org
SOURCE Care Management dba NextStep Care Columbus	2320 Double Churches Rd. STE A Columbus Ga 31909 Main Number: 888-762-2420 Fax: 706-257-1006	Chattahoochee, Clay, Harris, Muscogee, Quitman, Randolph, Stewart, Webster	clocke@nextstepcare.org
SOURCE Care Management dba NextStep Care Conyers	Ph: 888-762-2420 Fax: 770- 388 - 7539 1506 Klondike Road STE 201, Conyers, Ga. 30094	Rockdale, Walton, Newton, Henry, Dekalb	SWarren@nextstepcare.org

SOURCE Care Management **dba NextStep Care Duluth**	Ph: 888-762-2420 Fax: 770-717-2692 3885 Crestwood Pkwy, STE 250, Duluth, GA	Gwinnett, Fannin, Gilmer, Pickens, Cherokee, Union, Lumpkin, Dawson, Forsyth, Hall	MBarton@nextstepcare.org
SOURCE Care Management **dba NextStep Care Eatonton**	Ph: 888-762-2420 Fax: 706- 485-4159 951 Harmony Rd, Suite 104, Eatonton, GA	Baldwin, Greene, Hancock, Jasper, Lincoln, McDuffie, Morgan, Putnam, Taliaferro, Warren, Wilkes	EBrooks@nextstepcare.org
SOURCE Care Management **dba NextStep Care Macon**	2000 A Northside Crossing Macon, Ga 31210 Main Number: 888-762- 2420 Fax: 478-621-7538	Bibb, Bleckley, Butts Dodge Houston, Jones, Lamar, Monroe, Pulaski, Twiggs	clocke@nextstepcare.org
SOURCE Care Management **dba NextStep Care Metter**	Ph: 888-762-2420 Fax: 912- 685-7640 58 SE Broad Street, P.O. Box 631 Metter, GA 30439	Bulloch, Candler, Emanuel, Evans, Jeff Davis, Jenkins, Montgomery, Screven, Tattnall, Telfair, Toombs, Treutlen, Wheeler, Appling, Atkinson, Bacon, Brantley, Bryan, Camden, Charlton, Chatham, Clinch, Coffee, Effingham, Glynn, Liberty, Long, McIntosh, Pierce, Ware, Wayne	mhowell@nextstepcare.org
SOURCE Care Management **dba NextStep Care Rome**	Ph: 888-762-2420 Fax: 706-378-1330 413 Shorter Ave., Suite 111, Rome, GA	Bartow, Catoosa, Chattooga, Cobb, Dade, Floyd, Gordon, Haralson, Murray, Paulding, Polk, Walker, Whitfield	MBarton@nextstepcare.org
SOURCE Care Management **dba NextStep Care Thomasville**	Ph: 888-762-2420 Fax: 229- 227- 6156 14004 Hwy. 19 S. Suite 101, Thomasville, GA 31757	Baker, Brooks, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Miller, Mitchell, Seminole, Thomas, Tift, Berrien, Cook, Lanier, Lowndes, Echols	SRogers@nextstepcare.org
SOURCE Care Management **dba NextStep Care Tyrone**	Ph: 888-762-2420 Fax: 770-742-0913 602 Dogwood Trail, Suite A, Tyrone, GA	Carroll, Coweta, Douglas, Fayette, Heard, Meriwether, Troup, Fulton, Clayton	BNelson@nextstepcare.org
SOURCE Care Management **dba NextStep Care Wrightsville**	Ph: 888-762-2420 Fax: 478- 864-9423 8647 Marcus Street, Wrightsville, GA 31096	Glascock, Jefferson, Johnson, Laurens, Washington, Wilkinson	OHumphrey@nextstepcare.org
The ARC of Southwest Georgia	(229) 883-2334; Fax: (229) 883-2710 2200 Stuart Ave., Albany, Georgia 31707	Baker, Calhoun, Clay, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth	shouston@thearcswga.org
Trinity Case Management	(706) 507-5510 or (706) 507-5517 Fax: (706) 507-5550 5510 Veterans Parkway Suite 103 Columbus, Ga. 31904	Chattahoochee, Clay, Harris, Muscogee, Meriwether, Marion, Quitman, Randolph, Stewart, Talbot, and Webster	Trinitycase@knology.net

Visiting Nurse Health System Alanta	5775 Glenridge Drive, NE Suite E200 Atlanta, GA 30328 Ph: 404-581-4782; Fax: 404-527-0606	Barrow, Butts, Carroll, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Jasper, Newton, Rockdale, Spalding and Walton	Suzanne.Salak@vnhs.org
Visiting Nurse Health System Rome	109 W. 8th Ave. Rome, Ga. 30161 Ph: 706.525.6053 Fax: 404.443.1296	Bartow, Chattooga, Cherokee, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk and Whitfield	Taesha.Ward@vnhs.org

EDWP Traditional + Enhanced Hearing Information

Georgia Department of Community Health
Elderly and Disabled Waiver Program
Traditional/Enhanced

REQUEST FOR HEARING, FORM 5383

I request that the Department of Community Health hold a fair hearing to review the adverse action taken in regard to my claim for assistance as provided under the Elderly and Disabled Waiver Program-Traditional/Enhanced.

The reason I want a hearing is:

_____

_____

_____

_____

Check one:

( ) I want to continue to receive Traditional/Enhanced services at the level that I am currently receiving.

( ) I do NOT want to continue to receive Traditional/Enhanced service.

_____ _____

Date Client's Signature or Mark*

_____ _____

Authorized Representative Signature of Witness*

_____

_____

Address of Witness*

* The signature and address of one (1) witness must appear above when the claimant signs with a mark (x).

Please return this completed form to your care coordinator whose address and phone number are indicated at the top of the denial, termination, or reduction in services letter from the Traditional Community Care Services Program.

FOR STATE OFFICE USE ONLY

Client's SSN:_____

Date Received:_____ Received by:_____

Date received by LSO _____

Form 5383

Instructions
Elderly and Disabled Waiver Program

REQUEST FOR HEARING, FORM 5383

Purpose: Form 5383 is used by applicants or clients to begin the appeal process for denial, termination, or reduction in EDWP services. Clients may appeal orally with a formal written request within 15 days.

Who Completes/When Completed: The applicant/client or representative completes Form 5383 within 30 calendar days from the date of the notice of adverse action and forwards to the care coordinator or directly to the Legal Services Office.

Instructions:

The reason I want a hearing is: Client or client representative indicates reason for requesting a hearing and why s/he believes adverse action to be in error.

NOTE: Use of this form, while recommended, is optional with the client. Any written or oral request for an appeal must be accepted. A client need not state a reason for the request.

Date: Enter date request form is completed and signed.

Client's signature
or mark: Have client sign or enter his/her mark (X). If client signs by mark (X), a witness is required.

Client representative: Enter signature of client representative, if applicable.

Signature of witness: Enter signature of witness if client signs by mark (X).

Address of witness: Enter address of witness if client signs by mark (X).

Sample Letter

Elderly and Disabled
Waiver Program
Office Letterhead

Telephone Number ( )_____
Date_____

Applicant Name_____

Address _____

_____

_____

NOTICE
DENIAL OF LEVEL OF CARE
ELDERLY AND DISABLED WAIVER PROGRAM

State and federal law require that if you receive care in the Elderly and Disabled Waiver Program, your medical condition must be such that you require the level of care provided in a nursing facility. This letter is to notify you that according to our evaluation, your medical condition does not require the level of care provided in a nursing facility because_____

_____

_____

_____

In accordance with the Code of Federal Regulations, 42 CFR, S 441.301(b)(l)(ii), services for you through the Elderly and Disabled Waiver Program will be denied unless additional medical information justifies a need for the services.

You may obtain a review of this decision by sending additional medical information within ten (10) days of the date of this letter. Contact your attending physician or your original referring agency if you need help with your request. You must submit all information to the Traditional Community Care Services Program at the address shown above.

If you do not send additional medical information within ten (10) days, this decision will become effective on_____. If you choose not to send additional medical information but you disagree with this denial, you may request a hearing. You have thirty (30) days from the date of this letter to request a hearing. If you make your request orally, you must submit a written request within fifteen (15) days from the date of your oral request. An Administrative Law Judge will conduct the hearing in your county. At that hearing, you may represent yourself or use legal counsel, a friend, a relative or any other spokesperson to represent you.

You should contact this office immediately at the address and phone number above to request a hearing. The office will forward your request for a hearing to the Legal Services Office of the Georgia Department of Community Health.

Sincerely,

ADRC RN Care Coordinator_____

Title_____

Telephone Number (___)_____

cc Area Agency on Aging (Name)

Instructions
Elderly and Disabled Waiver Program

NOTICE OF DENIAL OF LEVEL OF CARE – ELDERLY AND DISABLED WAIVER PROGRAM

Purpose: This form is used to notify applicants that evaluation of their medical condition does not require the level of care provided in a nursing home.

Who Completes/When Completed: This form is completed by the ADRC Gateway RN and mailed to the client immediately after the RN determines that the applicant does not meet the level of care.

Instructions:

1. Use the ADRC agency letterhead stationary with the information in the sample letter to notify applicants of the denial of level of care.

2.	Telephone Number:	Enter the telephone number of the care coordination agency.
3.	Date:	Enter the date the notice was prepared and mailed.
4.	Applicant's Name:	Enter the applicant's name.
5.	Address:	Enter the applicant's mailing address.
6.	Denial Reason:	State specifically in the space provided why the applicant does not meet the level of care.
7.	Effective Date:	Enter the last day for which the applicant may submit additional information for reconsideration of the denial decision. This date is 10 days from the date the denial letter was prepared and mailed.
8.	Sincerely:	Enter the signature of the person authorized to sign on behalf of the agency.
9.	Care Coordinator:	Enter the name of the care coordinator RN who assessed the applicant and denied the level of care.
10.	Title:	Enter the title of the AAA Gateway RN

11. Telephone Number: Enter the telephone number of the AAA Gateway RN who assessed applicant and denied the level of care.

Distribution: Original to the client, copy to the ADRC, copy filed in applicant's electronic case record.

NOTE: Client files may be kept electronically.

EDWP
Traditional
+
Enhanced
Cover Letters

Your Letterhead Here

DATE:

CLIENT NAME: DOB: SSN XXX - XX -

TO: FROM:

The attached Level of Care page attached was signed by your office and certified on the above named client during a home assessment for (certification/recertification) into the **Elderly and Disabled Waiver Program-Traditional/Enhanced**. Also attached is the Comprehensive Care Plan developed for:_____.

The Home and Community-Based Services Medicaid Waiver Program allows states to provide non-institutional services, reimbursable by Medicaid, to individuals at risk of institutional placement or who are receiving institutional care and need help in returning to the community.

Subsequent to the date of your approval on the attached Level of Care page, _____has experienced a change in circumstances which necessitate a change in his/her plan of care. Below, we have listed the changes which prompted a change in services, as well as, the new services planned for .

Client changes necessitating service revisions:

Changes to plan of care:

Your signature below approves the changes to the service plan on the above named client and signing certifies that your patient requires the intermediate level of care provided by a nursing facility and that your patient' condition can be managed by the provision of services in the community. (This program is in lieu of nursing home placement)

Signature: _____ Date:_____

PLEASE return no later than This fax contains pages (including cover)

Thank You,

RN/LPN/Care Coordinator

Instructions
Traditional/Enhanced EDWP Change in Service Cover Letter (within 180 Days of last assessment)

Purpose: Care Coordination to use the change form to provide client and care plan change information to the physician regarding the existing 5588 when no reassessment is necessary **and** an existing waivered service is in place.

Who Completes/When Completed: *Care Coordinators* use the change form to request approval from the client physician office when the client's situation changes and a NON-SKILLED service (s) needs to be added or changed to meet the client's needs in the community. The most recent 5588 signed by the physician MUST accompany the change form when requesting a change in service. For situations when SKILLED service is needed, the RN/LPN will complete a formal review home visit for determination of needs of the client's situation. The most recent 5588 signed by the physician MUST accompany the change form submitted to the physician with the request for physician orders for skilled care.

Complete this form when the following occurs:

Level of Care Certification was completed within the last 270 days (9 months) AND:

- Client needs a change from one service category to another due to changes in informal supports
  IE. Previously lived with family, now requires placement in residential service (ALS)
- Client needs an additional service which was not ordered on the most recent LOC – line 23
  IE. Previously, client never left alone; now, informal caregiver has a job and client is home alone for periods time

Instructions:

Date:	Enter date letter sent to physician
General Information:	Enter client name, client date of birth and the last four digits of client Social Security number
Greeting:	Enter name of physician and the CCSP RN Care Coordinator name
Client Changes:	Enter all necessary information related to client changes which support the requested change (s) to plan of care
Care Plan Changes:	Enter all service changes/additions for which you are requesting approval
Physician Signature:	Entered by physician
Date of Physician Signature:	Entered by physician
Date Returned:	Enter the requested date of return and supply CCSP fax number, with area code
RNCC Signature:	RN who signed the most recent LOC, signs the document

The signed cover letter must be received from the physician with the approved requested changes in place before to the new services are to begin.

YOUR LETTERHEAD HERE

Date _____

To: _____

Client Name: _____

DOB_____SS# .

_____

1. Documentation of client's symptoms or observations that require medical assessment and diagnosis.

_____

_____

_____

2. Reported Medical Problems

_____ _____

_____ _____

_____ _____

_____ _____

3. Indicate Developmental/Mental Health diagnosis

_____

We have assessed/reassessed this client to assess for services through the Elderly and Disabled Waiver Program-Traditional/Enhanced. EDWP is a waivered program under Medicaid that provides services in the community for the client who, otherwise, would qualify for nursing home placement. Attached you will find the client's problems and needs identified. Please review these documents.

Please sign and return forms to our office as soon as possible to allow us to arrange/continue to arrange for delivery of services.

Respectfully,

_____
Care Coordinator
Phone Number (if not on agency/company letterhead)

Original PHYSICIAN'S or NP SIGNATURE REQUIRED FOR APPROVAL of Level of Care
Please return no later than _____

Instructions
Elderly and Disabled Waiver Program

COVER LETTER FOR LEVEL OF CARE (LOC) FORM

Purpose: The intent of the letter is to identify medical problems, signs and symptoms, and observations to assist the physician in the diagnosis.

Who Completes/When Completed: The RN or LPN care coordinator completes the cover letter and attaches it to the Level of Care (LOC) form and care plan sent to the physician at the time of the initial assessment or reassessment of the client.

Instructions:

Date: Enter date care coordinator completes LOC cover letter.

To: Name of primary physician responsible for medical oversight.

Client Name: Enter name as it is written on Level of Care form.

Date of Birth: Enter same DOB as is written on LOC form.

Social Security Number: Enter client Social Security number.

1. Enter any pertinent information required to meet the Intermediate Level of Care. This area applies to sign/symptoms/observations the physician may need to assess in the absence of a diagnosis. An example may be short-term memory loss with resulting ADL deficits.

2. Enter diagnosis included on the referral form and those stated by the client and/or family. The priority of diagnosis listing should be reflective of those diseases that result in deficits that meet the criteria of the intermediate LOC.

3. Enter any known or stated mental health and or mental retardation diagnosis.

4. The RN/LPN care coordinator signs the form.

5. Enter date the signed form is required to be returned to meet the SOP.

6. Add phone number where the care coordinator may be reached if not included on agency/company letterhead.

Georgia Department of Community Health

NOTICE OF DENIAL, TERMINATION, OR REDUCTION IN SERVICE FROM THE ELDERLY AND DISABLED WAIVER PROGRAM- Traditional/Enhanced, FORM 5382

To_____ Date _____

_____

_____

Your participation in the Elderly and Disabled Waiver Program-Traditional/Enhanced has been given careful consideration. In accordance with the Code of Federal Regulations, 42 CFR 431 subpart E, the following determination has been made:

A. You have been determined ineligible for Traditional/Enhanced Services because

_____

_____

B. You have been determined no longer eligible for Traditional/Enhanced Services because

_____

_____

C. You have been determined to require fewer services because

_____

_____

D. You have been determined ineligible for the requested increase in services because

_____

_____

If for any reason, you think the proper consideration has not been given to your situation, or if you disagree with this decision, you have the right to a hearing conducted by the Office of State Administrative Hearings. You may request a hearing orally or in writing by notifying the Area Agency on Aging or the Case Management listed at the bottom of this letter within 30 days of the date of this form. If you want a hearing, call your Area Agency on Aging or Case Management agency or send your written request to the address listed below. If you are currently receiving Traditional/Enhanced Services and have been sent a notice advising termination or reduction of services, you must request a hearing within 10 days of the date of this form to continue receiving service at the current level. If you are appealing a denial, you must wait for the Office of State Administrative Hearings to conduct a hearing and rule in your favor before you can receive Traditional/Enhanced Services.

If you request a hearing within the time frames stated above, it will be held in your county by an Administrative Law Judge employed by the Office of State Administrative Hearings.

You have the right to be represented at such hearing by a legal representative, friend, or other spokesperson. Contact the person indicated below for information about legal services which may be available in your community without cost to you.

_____ ( )_____

Screening Specialist/Care Coordinator Telephone

AAA or Case Management agency

Instructions
Elderly and Disabled Waiver Program-Traditional/Enhanced

NOTICE OF DENIAL, TERMINATION, OR REDUCTION IN SERVICE FORM 5382

Purpose: This form is used to notify applicant/client of Traditional/Enhanced eligibility status or service reduction.

NOTE: Do not use this form to notify a client of a Level of Care denial or termination.

Who Completes/When Completed: The Gateway screening specialist or care coordinator completes this form to advise a client of adverse action.

Instructions:

To: Enter name and address of the person to whom correspondence is being mailed.

Date: Enter date correspondence is mailed.

A. Enter the reason why applicant is not eligible for Traditional/Enhanced. Indicate which eligibility criteria are not met. Enter the reason for denial.

B. Complete this section when client is no longer eligible for any other reason other than level of care. Indicate which eligibility criteria are not met. Enter the reason for termination.

C. Complete this section when client is determined to be eligible for fewer services or units of service than s/he is currently receiving. Section C is not used for temporary increases that are returning to the previous frequency level.

D. Complete this section when client is determined to be ineligible for increased service requests.
   - NOTE: A request made to continue a temporary increase that results in a denial of the request is used here.

NOTE: Form 5382 is not mailed to client when Utilization Review determines a client is inappropriate or reduces or terminates service.

Screening specialist or care coordinator completing the form signs on appropriate line.

Telephone: Enter area code and telephone number of screening specialist or care coordinator completing form.

Distribution: Original is mailed to the client. Copy is filed in case record. **Note:** Client record may be electronic.

NOTICE OF STATUS OF REQUEST FOR SERVICES FROM
THE ELDERLY AND DISABLED WAIVER PROGRAM
Traditional/Enhanced

To: _____

_____

_____

Date of Request: _____

Based on your telephone screening assessment, you have been determined eligible for the Elderly and Disabled Waiver Program-Traditional/Enhanced. We have added your name to the list of individuals waiting to be served through the EDWP.

When funds become available, a nurse will contact you to make an appointment to visit you to work with you in developing a service plan that meets your needs. **Your name will remain on the waiting list until otherwise notified.**

If you have questions about this information or your situation changes, please contact the person listed below.

_____ ( )_____
Screening Specialist Telephone

_____ _____
Area Agency on Aging Fax

_____
Address

_____

_____
Date

Rev. 05/2018

Instructions Elderly and Disabled Waiver Program

NOTICE OF STATUS OF REQUEST FOR SERVICES FROM THE ELDERLY AND DISABLED WAIVER PROGRAM

Purpose: The Notice of Status form is used to notify applicants of their EDWP eligibility and placement on the waiting list.

Who completes/When completed: The screening specialist completes the form when notifying an applicant of the waiting list status.

Instructions:
Enter the applicant's name and address.

Enter the date of the applicant's request or the referral for EDWP.

Enter the name and phone number of the screening specialist.

Enter the name, address, fax number of the Area Agency on Aging and the date the letter is being mailed.

Distribution: The screening specialist completes this form and sends it to the applicant or representative. Indicate in the case notes that the form was sent to the applicant.

Revised 5 15 18

EDWP Traditional + Enhanced Visit Forms:

Level of Care Placement Form Instructions

SUMMARY STATEMENT:	The Level of Care (LOC) page summarizes the client's physical, mental, social, and environmental status to help determine the client's appropriateness for the Community Care Services Program (CCSP) Traditional/Enhanced or other services. In addition, the LOC page represents the physician's order for all waivered services provided by CCSP Traditional/Enhanced.
BASIC CONSIDERATIONS	Initial assessments are completed by the RN care coordinator. Subsequent reassessments are completed by the RN or LPN. LOC is validated by the Georgia Medical Care Foundation (GMCF) through a contractual agreement with the Department of Community Health. When care coordination receives the LOC approval from GMCF, the LOC page (5588) is sent to the client's personal physician for attestation of the LOC and approval of the service plan. The client's physician, nurse practitioner or physician assistant is responsible for completion of designated sections of the LOC page and signing the form. When the completed 5588 is received by the care coordination agency from the doctor, the RN care coordinator certifies the LOC page at initial assessments and reassessments.
PROCEDURES	CCSP Nurse Care Coordinators will complete SECTION I: A. IDENTIFYING INFORMATION Client Information in Section I is completed from information obtained from referral source or individual (patient) being referred. 1. Enter complete name, address & telephone number, including area code, of care coordination team. 2. Enter client's last name, first name, and middle initial, in that order, exactly as it appears on the Medicaid, Medicare, or social security card. 3. Enter home address of client, including street number, name of street, apartment number (if applicable), or rural route and box number, town, state and zip code. 4. Enter client's area code and telephone number. 5. Enter client's county of residence. 6. Enter planning and service area (PSA) number where client resides. 7. Enter client's Medicaid number exactly as it appears on the Medicaid card. **NOTE:** Potential Medical Assistance Only (PMAO) applicants do not have a current Medicaid number. For PMAO applicants, please leave this item blank.

PROCEDURES (cont')

8. Enter client's nine-digit social security number.
9. Enter client's mother's maiden name.
10, 11, 12. Enter client's sex ("M" or "F"), age, and date of birth (month/day/year).
13. Enter client's race as follows:
    A = Asian/Pacific Islander
    W = White
    B = Black
    NA = Native American
    H = Hispanic
14. Enter client's marital status as follows:
    S = Single
    W = Widowed
    D = Divorced
    SP = Separated
    M = Married
15. Check (□) appropriate type of recommendation:
    1. Initial: First referral to CCSP or re-entry into CCSP after termination
    2. Reassessment: Clients requiring annual recertification or reassessment because of change in status.
16. Enter referral source by name and title (if applicable), or agency and type as follows:
    MD = Doctor
    S = Self
    HHA = Home health agency
    NF = Nursing facility
    FM = Family
    PCH = Personal Care Home
    HOSP = Hospital
    ADH = Adult Day Health
    APS= Adult Protective Services
    O = Other (Identify fully)
    DFCS = Division of Family & Children Services

17- 18. Client signs and dates in spaces provided. If client is unable to sign, spouse, parent, other relative, or legal/authorized representative may sign and note relationship to client after signature.

NOTE: This signature gives client's physician permission to release information to care coordinator regarding level of care determination.

Once completed by the CCSP nurse, the 5588 is scanned and

PROCEDURES (cont')

uploaded to GMCF along with other required documents referenced in Chapter 600/Section 620 of this manual.

Section B is completed and signed by licensed medical person completing medical report (Physician, Advance Practice Nurse or Physician Assistant)

SECTION I: B. PHYSICIAN'S EXAMINATION REPORT AND DOCUMENTATION

19. The licensed physician/nurse practitioner/physician assistant enters client's primary, secondary, and other (if applicable) diagnoses. RNCC may pre fill Line 19 based on client self- report when physical impairments and/or medication(s) indications support the self- reported diagnosis. In situations where the RNCC completes the primary diagnosis; a cover letter to the physician which clarifies the nurse's completion of Line 19 must accompany the assessment documents.

* The primary diagnosis should support CCSP Traditional/Enhanced eligibility.

NOTE: After the physician/ nurse practitioner returns signed LOC page, care coordination team indicates ICD codes (ICD-9 and ICD-10). Enter ICD codes for "primary diagnosis", "secondary diagnosis" or "third diagnosis" in the appropriate box. Care coordination teams secure codes from ICD code book, local hospitals or client's physician.

20. The physician/nurse practitioner (RNP)/physician assistant (PA) checks appropriate box to indicate if client is free of communicable diseases.

21. List all medications, including over-the-counter (OTC) medications and state dosage, how the medications are dispensed, frequency, and reason for medication. Attach additional sheets if necessary and reference.

22. List all diagnostic and treatment procedures the client is receiving.

23. List all waivered services ordered by care coordination team.

NOTE: Waivered services ordered by care coordination and approved by the physician/nurse practitioner/physician assistant are considered physician's orders for CCSP waivered services.

24. Enter appropriate diet for client. If "other" is checked (□),

PROCEDURES (cont')

please specify type. Completion of this item is important as this information may serve as the service order for home delivered meals. Nutrition Screening Initiative (NSI), Appendix 100, is to be completed in conjunction with the LOC page, MDS-HC and CCP.

25. Enter number of hours out of bed per day if client is not bedfast. Check (☐) intake if client can take fluids orally. Check (☐) output if client's bladder function is normal without catheter. Check (☐) all appropriate boxes.

26. Check (☐) appropriate box to indicate client's overall condition.

27. Check (☐) appropriate box to indicate client's restorative potential.

28. Check (☐) all appropriate boxes to indicate client's mental and behavioral status. Document on additional sheet any behavior that indicates need for a psychological or psychiatric evaluation.

29. Check (☐) appropriate box to indicate if client has decubiti. If "Yes" is checked and surgery did occur, indicate date of surgery.

30. Check (☐) appropriate box. (Bowel)

31. Check (☐) appropriate box. (Bladder)

32. If applicable, enter number of treatment or therapy sessions per week that client receives or needs.

33. Enter appropriate numbers in boxes provided to indicate level of impairment or assistance needed.

NOTE: Information on the MDS-HC must match the LOC form.

34. Care coordination team or the admitting/attending physician/nurse practitioner/physician assistant indicates whether client's condition could or could not be managed by provision of Community Care or Home Health Services by checking (☐) appropriate box.

NOTE: If physician/nurse practitioner/physician assistant indicate that client's condition cannot be managed by provision of Community Care and/or Home Health Services, the physician may complete and sign a DMA-6 to initiate placement into a nursing facility.

35. Care coordination team or the admitting/attending physician/nurse practitioner/physician assistant certify that client requires level of care provided by an intermediate care facility.

PROCEDURES (cont')

36. Admitting/attending physician (RNP or PA) certifies that CCP, plan of care addresses patient's needs for Community Care. If client's needs cannot be addressed in CCSP and nursing facility placement is recommended, the physician may complete and sign a DMA-6.
37. This space is provided for signature of admitting/attending physician/ nurse practitioner/ physician assistant indicating his certification that client needs can or cannot be met in a community setting. Only a licensed physician (MD or DO), nurse practitioner or physician assistant may sign the LOC page.

NOTE: MD, DO, RNP or PA signs after GMCF validation of the LOC. Physician/nurse practitioner's signature must be original. Signature stamps are not acceptable. Electronic signatures are acceptable when Medicaid criteria for electronic signatures are met. See Policies and Procedures for Medicaid/PeachCare for Kids Part I –Definitions and Part I/Section 106 (R). Utilization Review will recover payments made to the provider if there is no physician/RNP/PA signature. "Faxed" copies of LOC page are acceptable.

38, 39, 40, 41, 42. Enter admitting/attending physician's name, address, date of signature, licensure number, and telephone number, including area code, in spaces provided. If nurse practitioner or physician assistant is completing the document, he or she will provide information relative to his/her license and contact information. LOC cover letter will reference instructions for RNP and PA.

NOTE: The date the physician and the CCSP Traditional/Enhanced RN care coordinator sign the form is the service order for CCSP Traditional/Enhanced services to begin. UR will recover money from the provider if date is not recorded.

REGISTERED NURSE (RN) USE ONLY 4

3. The registered nurse checks (□) the appropriate box regarding Nursing Facility Level of Care (LOC). When RN denies a level of care, the nurse signs the form after the "No" item in this space. The RN does not use the customized "Approved" or "Denied" stamp.
44. Indicate time frame for certification, the date that the LOC is validated by GMCF through the 365th day unless GMCF has indicated a shorter length of stay (LOS).
45. Licensed person certifying level of care signs in this space

PROCEDURES (cont')	and indicates title (R.N.) and date of signature. **NOTE:** Date of RN signature is after the date GMCF validated the LOC for initial levels of care and before the GMCF validation date when recertifying consecutive years from GMCF. Length of stay is calculated from date shown in Number 44. The RN completes a recertification of a level of care prior to expiration of length of stay. Distribution: The original is filed in the case record. Attach a copy with the CCC to DFCS at Initial Assessment and Reassessment. Include a copy with the provider referral packet.

Physicians please fill in highlighted areas, specifically items 19, 20 and your signature on line 37. Thank you

PLEASE RETURN THIS PAGE (LOC) TO OUR AGENCY: ALL OTHER DOCUMENTATION MAY BE RETAINED FOR YOUR PATIENT FILE.

Georgia Department of Community Health

ELDERLY AND DISABLED WAIVER SERVICES PROGRAM LEVEL OF CARE AND PLACEMENT INSTRUMENT

Section 1 - A. Identifying Information

1. EDWP ASSESSMENT TEAM NAME AND ADDRESS	2. Patient's Name (Last, First, Middle Initial)	Client ID
	3. Home Address:	
	4. Telephone Number	5. County: / 6. PSA

7. Medicaid Number	8. Social Security Number	9. Mother's Maiden Name:

10. Sex	11. Age	12. Birthday	13. Race	14. Marital Status	15. Type of recommendation
					☐ Initial Assessment ☐ Reassessment

16. Referral Source _____

This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance and the Department of Community Health with necessary information including medical data.

17. Signed _____ 18. Date _____

(Patient, Spouse, Parent or other Relative or Legal Representative)

B. Physician's Examination Report, Recommendation and Nursing Care Needed

19. Diagnosis on Admission to Community Care (Hospital transfer record may be attached)

1. Primary _____ 2. Secondary _____ 3. Other _____

ICD 10 CODE	ICD 10 CODE	ICD 10 CODE

20 Is Patient free of communicable disease? ☐ Yes ☐ No

21. Medications (including OTC) ☐ see attached sheet for listing

Name	Dosage	Route	Frequency

22. Diagnostic and Treatment Procedures

Type/Frequency

23. EDWP SERVICES ORDERED: ECM ☐ TCM ☐ PSS ☐ PSSX ☐ HDM ☐ ERS ☐ ADH I ☐ ADH II ☐ ALS ☐ HDS ☐ SNS ☐ OHR ☐

24. Diet	25. Hours Out of Bed Per Day	26. Overall Condition	27. Restorative Potential	28. Mental and Behavioral Status
☐ Regular	☐ Intake ☐ IV	☐ Improving	☐ Good	☐ Agitated ☐ Noisy ☐ Dependent
☐ Diabetic	☐ Output ☐ Bedfast	☐ Stable	☐ Fair	☐ Confused ☐ Nonresponsive ☐ Independent
☐ Formula	☐ Catheter Care	☐ Fluctuating	☐ Poor	☐ Cooperative ☐ Vacillating ☐ Anxious
☐ Low Sodium	☐ Colostomy Care	☐ Deteriorating	☐ Questionable	☐ Depressed ☐ Violent ☐ Well Adjusted
☐ Tube Feeding	☐ Sterile Dressings	☐ Critical	☐ None	☐ Forgetful ☐ Wanders ☐ Disoriented
☐ Other	☐ Suctioning	☐ Terminal		☐ Alert ☐ Withdrawn ☐ Inappropriate Reaction

29. Decubiti	30. Bowel	31. Bladder
☐ Yes	☐ Continent	☐ Continent
☐ No	☐ Occas. Incontinent	☐ Occas. Incontinent
☐ Infected	☐ Incontinent	☐ Incontinent
☐ On Admission	☐ Colostomy	☐ Catheter
☐ Surgery Date		

32. Indicate Frequency per Week

Physical Therapy	Occupational Therapy	Remote Therapy	Reality Orientation	Speech Therapy	Bowel/Bladder Retrain	Activities Program

33. Record Appropriate

Legend

1. Severe
2. Moderate
3. Mild
4. None

IMPAIRMENT

Sight	Hearing	Speech	Limited Motion	Paralysis

1. Dependent
2. Needs Assistance
3. Independent
4. Not Applicable

ACTIVITIES OF DAILY LIVING

Eats	Wheel Chair	Transfers	Bath	Ambulation	Dressing

34. This patient's condition ☐ could ☐ could not be managed by provision of ☐ EDWP or ☐ Home Health Services

35. I certify that this patient ☐ requires ☐ does not require the intermediate level of care provided by a nursing facility.

36. I certify that the attached plan of care addresses the client's needs for The Elderly and Disabled Waiver Program.

38. Physician's Name (Print) _____

39. Physician's Address _____

40. Date signed by Physician	41. Physician's License No.	42. Physician's Phone/Fax
		FAX:

37. Physician's Signature _____

ASSESSMENT TEAM USE ONLY

43. Nursing Facility Level of Care ☐ Yes ☐ No 44. L.O.S._____365 DAYS Certified_____thru _____

45. Signed by person certifying LOC: _____ Title:_____ Date Signed: _____

Revised 5/2018

- INTERMEDIATE LEVEL OF CARE INDICATORS

Intermediate level of care is defined as that continuous care which is limited to persons who, because of physical or mental impairment, require nursing care and supervision under the direction of a physician. Their physical or mental impairment are such that self-execution of the required nursing care is improbable or impossible.

NOTE: The Minimum Data Set (MDS) is used to complete comprehensive assessments of nursing home residents to measure cognitive loss. It is a federal mandate for facilities participating in Medicaid or Medicare Programs. The Community Care Services Program Traditional/Enhanced Level of Care (LOC) page, Minimum Data Set-Home Care (MDS-HC) and Comprehensive Care Plan (CCP) are used for CCSP Traditional/Enhanced clients.

Use the Intermediate Level of Care Criteria to determine a CCSP Traditional/Enhanced client's degree of medical, mental, and functional disability. Applicant must meet the first criteria listed in Column A plus one or more of the criteria in Column A and one from Column B or C, with the exception of # 5 alone in Column C.

Intermediate care services may be provided to an individual with a stable medical condition requiring intermittent skilled nursing services under the direction of a licensed physician (Column A- Medical Status) **AND** a mental or functional impairment that would prevent self-execution of the required nursing care (Column B- Mental Status and Column C- Functional Status).

Special attention should be given where psychiatric treatment is involved. A patient is not considered appropriate for intermediate care services when the primary diagnosis or the primary needs of the patient are psychiatric rather than medical. **This individual must also have medical care needs that meet the criteria for intermediate care facility placement.** In some cases a patient suffering from mental illness may need the type of services which constitute intermediate care because the mental condition is secondary to another more acute medical disorder.

REQUIREMENTS: TWO CONDITIONs MUST EXIST FROM COLUMN A (Medical Status) **AND ONE FROM COLUMN B** (Mental Status) **OR COLUMN C** (Functional Status) **WITH THE EXCEPTION OF #5 IN COLUMN C.**

Column A
Medical Status

1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician.
   I1a-u, I2a-f, N2a-k=1,2,or 3

In addition to the criteria listed immediately above, the patient's specific medical condition must require any of the following plus one item in Column B or Column C.

2. Nutritional management; which may include therapeutic diets or maintenance or hydration status.
   K2a-d=1 or an issue
   K3(1-9)=5,6,7,or 8 is selected
   N2d=2 or 3

3. Maintenance and preventative skin care and treatment of skin conditions, such as cuts, abrasions, or healing decubiti.
   L1=2,3,4,5 L3:L4:L5=1/yes
   L7=2 or 3 N2=k (wound care/present)

4. Catheter care such as catheter change and irrigation.
   H1=1 H2= 2 or 3

5. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy (3 times per week or less).
   N3b, 3e, 3f, 3g =Present
   N2a-k=Present/1,2,3

6. Restorative nursing services such as range of motion exercises and bowel and bladder training.
   N3e and N2l= Present

7. **Monitoring of vital signs and** laboratory studies or weights.
   N1a=1 N2a,b,d, and i = Present
   N3b= Present K2a=Present

8. Management and administration of medications including injections.
   G1d 1-6 (performance)
   N2a, N2d, N2i = Present
   M1d=IM(intramuscular), IV (intravenous), Sub-Q (Subcutaneous or ET (Enteral Tube)
   M3=1 or 2 is selected

Column B
Mental Status

The mental status must be such that the cognitive loss is more than occasional forgetfulness.

1. Documented short or long-term memory deficits with etiologic diagnosis. Cognitive loss addressed on MDS/ care plan for continued placement.
   C2a, b, or c = 1

2. Documented moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making. Cognitive loss addressed on MDS/ care plan for continued placement.
   C1= 3, 4 5 C5=2

3. Problem behavior, i.e. wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention.
   E3a-f =1, 2 or 3

4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia.

J3j=2,3, or 4 ---I1j; I1c; I1d=1,2,3---I2a-f*
Possible Diagnoses: severe seizure do, TBI, ABI, Anoxic brain injury

Client Name_____

Completed by_____

Date of Visit___

RN Approving LOC _____

Date of LOC_____

Column C
Functional Status

One of the following conditions must exist (with the exception of #5).

1. Transfer and locomotion performance of the resident requires limited/extensive assistance by staff through help of one person physical assist.
   G2g, G2f=3,4,5,or 6 G8b=2 or 3
   G3c, G3d = 0 J3a; J3b = 1,2,3, 4

2. Assistance with feeding. Continuous stand-by supervision, encouragement, or cueing required and set up of meals.
   G2j= 3,4,5,or 6

3. Requires direct assistance of another person to maintain continence.
   G2g; G2h=3,4,5 or 6

4. Documented communication deficits in making self understood or understanding others. Deficits must be addressed in medical record with etiologic diagnosis addressed on MDS/ care plan for continued placement.
   D1; D2= 3 or 4

5. Direct stand-by supervision or cueing with one person physical assistance from staff to complete dressing and personal hygiene. **(If this is the only evaluation of care identified, another deficit in functional status is required.)**
   G2a;G2b,G2c ;G2d= 3,4,5 or 6

**If J3a-b is circled (C1), is this compensated by walker, cane, slower movements, or use of furniture? Y/N If so, this is NOT enough for NH level.

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

ELDERLY AND DISABLED WAIVER PROGRAM
Traditional/Enhanced
AUTHORIZATION FOR RELEASE OF INFORMATION
& INFORMED CONSENT

Client Name: _____ **ID:** _____

_____1. This is to certify that the Elderly and Disabled Waiver Program is hereby authorized to release necessary information including medical data to the agencies which will provide services to me as outlined in the Traditional/Enhanced Comprehensive Care Plan.

_____2. This is to certify that I choose to participate in the Elderly and Disabled Waiver Program-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 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 Comprehensive 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 care coordinator with any service issues/problems.

_____9. I acknowledge the responsibility for the completion of the Elderly and Disabled Waiver Program-Traditional/Enhanced 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 CCSP CARE COORDINATOR DATE

Instructions

Elderly and Disabled Waiver Program-Traditional/Enhanced

AUTHORIZATION FOR RELEASE OF INFORMATION & INFORMED CONSENT

Purpose: This form allows care coordinators to release necessary information including medical data to the agencies that will provide services to the client. It also serves as the client's acknowledgment of information received regarding the Traditional/Enhanced, and indicates whether the client chooses Traditional/Enhanced EDWP or Nursing Home Placement.

Who Completes/When Completed:

- At initial assessment, the Nurse completes all sections of the form, except #5.
- At reassessment, the RN/LPN completes all sections of the form, except #5.
- At CCP Review, the care coordinator completes all applicable sections.

Instructions:

1. Client initials in the space provided allowing the care coordinator to release necessary information to the agencies which will provide his/her services

2. Client initials if he/she chooses to participate in the Traditional/Enhanced EDWP

3. Client initials if he/she receives information about CD-PSS option

4. Client initials if he/he receives information about Abuse, Neglect and Exploitation.

5. Client initials if he/she chooses Nursing Home Placement

6. Client initials confirming that discharge plan(s) + emergency preparedness plan(s) have been discussed with client/representative and care coordinator

7. Client initials that he/she has received an opportunity to provide input in determining services which will be provided and which providers (list provided) will be involved by Traditional/Enhanced EDWP as ordered in the CCP

8. Client initials that he/she has received instruction to report problems related to Traditional/Enhanced EDWP services to his/her Care Coordinator

9. Client initials that he/she understands the responsibility of the completion of the Medicaid application for EDWP-Traditional/Enhanced

10. Client initials that all medical, social and financial information provided is true and complete to the best of their knowledge

11. Client or representative signs and dates form

12. Care coordinator signs and dates form

Distribution: At initial assessment and reassessment, send a copy to providers. Place the original in the case record.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Name of Individual/Consumer/Patient/Applicant

Date of Birth

IF AVAILABLE:

ID Number Used by Requesting Agency

ID Number Used by Releasing Agency

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize _____

(Name/Address of Person or Agency Requesting Information)

to obtain from:

(Name/Address of Person or Agency Holding the Information)

the following type(s) of information from my records (and any specific portion thereof):

for the purpose of:

I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

☐ ninety (90) days unless I specify an earlier expiration date here: _____ (Date)

☐ one (1) year.

☐ the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

(Date) (Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness) (Title or relationship to Individual) (Date)

(Signature of Parent or other legally Authorized Representative, where applicable) (Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

(Date this authorization is revoked by Individual)

(Signature of Individual or legally authorized Representative)

Instructions for
Form 5459
Authorization for Release of Information

Purpose: This form is used to obtain permission from an EDWP client or prospective client to share or secure information about the client.

Who Completes/When Completed: EDWP Staff, including APS and Public Guardianship Case Managers; Community Care Services Program (Traditional/Enhanced) Care Coordinators; Money Follows the Person Transition Coordinators or Option Counselors; Other appropriate DCH/DAS, Area Agency on Aging or Sub-contractor staff.

Instructions:
Explain the purpose of the form to the client. Complete the form and ask the client to sign or indicate a witnessed mark (X)
****

Name of Individual/Consumer/Patient/Applicant: Enter the name of the individual/consumer/patient/applicant.

Date of Birth: Enter the birth date of the individual/consumer/patient/applicant.

IF AVAILABLE:
ID Number Used by Requesting Agency: Enter the ID number used by the requesting agency (may be SSN, Medicaid or Medicare Number, Harmony ID, etc.)

ID Number Used by Releasing Agency: Enter the ID number used by the releasing agency (may be SSN, Medicaid or Medicare Number, AIMS ID, etc.)
****

Name of Person or Agency Requesting Information: Enter the name of the agency requesting information. If DCH: include the Department of Community Health, CCSP Traditional/Enhanced, and the Section Name.

Address of Requesting Agency: Enter the complete address of the requesting agency.

Type of Information requested: Enter the type of information requested. Example: Any medical, social, psychological or treatment information.

For the purpose of: Enter the purpose of the information requested.

Duration of request: Specify the duration of the authorization release (not to exceed one year)

Date/Signature of Individual/Consumer/Patient/Applicant: Enter the date the client signed the form and have client sign in the space indicated.

Signature of witness: Have witness sign in space indicated and include title or relationship to the Individual/Consumer/Patient/Applicant If the client signs by mark (X)

Signature of Parent or other legally Authorized Representative/Date: Signature of parent, guardian or legally authorized representative if Individual/Consumer/Patient/Applicant is incompetent/under age 18 or has a physical disability that prevents his signing. PGO staff sign here for persons under guardianship where DHS is the guardian.

****

If Authorization is Withdrawn:

Enter date and have Individual or legally authorized representative sign where indicated.

****

Routing: At each completion, place the original in the case record and send copies to each agency/person holding information about the client.

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Caylee Noggle, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

Georgia Department of Community Health Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

MEDICAID'S PRIVACY COMMITMENT TO YOU

We at the Georgia Department of Community Health (DCH) understand that medical information about you and your family is personal. We are committed to protecting your information. This notice tells you how DCH may use and disclose medical information about you. It tells you your rights and Medicaid's requirements about your information.

The privacy practices described in this notice were effective June 2, 2003.

By law, Medicaid must use and disclose your personal medical information to provide information:

- To you or to someone who has the legal right to act for you
- To the Secretary of the U.S. Department of Health and Human Services, if necessary, to make sure your privacy is protected
- When required by law

YOUR MEDICAL INFORMATION RIGHTS

- You have the following rights regarding the medical information that DCH has about you.
- You have the right to see and obtain a copy of your personal medical information held by Medicaid. An exception is information that is needed for a legal action relating to DCH.
- You have the right to ask DCH to correct your personal medical information if you believe that it is wrong or incomplete. DCH may deny your request under certain circumstances.
- You have the right to request a listing of disclosures that DCH has made of your personal medical information. The listing would not include disclosures to you or your personal representative, or for payment for your health care, or for Medicaid administration.
- You have the right to request additional restrictions on certain uses or disclosures of your health information. DCH is not legally required to agree with your request.
- You have the right to request that DCH communicates with you about your health in a way or at a location that will help you keep your information confidential.
- You have the right to be notified following a breach of unsecured protected health information.

• You have the right to receive a paper copy of this notice. You may get another copy of this notice from DCH by calling 770-325-2331. You may obtain a copy from the DCH Web site, http://dch.georgia.gov/hipaa-privacy-notices

PRIVACY LAW'S REQUIREMENTS

DCH is required by law to:

• Maintain the privacy of your personal medical information
• Give you this notice of DCH legal duties and privacy practices regarding the medical information that DCH has about you
• Follow the terms of this notice
• Not use or disclose any medical information about you without your written authorization, except for the reasons given in this notice. You may take away your authorization at any time, in writing, except for the information that DCH disclosed before you stopped your authorization.
• In an emergency, DCH may disclose information only if the disclosure is in your best interest.
• DCH must notify you as soon as possible of that emergency disclosure.
• Never disclose psychotherapy notes, use and disclose protected health information for marketing purposes, and/or make any disclosures that constitute a sale of protected health information without your written authorization to do so.

In the future, DCH may change its privacy practices. If there is a material change in its privacy practices, DCH will provide a new notice to you. DCH will post the new notice on its Web site at http://dch.georgia.gov/hipaa-privacy-notices

HOW DCH USES AND DISCLOSES HEALTH CARE INFORMATION

Medicaid provides some services through contracts with other agencies and private companies. For example, your county Department of Family and Children Services determines Medicaid eligibility. When services are contracted, Medicaid may disclose some or all of your information to the other agency or company so that they can perform the job Medicaid has asked them to do. To protect your information, Medicaid requires the other agency or company to safeguard your information in accordance with the law.

The following categories describe ways that Medicaid uses and discloses your health information. For each category, we will explain what we mean and give an example.

For Payment: Medicaid may use and disclose information about you so that we can pay for the health services that you received. For example, when you receive a Medicaid service, your health

care provider sends a claim to the Medicaid fiscal agent for payment. The claim includes information that identifies you, as well as your diagnoses and treatments.

For Medical Treatment: Medicaid may use or disclose information about you to ensure that you receive necessary medical treatment and services. For example, Medicaid may send you appointment reminders for Health Check services.

To Operate the Medicaid Program: Medicaid may use or disclose information about you to run the Medicaid program and ensure that you receive quality care. For example, Medicaid may contract with a company that reviews hospital records to check on the quality of care that you received and the outcome of your care.

To Conduct Outreach, Enrollment, Care Coordination, and Case Management: Medicaid may share your information with other government agencies that may provide public benefits or services to you. For example, Medicaid may share your information with a Medicaid Care Management Organization (CMO) for case management.

To Keep You Informed: Medicaid may mail you information about your health. Examples are information about managing a disease that you have, information about your managed care choices, and appointment reminders for your children's Health Check services. Equal Opportunity Employer Health Information Technology | Healthcare Facility Regulation | Medical Assistance Plans | State Health Benefit Plan

For Overseeing Health Care Providers: Medicaid may disclose information about you to the government agencies that license and inspect medical facilities such as hospitals.

For Research: Information about you may be disclosed for a research project that has been approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information. The research must be for the purpose of helping the Medicaid program.

For the Health Information Exchange: Medicaid, as a payer of Medicaid claims, is a member of the Georgia Health Information Network, Inc. ("GaHIN"). GaHIN is the statewide health information exchange network through which Medicaid, its member affiliates, and other members and their member affiliates, securely share and access medical information in accordance with applicable state and federal laws and regulations. This exchange of information allows Medicaid Providers to provide you with access to better treatment and coordination of healthcare services. GaHIN has established Network Operating Policies and Technical Requirements, which members and member affiliates of the GaHIN must meet, to ensure the confidentiality and integrity of data.

As Required by Law: Medicaid will disclose information about you when required by law.

FOR MORE INFORMATION OR TO REPORT A PRIVACY PROBLEM

If you believe your privacy rights have been violated:

- You may file a complaint with Medicaid by calling the Member Inquiry Unit at 770-325-2331 (in the Atlanta area) or 1-866-211-0950 (outside the Atlanta area).
- You may file a complaint with the Georgia Medicaid agency by writing to :

Georgia Department of Community Health
Privacy Officer, Office of General Counsel
2 Peachtree St., NW – 40th Floor
Atlanta, GA 30303-3159

You may also file a complaint with the Health and Human Services' Office for Civil Rights by writing to:

U.S. Department of Health & Human Services
Office for Civil Rights, Region IV
61 Forsyth Street SW, Suite 3B70
Atlanta, GA 30303-8909

There will be no retaliation for filing a complaint

If you have questions about your health or your health care services, you should contact your health care provider (physician, pharmacy, hospital or others).

I have read, understand, and acknowledge receipt of the DCH HIPAA Notice of Privacy Practices.

_____ _____
Signature Date

_____
Print Name

Elderly and Disabled Waiver Program-Traditional/Enhanced

CLIENT RIGHTS AND RESPONSIBILITIES

As a client, you have the following *rights*:

To be treated with respect and maintain one's dignity and individuality.

To be free of any discrimination because of race, creed, color, religion, national origin, or handicap.

To voice grievances and complaints regarding treatment or care that is furnished or fails to be furnished, without fear of retaliation, discrimination, coercion, or reprisal.

To a choice of approved service provider(s).

To accept or refuse services.

To be informed of your service plan and the right and responsibility to participate in the development of your individualized plan of care.

To be advised in advance of the provider(s) that will furnish care and the frequency of visits ordered.

To be promptly and fully informed of any changes in the services plan.

To be informed of any charges and/or cost of services rendered.

To confidential treatment of all information, including information in your record.

To receive services in accordance with the current care plan.

To expect to be notified by the provider agency(s) of any temporary changes in the service plan.

To have your property and residence treated with respect.

As a client, you have the following *responsibilities:*

To notify service provider(s) of temporary changes in your care needs.

To treat provider staff in a courteous and respectful manner, including not discriminating because of race, creed, color, religion, national origin, or handicap.

To be as accurate as possible when providing information on your health history and personal care needs.

To actively participant in decisions regarding your health care.

To be available for monthly contact (phone or in person) with Care Coordination staff.

To participate, provide and assist in the completion of the initial and renewal Medicaid application process.

To follow your physician's advice and instructions.

To notify your physician, service provider(s), or caregiver if you notice a change in your condition.

To cooperate with and respect the rights of the care givers providing services.

To maintain a safe home environment.

To inform provider(s) of safety hazard(s) in the home.

I acknowledge that I have reviewed this information and I understand my rights and responsibilities as a client.

_____ _____

Client/Client Representative Signature Date

CLIENT RIGHTS AND RESPONSIBILITIES

Instructions
Elderly and Disabled Waiver Program

CLIENT RIGHTS AND RESPONSIBILITIES

Purpose: This form is used to inform clients of their rights and responsibilities as participants in the EDWP.

Who Completes/When Completed: During the initial assessment, the care coordinator gives this form to new participants in the EDWP.

1. Client reads or has someone read the contents of this form.
2. A signature or witnessed mark (X) indicates that client and/or representatives understand the rights and responsibilities of CCSP participation.

Distribution: The original is given to the client at initial assessment and a copy is filed in the client's case record.

ELDERLY AND DISABLED WAIVER COMMUNICATOR

CLIENT NAME _____ COUNTY _____

ADDRESS (STREET AND NUMBER) _____ SOCIAL SECURITY NUMBER _____ MEDICAID NUMBER _____

CITY _____ STATE _____ ZIP CODE _____ DATE OF BIRTH _____ TELEPHONE NUMBER _____

SECTION I COMPLETED BY EDWP CASE MANAGEMENT:

I. The client has elected to accept The Elderly and Disabled Waiver Program:

- ☐ Case Management service began effective _____.
- ☐ The client is currently receiving MAO. Please calculate cost share.
- ☐ The client has been referred for eligibility determination and cost share.
- ☐ The client will require a home visit for application (Reason in Remarks).

Signature_____ Telephone No._____ Date_____

SECTION II COMPLETED BY DFCS MEDICAID WORKER:

II. ☐ The date client applied for MAO _____

- ☐ The client has been determined Medicaid eligible effective_____.
- ☐ The client is receiving EDWP Services and is responsible for contributing toward the cost.
  - ☐ The client has a change in cost share.

$_____EFFECTIVE _____ $_____EFFECTIVE _____ $_____EFFECTIVE _____

- ☐ The client has been determined ineligible, effective _____(Reason in Remarks).

Signature_____ Telephone No. _____ Date _____

SECTION III COMPLETED BY CASE MANAGEMENT:

III. The above named client is being released from the Elderly and Disabled Waiver Program effective_____. for the following reason:

- ☐ Client deceased; Date of Death _____
- ☐ Condition has improved; services no longer needed.
- ☐ Condition has worsened; entering a nursing home. Name, if known_____
- ☐ Other _____

Signature_____ Telephone No._____ Date _____

SECTION IV COMPLETED BY CASE MANAGEMENT or DFCS MEDICAID WORKER:

REMARKS: _____

EDWP COMMUNITY CARE COMMUNICATOR (CCC)

COMMUNITY CARE COMMUNICATOR (CCC)

Purpose: The EDWP Community Care Communicator (CCC) provides information about clients entering the EDWP. The CCC is the primary line of communication between the DFCS MAO caseworker, care coordi nator, and nursing home.

Who Completes/When Completed: DFCS and care coordinators use the CCC to share eligibility information and other changes in a client's situation, such as ineligibility, death, nursing home placement.

Instructions:

Enter the client's full name, complete address, county, social security number, date of birth, Medicaid number, if known, telephone number (including area code), and the name, address and telephone number of any client representative.

Section I: Care coordinator completes all required information for MAO clients requesting cost share determination and potential MAO clients applying for Medicaid benefits and determination of cost share. Care coordinator forwards information to DFCS with a copy of the Level of Care (LOC) page and PMAO worksheet. Care coordinator indicates date care coordination began/case management, date client was placed in service, checks appropriate box identifying reason for referral to DFCS, signs and dates form. Case Management begin date and service effective date is the day the Nurse performs the assessment. Care coordinator's telephone number, including area code, is written after signature.

Section II: DFCS Medicaid caseworker, upon receipt of CCC, begins the Medicaid eligibility process. Medicaid caseworker lists Medicaid number, completes Section III, and returns one copy of CCC or sends a computer-generated notice to the care coordinator. Medicaid caseworker notifies care coordinator of any changes affecting the recipient's eligibility or cost share liability. Medicaid caseworker signs and dates form.

Section III: Care coordinator notifies DFCS caseworker of changes in client's situation, including: change of address, change in financial circumstances, if client no longer receives a waivered service, or if client is terminated from CCSP.

Section IV: Care coordinator and DFCS caseworker use this section for additional comments. Additionally, CC adds name of Care Coordination Agency, mailing address and request to receive copies of written notifications related to Medicaid initial and ongoing eligibility.

Distribution: Care coordinator sends original of CCC and copy of LOC page to Medicaid caseworker at initial assessment and reassessment and retains a copy. Medicaid caseworker returns original with appropriate information or sends a computer-generated notice to care coordinator.

EDWP PROGRAM PARTICIPATION FORM 5389

Dear_____: Date _____

Welcome to the Elderly and Disabled Waiver Program- Traditional/Enhanced Services. The EDWP Nurse reviewed your situation and recommended community-based services through Traditional/Enhanced services.

The providers you selected are listed below. Someone from each service agency will be contacting you within a week from the date of this letter.

1. _____
Provider Agency

_____
Contact Person

(____)_____Telephone Number

2. _____
Provider Agency

_____
Contact Person

(____)_____Telephone Number

3. _____
Provider Agency

_____
Contact Person

(____)_____Telephone Number

4. _____
Provider Agency

_____
Contact Person

(____)_____Telephone Number

As a participant in the Elderly and Disabled Waiver Program:

1. You will not lose any medical assistance benefits that you are currently receiving by participating in the Elderly and Disabled Waivered Services Program.

2. You are responsible for the completion of your Medicaid application and submission of any documents required to determine your eligibility.

3. You may withdraw from the Traditional/Enhanced services at any time

Please contact the care coordinator listed below by_____to discuss
(Date)
your services in general, when services are not delivered as ordered or you have not been contacted by the provider(s) listed above within 10 days of order . You may have someone call on your behalf.

_____ (____)_____
Care Coordinator Telephone Number

Instructions

EDWP PARTICIPATION FORM 5389

Purpose: This form is used to notify the client of acceptance into the Traditional/Enhanced EDWP and to advise that someone will be in contact to provide services. Furthermore, it serves as a tickler to the care coordinator to check to see if services have begun.

Who Completes/When Completed: The care coordinator completes Form 5389 when services have been brokered with providers.

Instructions:

Date:	Enter date services were brokered with provider.
Greeting:	Enter client's name.
Provider Agency:	Enter name(s) of provider agency chosen by client or by rotation system.
Contact Person:	Enter name(s) of person(s) within provider agency that client or family member may contact, if necessary.
Telephone Number:	Enter telephone number(s) of provider agency.
Care Coordinator:	Enter signature of care coordinator assigned to case.
Date:	Enter date client/representative will contact care coordinator to follow- up on services. If client fails to call, care coordinator contacts client.
Telephone Number:	Enter the care coordinator's telephone number, including area code.

Distribution: Original - Client Copy - Client case record.

NOTE: It is suggested that the copy be placed in a tickler file until the client contacts care coordinator. If the client fails to contact the care coordinator, the tickler is a reminder for the care coordinator to contact the client. The copy may then be placed in the case record.

COST REVIEW FORM

COST REVIEW FORM FOR EDWP CLIENTS WITH HIGH MONTHLY BUDGETS

Client Name: _____ ID # _____

Current Cost of Services: $ _____ Budget Approval Date: _____

1. Is this an active MFP client? Yes No
2. Any significant changes in physical or mental health since last visit? Yes No
3. Any ER/hospitalizations/ NH or rehab admissions since the last review? Yes No
4. Any falls or other significant incidents since the last review? Yes No
5. Is client compliant with MD appointments, medications or treatment prescribed? Yes No
6. Does client receive any Home Health, Dialysis, Hospice or Mental Health services? Yes No
7. Any new referrals made to community resources? Yes No
8. Any changes in caregiver(s) physical or mental health? Yes No
9. Any changes in caregiver's or primary residence? Yes No
10. Does documentation indicate client's health and safety is being maintained? Yes No
11. Any provider complaint issues received during this review period? Yes No
12. Do any CCNFs indicate any missed or incomplete visits by the EDWP provider or client cancellations of care? Yes No
13. Are SAFs correct and correspond with services currently ordered? Yes No
14. CD Clients: Do FI financial statements indicate client is staying within budget? Yes No

Reviewed by: _____ Date: _____

Form Revised 1/15/2019

Instructions

Elderly and Disabled Waiver
Program

COST REVIEW FORM

Purpose: To provide assistance and written documentation for the purpose of service cost review related to care plan service assignment and frequency.

Who Completes/When Completed:

- At the 30 Day Comprehensive Care Plan Review, the care coordinator reviews the document with the client/caregiver to evaluate service frequency appropriateness
- At each subsequent Care Plan Review, the care coordinator (nurse or social services) will review the form with the client/caregiver to evaluate service frequency appropriateness

Instructions:

Enter client name, Harmony ID, current care plan cost of waivered services and date of approved current frequency of care plan

1. Review and complete all sections (1-14) of the Cost Review form for Traditional/Enhanced Services E D W P Program participants with the client/care giver

2. Review the form with the client/care giver at each care plan review and update when change in needs

Distribution: A copy is filed in the client's case record.

NOTICE OF RIGHT TO APPEAL DECISIONS REGARDING
ELDERLY AND DISABLED WAIVER PROGRAM
FORM 5381

_____ _____

Client's Name/Signature Date

As an applicant for services or an individual receiving services through the Elderly and Disabled Waiver Program-Traditional/Enhanced Services, you have the right to appeal any decision with which you disagree in regard to your participation in the Traditional/Enhanced EDWP Services Program. If you are receiving services, any or all services may change due to any of several reasons. If you disagree with a decision to change your current services or feel that a mistake has been made with regard to the services you are receiving in the Traditional/Enhanced EDWP Program, you have the right to a hearing.

You may request a hearing either orally or in writing within thirty (30) days of the adverse action by notifying the care coordinator, whose address and telephone number are at the bottom of this letter. If you are currently receiving Medicaid services under the Traditional/Enhanced EDWP and wish them to continue at the current level, you must request a hearing within ten (10) days of the date of the letter you receive advising you of the decision. The hearing will be held in your county by an Administrative Law Judge from the Office of State Administrative Hearings. The care coordinator will be available to provide the necessary forms and to assist you in preparing for the hearing.

You have the right to be represented at your hearing by an attorney, a relative or friend, or other spokesperson. Contact the care coordinator for information about legal services which may be available in your community without cost to you.

Care Coordinator _____

Telephone Number (_____) _____

Address _____

_____

_____

Instructions
Elderly and Disabled Waiver Program

NOTICE OF RIGHT TO APPEAL DECISIONS REGARDING Traditional/Enhanced Services FORM 5381

Purpose: Form 5381 is used to advise client at the initial face-to-face assessment of the right to appeal any adverse action decision.

Who Completes/When Completed: The Nurse completes this form.

Instructions:

Enter client's name- have client provide signature

Enter date the form is mailed or given to client.

Enter care coordinator's name, telephone and address of the care coordination agency.

Distribution: During the initial assessment, the original is given to client. A copy is filed in the client's case record.

Determine Your Nutritional Health

The Warning Signs of poor nutritional health are often overlooked. Use this checklist to find out if you or someone you know is at nutritional risk.

Read the statements below. Add up the numbers in the "YES" column for those that apply for you.

	YES
I have an illness or condition that made me change the kind and / or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables, or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 2 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and / or feed myself.	2
Total	

Total your Nutritional Score: If it's-

0-2	**GOOD!** Recheck your nutritional score as needed if signs of decline
3-5	**You are at Moderate nutritional risk.** See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Check your score again as needed if signs of decline
6 or more	**You are at high nutritional risk** Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk to them about any problems you may have. Ask for help to improve your nutritional health.

Instructions

Elderly and Disabled Waiver Program

NUTRITIONAL SCREENING INITIATIVE (NSI) NUTRITIONAL HEALTH CHECKLIST

Purpose: The purpose of the NSI Checklist is to identify individuals who are at high risk of nutritional problems or who have poor nutritional status.

Who Completes/ When Completed: The Nurse completes the NSI in Harmony at initial assessment and reassessments. Should the client's condition or situation change, the care coordinator, completes the NSI, as needed, between reassessments.

NOTE: Referral sources include but are not limited to physicians, dietitians or other health professionals, social services, oral health, mental health, nutrition education, support or counseling services.

Instructions:

For each of the ten statements, read and circle the appropriate number in the "Yes" column which describes each client/ client representative response. Total the numbers circled to identify the client's nutritional score.

Based on the total score, make the appropriate referrals, if indicated, as suggested in the reference - Nutrition Interventions Manual for Professionals Caring for Older Americans Executive Summary 1992. Document all activity relative to the NSI checklist referral, such as follow-up and outcome results. Complete the NSI checklist as needed.

Distribution: A copy is filed in the client's case record along with documentation regarding any deviation from normal, specific instructions or referral information.

The Nutrition Checklist is based on the Warning Signs described below. Use the word DETERMINE to remind you of the Warning Signs.

Disease

Any disease, illness or chronic condition which causes you to change the way you eat, or makes it hard for you to eat, puts your nutritional health at risk. Four out of five adults have chronic diseases that are affected by diet. Confusion or memory loss that keeps getting worse is estimated to affect one out of five or more older adults. This can make it hard to remember what, when or if you've eaten. Feeling sad or depressed, which happens to about one in eight older adults, can cause big changes in appetite, digestion, energy level, weight and well-being.

Eating Poorly

Eating too little and eating too much both lead to poor health. Eating the same foods day after day or not eating fruits and vegetables, and milk products daily will also cause poor nutritional health. One in five adults skip meals daily. Only 13% of adults eat the minimum amount of fruits and vegetables needed. One in four older adults drink too much alcohol. Many health problems become worse if you drink more than one or two alcoholic beverages per day.

Tooth Loss/Mouth Pain

A healthy mouth, teeth and gums are needed to eat. Missing, loose, or rotten teeth or dentures which don't fit well or cause mouth sores make it hard to eat.

Economic Hardship

As many as 40% of older Americans have incomes of less than $6,000 per year. Having less -- or chosing to spend less -- than $25-30 per week for food makes it very hard to get the foods you need to stay healthy.

Reduced Social Contact

One-third of all older people live alone. Being with people daily has a positive effect on morale, well-being and eating.

Multiple Medicines

Many older Americans must take medicines for health problems. Almost half of older Americans take multiple medicines daily. Growing old may change the way we respond to drugs. The more medicines you take, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and others. Vitamins or minerals when taken in large doses act like drugs and can cause harm. Alert your doctor to everything you take.

Involuntary Weight Loss/Gain

Losing or gaining a lot of weight when you are not trying to do so is an important warning sign that must not be ignored. Being overweight also increases your chance of poor health.

Needs Assistance to Self Care

Although most older people are able to eat, one of every five have trouble walking, shopping, buying and cooking food, especially as they get older.

Elder Years Above Age 80

Most older people lead full and productive lives. But as age increases, risk of frailty and health problems increase. Checking your nutritional health regularly makes good sense.

Reprinted with permission from the Nutrition Screening Initiative, a project of the American Academy of Family Physicians, the American Dietetic Association and the National Council on the Aging, Inc., and funded in part by a grant from Ross Products Division, Abbott Laboratories.

CLIENT REFERRAL FORM/EVALUATION FORM - HOME DELIVERED MEALS

Date Medicaid ID:

Member Name Member Address

Case Management Provider Agency

PHYSICAL/MENTAL EVALUATION: Fair ☐ Good ☐ Poor ☐ (needs assistance) ☐

Motor Tasks:
Ability to perform small motor tasks (i.e., open cans, milk carton)
Yes ☐ No ☐

Mental Condition: Ability to cook/heat food safely.
Yes ☐ No ☐

ADEQUATE COOKING EQUIPMENT:

Working refrigerator **Yes** ☐ **No** ☐ Working oven **Yes** ☐ **No** ☐

Working microwave **Yes** ☐ **No** ☐ Working toaster oven **Yes** ☐ **No** ☐

Adequate kitchen utensils, towels/hot pads to remove hot meal plates from oven safely **Yes** ☐ **No** ☐

Adequate refrigerator and freezer space to store one week's supply of meals if needed **Yes** ☐ **No** ☐

Meal Delivery Instructions

Number per day:
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday

Days per week:
☐M ☐T ☐W ☐Th ☐F ☐Sat ☐Sun
(Please mark specific days for meals)

Type of Meal: ☐ Regular ☐Alternative(explain)

Meal/Diet Specifics:

☐ Hot ☐ Therapeutic ☐ Chilled ☐ Shelf-Stable ☐ Modified ☐ Special ☐ Frozen

☐ADA (how many calories)

Nutrition Education and Counseling Needs:

Special Instructios/Notations:
Comments:

Care Coordinator
Telephone
Email

Elderly and Disabled Waiver Program-Traditional/Enhanced

CLIENT REFERRAL FORM - HOME DELIVERED MEALS

Date _____

Medicaid ID:_____

Member Name _____
Member Address_____
_____
_____

Meal Delivery Instructions

Number per day M T W T F S S_
Days per week M T W T F S S
(Please circle specific days for meals)

Type of Meal: Regular____ Alternative _____

Meal/Diet Specifics: Hot___ Therapeutic___ Chilled___ Shelf-Stable___ Modified___
Special___ Frozen___

__ADA (how many calories)_____

Nutrition Education and Counseling Needs:

_____
_____
_____
_____
_____

Special Instructions/Notations:

_____
_____
_____
_____
_____

Comments:

_____
_____
_____

Care Coordinator: _____

Telephone: (_____) _____

Instructions
Elderly and Disabled
Waiver Program-
Traditional/Enhanced

CLIENT REFERRAL FORM- HOME DELIVERED MEALS

Purpose: The Client Referral Form is used to initiate Home Delivered Meals (HDMs) from the home delivered meals provider on behalf of the EDWP client. The form contains information needed by the HDMs provider regarding the client's condition, dietary needs and specific instructions.

Who Completes/When Completed: The care coordinator completes this form when:

- ordering HDM service and
- reporting changes.

Instructions:

Enter the clients name, social security number and the date of the referral.

Indicate the number of meals ordered per day.

Circle the specific days of the week that the meals are to be delivered.

Indicate the type of meal required by the client. Therapeutic meals must have physician's orders on the LOC page.

Indicate any nutrition education and counseling needs of the client.

Indicate any special instructions/notations such as limitations which might impact the delivery of the meal. For example the client has arthritis and is slow to answer the door, or client is very hard of hearing- KNOCK LOUDLY.

Indicate any other additional comments that may be helpful to the provider, such as instructions to the home etc.

Enter name and phone number of the care coordinator.

Distribution: The care coordinator completes this form and sends it to the home delivered meals provider. A copy of the form is kept in the client's case record.

HOME DELIVERED MEAL
EVALUATION FORM FOR
HOT, CHILLED, FROZEN, AND/OR SHELF-STABLE MEALS

Member Name: _____ Date: _____

Provider Agency: _____

Form Completed By: _____ Title: _____

PHYSICAL/MENTAL EVALUATION: **Fair ___ Good ___ Poor ____**
(needs assistance)

Motor Tasks:
Ability to perform small motor tasks (i.e., open cans, milk carton)
Yes _____ No _____

Mental Condition: Ability to cook/heat food safely.
Yes _____ No _____

ADEQUATE COOKING EQUIPMENT: **Yes _____** **No _____**

Working refrigerator _____ _____

Working oven _____ _____

Working microwave _____ _____

Working toaster oven _____ _____

Adequate kitchen utensils, towels/hot pads
to remove hot meal plates from oven safely _____ _____

Adequate refrigerator and freezer space to
store one week's supply of meals if needed _____ _____

ADDITIONAL COMMENTS/RECOMMENDATIONS:
Rev, 7/01 Rev 10/19

Type of meal recommended for use:

Shelf Stable _____ Hot _____ Frozen _____ Chilled _____ Therapeutic_____ Special_____
Modified _____ Other _____

INSTRUCTIONS FOR HDM EVALUATION FORM

HDM and/or Case Management providers use this form to document the member's meal choice(s). Regardless of whether the meals are on weekends, holidays, or otherwise, the provider completes this form when service is ordered and as needed when meal type changes are requested . The provider uses the form to monitor member's refrigerator/freezer and cooking equipment, and if appropriate, communicates this information to the chosen meal provider and Case Management Rev 10/2019

When there is a change in environment, or health status of the member, the provider telephones the Case Management within 24 hours and sends a CCNF with an explanation of the change(s) within three (3) business days.

The Home Delivered Meals provider staff completes the form by:

1) Filling in the member's name, date, the name of the provider agency, and the name of the person completing the form with her/his title

2) Evaluating the member's physical and mental status in relationship to preparing home delivered meals

3) Indicating the adequacy of the member's refrigerating and cooking equipment

4) Providing meal type recommendation and additional comments as appropriate.

Elderly and Disabled Waiver Program

POTENTIAL EDWP MEDICAL ASSISTANCE ONLY (MAO) FINANCIAL 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 Medicaid Cap, stop here and refer client to DFCS for information about a Medicaid Qualifying Trust.

.

Section II. RESOURCES	ESTIMATED VALUE
Cash	$_____
Checking account	$_____
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, place that is not producing income	$_____
Face Value of Life Insurance Policies	$_____
Burial Contract	$_____
Other (specify)	$_____
TOTAL RESOURCES	$_____
Subtract Individual or Spousal Impoverishment Resource Limit	- $_____

NOTE: Use the Spousal Impoverishment Resource Limit when one spouse is in EDWP and the other is not in EDWP, nursing home or other institutional living arrangement.

List any resource (including home place) that has been transferred in the last 60 months:

_____

_____

_____

_____

_____

Section III. Statement of Intent: Cost Responsibility

I have applied for services through the EDWP Enhanced/Traditional Services. I am aware that I am responsible for the cost of services under the Enhanced/Traditional Services Program until the Department of Family and Children services determines my eligibility for Medicaid and cost share amount. I understand that I must apply for EDWP Medicaid benefits through the county Department of Family and Children Services (DFCS). If DFCS determines that I have to pay a cost share, I will pay the monthly cost share to the appropriate provider(s). While waiting for DFCS to determine my cost share amount, I agree to pay to the appropriate provider(s) the full cost of services or the ESTIMATED cost share indicated on the line below, whichever the provider chooses.

$_____

ESTIMATED COST SHARE: Based on the information provided by the client/representative, this is an estimate of the client cost share. This estimated cost share was discussed with the client/representative. They agree to apply for EDWP Medicaid at DFCS, and understand the DFCS will determine Medicaid eligibility and exact cost share amount.

_____ _____

Care Coordinator Date

If DFCS determines that I am ineligible for Medicaid, I will pay provider full cost of services.
ALL THE INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____

Client / Client Representative's signature Date

This form is not an application for Medicaid benefits. The care coordinator will advise you when to apply for Medicaid.

Instructions

Elderly and Disabled Waiver Program

POTENTIAL EDWP MEDICAL ASSISTANCE ONLY (MAO) FINANCIAL WORKSHEET

Purpose: The Financial Worksheet is completed at the initial assessment of MAO or PMAO clients and when a change in income or resources may affect eligibility for the EDWP.

Who Completes/When Completed: The Nurse completes at the initial assessment. The care coordinator completes thereafter when income or resources change.

Instructions:

Section I. Income--record total income reported by client.

Section II. Resources--record client's statement of all resources based on current market value and total.

Section III. Statement of Intent: Cost share Responsibility--Explain cost share responsibility to client and include information that DFCS determines cost share amount. Give client written information about Medicaid and DFCS. Indicate the estimated cost share and discuss with client.

Distribution: Send a copy of this form to DFCS with the EDWP CCC and LOC. File the original in the client's case record.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

The Division of Aging Services (DAS) of the Georgia Department of Human Services (DHS) provides Adult Protective Services (APS) for the prevention of abuse, neglect and exploitation of older individuals (65+) or adults (18+) with a disability who do not reside in long-term care facilities. 1.866.552.4464 option 3 http://aging.dhs.georgia.gov

Healthcare Facility Regulation 1.800.878.6442 (Mandated reporters must report abuse in licensed facilities) www.dch.georgia.gov

State Long-Term Care Ombudsman- 1.866.552-4464 (Advocates for resident in long-term care facilities). www.georgiaombudsman.org

Aging and Disability Resource Connection- www.georgiaadrc.com (Web-based resource guide of partnering organizations) 1.866.552.4464 option 2.

- **Abuse** – is defined as any intentional or grossly negligent act or series of acts or intentional or grossly negligent omission to act which causes injury to a client, including but not limited to assault or battery, failure to provide treatment or care, or sexual harassment of the client. Abuse may be mental, verbal, sexual, or physical.
- **Neglect** – is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.
- **Exploitation** – is defined as an unjust or improper use of another person or the person's property through undue influence, coercion, harassment, duress, deception, false representation, false pretense, or other similar means for one's own profit or advantage.
- **Mistreatment** – is defined as any behavior or practice that has the potential to or results in any type of individual exploitation.
- **Unexpected Death** – is defined as death that occurs suddenly when the individual is in apparent good health or as the result of homicide, suicide, or accident.
- **Serious Injury** – is defined as bodily injury that involves a substantial risk of death, unconsciousness, extreme physical pain, sexual assault, violence, protracted and obvious disfigurement or impairment.
- **Elopement** – is defined as a cognitively impaired person successfully leaving a facility unsupervised and undetected.

Office of Inspector General- (OIG/HHS) Medicare /Medicaid Fraud Control Unit-1.800.447.8477 option 5 http://oig.hhs.gov/fraud/hotline

Food Stamp Fraud (OIG/USDA)- 1.800.447.8477 option 1

Social Security Fraud (OIG/SSA) 1.800.447.8477 option 2

Governor's Office of Consumer Protection- 1.800.869.1123 http://consumer.georgia.gov

Member Signature _____ **Date** _____

Elderly and Disabled Waiver Program (EDWP)

Physicians Evaluation

SECTION I – IDENTIFICATION (To Be Completed by Submitting Agency)

Date:	**Patient Name:**
Agency Name:	**Sex: Male or female**
Address, Phone, & Fax	**DOB:**

NOTICE TO PHYSICIAN: This member has requested home and community-based services from the EDWP (Elderly and Disabled Adults Waiver). In order to qualify a person must have a severe to moderate physical impairment and/or memory impairment that requires the assistance of another individual to perform their normal daily activities such as bathing, grooming, eating, and toileting.

Please complete the information below to document the patient's current condition and functional status.

Active and Important Diagnosis(es)n related to physical impairment or physiologic/neurologic problem (Please attach problem list)

Height ___ft. ___in; Weight ____

Medical	Mental Status	Functional Status
Does the patient require monitoring of a medical condition by a licensed MD? **Yes/No**	Is there documentation noting short or long-term memory deficits with etiologic diagnosis? **Yes/No**	Does the patient require extensive assistance with transfers and locomotion performance through help or one-person physical assist? **Yes/No** (If this is compensated by walker, cane, slower movements or use of furniture, this is NOT enough for the nursing home level of care requirement.)
Does patient require nutritional management? **Yes/No** ■ Therapeutic diet – yes/no ■ Hydration Maintenance – yes-no	Is there documentation noting moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making? **Yes/No**	Does the patient require assistance with feeding such as: continuous stand-by supervision, encouragement or cueing, and set-up help of meals? **Yes/No**
Does the patient require maintenance and preventive skin care? **Yes/No** ■ treatment of skin conditions, such as cuts, abrasions or healing decubiti? **Yes/No**	Does the patient exhibit a problem with behavior, i.e. wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring supervision or intervention? **Yes/No**	Does the patient require direct assistance of another person to maintain continence? **Yes/No**
Does the patient have a catheter care that requires a catheter change and irrigation? **Yes/No**	Does the patient have undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia? **Yes/No**	Are there communication deficits in making self-understood or understanding others? **Yes/No**
Is the patient currently receiving therapy services such as? ■ oxygen therapy: **Yes/No** ■ physical therapy: **Yes/No** ■ speech therapy: **Yes/No** ■ occupational therapy: **Yes/No**	**Note: Etiologies not covered in SOURCE or CCSP are those due to a mental health (i.e. Schizophrenia, mental retardation, developmental delay etc.). Cognitive loss (i.e. traumatic brain injury, dementia, etc.) is covered by SOURCE or CCSP**	Does the patient require direct stand-by supervision or cueing with one-person physical assistance from staff to complete dressing and personal hygiene? **Yes/No**
Does the patient require restorative nursing services such as range of motion exercises? **Yes/No** Does the patient Bowel and bladder training? **Yes/No**		**Graded Strength Scale of 1-5/5:** **1)**Muscle Flicker, but no movement **2)**Severe Weakness (no movement against gravity) **3)**Moderate Weakness (movement against gravity but not resistance) **4)**Mild Weakness (move against resistance) **5)**Normal Strength
Does the patient require monitoring of vital signs and laboratory studies or weights? **Yes/No**		
Does the patient's medical condition require management and administration of medications including injections? **Yes/No**. Is skilled nursing required for medication administration and management? **Yes/No**		

Upper Extremities		Lower Extremities	
Right	Left	Right	Left

Comments:

Print Physician Name/Title | Physician Signatures/Title | Phone Number | Date

Appendix D

SFC ADL validation and caregiver attestation

Part II Chapter 1400 Policies and Procedures for EDWP (CCSP and SOURCE) Personal Support Services/Consumer Direction/Structured Family Caregiver

Instructions: *Please indicate whether the ADL/IADL described in the left column requires intervention and assistance by a caregiver and provide the number of hours required for this specific task on a daily basis. If the task isn't required daily, please indicate number of times per week and hours required.*

Item D.1 further requires the relevant diagnosis.

ADL CARE-	
+D.1. MAKING SELF UNDERSTOOD (Expression) *Documented communication deficits in making self understood or understanding others. Deficits must be addressed in medical record with etiologic diagnosis addressed on MDS/ care plan for continued placement. (document acquired cognitive loss behavior issues that require caregiver oversight)*	☐ (inappropriate behavior, wandering, redirecting, resisting care etc)
+G2a Bathing - How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed; arms, upper and lower legs, chest, abdomen, perineal area -	☐ Task Performed Time spent ☐ Not Applicable
+G2b Personal hygiene - How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands -	☐ Task Performed Time spent ☐ Not Applicable
+G2c Dressing upper body - How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc. *Direct stand-by supervision or cueing with one person physical assistance from staff to complete dressing and personal hygiene. (If this is the only evaluation of care identified, another deficit in functional status is required.)*	☐ Task Performed Time spent ☐ Not Applicable
+G2d Dressing lower body - How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.	☐ Task Performed Time spent ☐ Not Applicable
G2e Walking - How walks between locations on same floor indoors *Transfer and locomotion performance of the resident requires limited/extensive assistance by staff through help of one person physical assist.*	☐ Task Performed Time spent ☐ Not Applicable
+G2f. Locomotion - How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair	☐ Task Performed Time spent ☐ Not Applicable

+G2g. Transfer toilet - How moves on and off toilet or commode *Requires direct assistance of another person to maintain continence.*	☐ Task Performed Time spent ☐ Not Applicable
+G2h. Toilet use - How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes -	☐ Task Performed Time spent ☐ Not Applicable
G2i. Bed mobility - How moves to and from lying position, turns from side to side, and positions body while in bed	☐ Task Performed Time spent ☐ Not Applicable
+G2j. Eating - How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition) *Assistance with feeding. Continuous stand-by supervision, encouragement, or cueing required and set up of meals.*	☐ Task Performed Time spent ☐ Not Applicable
IADL CARE -	
G1a-Meal Prep	☐ Task Performed Time spent ☐ Not Applicable
G1c-Managing Finances	☐ Task Performed Time spent ☐ Not Applicable
+G1d- Managing Medications	☐ Task Performed Time spent ☐ Not Applicable
G1e- Phone Use	☐ Task Performed Time spent ☐ Not Applicable
Other- light housekeeping, MD appointments, shopping) **(minimal time should be done re IADL)**	☐ Task Performed Time spent ☐ Not Applicable
Routine Health- How follow the directions of physicians, nurses or therapists, as needed for routine health care (BP/BS checks/vitals etc)	☐ Task Performed Time spent ☐ Not Applicable
Special Health- How follow directions of physicians, nurses or therapists as needed for specialized health care (dressing changes, dialysis (in-home) etc)	☐ Task Performed Time spent ☐ Not Applicable
Total hours per day- Met ☐ Not Met ☐	

Total hours per day- Met ☐ Not Met ☐

Date _____

Member Signature _____

1407.4 Caregiver Eligibility and Responsibilities

☐ The Primary identified caregiver is at least 18 years of age.
☐ The Primary caregiver is related to the CCSP or SOURCE member as described in 1003.1 of the CCSP and SOURCE General Services Manual. Relative Type _____
☐ The Primary caregiver is NOT the spouse, legal guardian or conservator of the family member for whom they are providing care.
☐ The Primary caregiver lives in the home with the CCSP or SOURCE member for whom they are providing care. (same home/same address)
☐ The primary caregiver is willing to work with the SFC provider's health coach, including entry of daily notes for the coach's review, participation at least monthly in a coaching session and participation in joint semi-annual home visits with the health coach and CCSP or SOURCE case manager.
☐ The primary caregiver is responsible for supporting the member to maximize the highest level of independence possible by providing necessary care and support, including the following:

a. Supervision or assistance in performing ADLs;
b. Supervision or assistance in performing IADLs;
c. Protective supervision provided solely to assure the health and welfare of a recipient;
d. Supervision or assistance with health-related tasks;
e. Supervision or assistance while escorting/accompanying the member outside of the home to perform tasks, including IADLs, health maintenance or other needs as identified in the care plan and to provide the same supervision or assistance as would be rendered in the home; and
f. Submission of daily notes electronically which reflect the member's health and the caregiver's performance

*Caregiver affirms the accuracy of the information provided in this document in entirety

Caregiver Signature _____

*Case Manager affirms the accuracy of the information provided in this document to the best of his/her knowledge.

Case Management RN/LPN/ Case Manager _____

Instructions

Elderly and Disabled Waiver Program-Traditional/Enhanced

SFC ADL validation and caregiver attestation

Purpose:

This form is used to validate the requirement for at least 5 hours of daily personal care services such as those provided in a nursing home and to validate caregiver eligibility,1407.4 PART II – Chapter 1400 POLICIES AND PROCEDURES for EDWP (CCSP and SOURCE) PERSONAL SUPPORT SERVICES/ CONSUMER DIRECTION/ STRUCTURED FAMILY CAREGIVER.

Who Completes/When Completed:

Completed initially by the Case Management agency upon the request by the caregiver/member for Structured Family Care. Follow up completion annually is done per policy 1407.2 2B at the semi-annual collaborative visit done with the member by the SFC provider and Case Management. **A new document is generated with a request for a new caregiver. See 1407.2 #14**

Instructions:

Complete the column to the right if tasks are performed by caregiver and record time spent per day on the duty. Member, caregiver and case management all sign and date initially and annually.

Distribution:

Original is filed in Case Management case record. Copy in SFC provider record.

Enhanced Case Management

Appendix DD/Nursing Supervisory Visit Form

ADH/ALS/PSS/X - Completed upon request of the Case Management at each supervisory visit that is conducted by the agency nurse, to assist in the determination of the member in Enhanced Case Managment.

SNS- Completed at each nursing visit that includes a service/care plan update that is conducted by a Registered Nurse (RN) or at each Case Management ordered SNS visit to facilitate a telehealth visit with the member's PCP.

Client Name: Client Medicaid ID

Dates of Supervisory visits for the last 3 months

Noted changes found during these visits:

Skin (changes/issues)

Weight (changes/issues)

Vitals- BP Pulse Resp. BS Check

Cognition (changes/issues)

Functional (changes/issues)

Home environment (changes/issues)

Medications (changes/issues)

Hospitalizations (changes/issues)

Falls (changes/issues)

ADL/IADL (changes/issues)

Support system (changes/issues)

Other

Provider or RN Name

Provider or RN Signature _____

Date:

Case Management RN Name

Case Management RN Signature _____

Date:

***Send a copy of the completed form to the client's case manager and retain the original in the client's clinical record.**

Purpose:

1-To determine ongoing level appropriateness for the member in Enhanced Case Management.

2- To assist the SNS at care plan update for payment of service rendered.

3- To assist in the case management order of a telehealth visit, facilitated by the service provider RN, between the member and the PCP.

Who completes/When completed:

ADH/ALS/PSS/X

The *Appendix DD –Nursing Visit Form* is completed upon request by Case Management for ECM eligibility in CCSP, performed at each supervisory visit that is conducted by the service provider RN/LPN, with a copy of the completed form sent to the member's waiver case manager and the original maintained in the member's clinical record.

SNS-

The Appendix DD Nursing Visit Form is completed during-

1. each service/care plan update that is conducted by the RN, at least every 62 days, with a copy of the completed form sent to the member's waiver case manager and the original maintained in the member's clinical record
2. each home visit where a Case Management ordered, scheduled telehealth visit with the member's PCP and Provider's RN is performed, with a copy of the completed form sent to the member's waiver case manager and the original maintained in the member's clinical record Rev

SNS must have MD orders for skilled nursing with duties performed. Example- medication monitoring. Providers can't be paid for supervisory work only. Can be RN visit request by Case Management for Provider RN facilitator of telehealth visit between member and PCP.

The reimbursement to SNS agencies (private home care providers) for a "supervisory visit" is **ONLY for clients who are receiving *skilled nursing visits*** as part of their CCSP or SOURCE services, regardless of whether they're receiving traditional or enhanced case management.

The "supervisory visit" referred to is actually the RN visit for the care/service plan update that's required at least every 62 days for any member who receives nursing visits from their private home care provider. **If the RN performs the nursing visit tasks specified in the care plan in the same visit the care plan update is performed, the private home care provider can bill for the visit as an RN visit.**

The private home care provider can get paid at the RN rate of $65 for these visits if all the above is met.

The reimbursement will also be made when the request by case management is for the Provider RN to facilitate a telehealth visit between the member and his/her PCP.

A service provider can use the form as part of their supervisory visit form or use it instead of the supervisory visit form they are currently using. They can use it at every supervisory visit, even those conducted by the LPN, and have the RN sign off behind the LPN. If their current supervisory visit form contains ALL the information on the appendix DD, they can use the appendix DD form instead. Rev 7/2018 1/2021

ENHANCED CHECKLIST

Client Name- Medicaid ID- Harmony ID-

Current Date- Next Quarterly Due date-

Diagnosis from current LOC- Primary Secondary

Current Level- ☐ ECM ☐ TCM

Level Change Request- ☐ ECM ☐ TCM ☐ NA

All EDWP clients meet the 'Traditional' definition per items listed below-

TCM

☒ Meets functional and financial eligibility required for nursing care
☒ Functional impairment caused by physical limitations
☒ Requires assistance with IADL and ADL care
☒ HDM and Case Management do not stand alone as service needs
☒ Approved level of care by RN, validated by GMCF and approved by an MD.

EDWP 'Enhanced' clients must have active participation by the office Medical Director, one additional item listed below and have required need for SNS/HDS and/or ADH to qualify for ECM.

☒ Active participation by the office Medical Director
☒ Submission of the ECM DM Physician letter initially/annually **AND** **one item below**

ECM

☐ Vent/trach
☐ Bed confinement with acute, unstable clinical issues
☐ Nursing Home/Rehab discharge in the last 90 days
☐ Daily ducubiti/ wound care requirement
☐ Multiple Falls in last month
☐ Multiple ER trips/Hospital stays in last quarter
☐ Monthly disease management education by the SNS for any/all *uncontrolled* chronic illnesses
(DM, HTN, COPD, ESRD, CHF, new onset CVA, MI)/requires teaching/monitoring
*submission of DM Physician letter ☐
☐ IV medication regimen
☐ Depressive Disorder/Depression (not adequately managed)
☐ Cognitive Loss- (Dementia/Alz/TBI/OBS etc) diagnosis with required and frequent redirection needed
☐ MFP discharge for the first 3 months
☐ Incontinence (skin care related to)
☐ Renal Dialysis
☐ Foley Catheter
☐ Any type of ostomy
☐ Amputee (new onset amputee/with therapy….
Elderly and weak and unable to transfer…. Dementia and forgetful with ambulating etc)
☐ Client requiring non-ALS proxy care for medication admin or any other condition

AND

☒ Requires SNS/HDS and/or ADH

****** All Hospice, ALS and PSS/X clients can remain as TCM.**

Other/Notes-

RN Reviewer Name RN Reviewer Signature _____

Medical Director Name Medical Director Signature _____

Purpose: To initially establish and/or provide ongoing evaluation of member level participation in the Elderly and Disabled Waiver Program/Enhanced Case Management.

Applicable for those members receiving PSS/X services and needing skilled nursing (SNS) or home delivered services (HDS) ordered by a physician. Services can be medication management/example. Supervisory work alone cannot be reimbursed.

ADH can stand alone with RN supervisory input.

Who Completes/When Completed: Completed quarterly by Case Management RN with review by the Medical Director with applicable ECM review at site visits by the case manager with consult with the RN.

All of the above require active participation and sign-off by the office Medical Director. The medical director will review the case midway through the current year's length of stay, or about 3 months before the annual in-home reassessment, and will be actively involved in reviewing the annual reassessment and care plan to decide whether the member needs to continue ECM during the next annual length of stay

Policy 1823
Case Management level changes (ECM/TCM) require physician or the agency's Medical Director orders using the change of service letter. If billing already occurred for the current month at the current level, a claim can be edited on Gammis for the current month to the newest established rate or the new rate can start the following month.

Enhanced Case Management DM Physician letter

Member Name-_____ Member DOB-_____
Physician Name-_____
Sent via fax: # _____ ☐ NA
Sent via mail: address _____ ☐ NA
Hand delivered: date_____ ☐ NA
Sent via email: address _____ ☐ NA

The Member above is active in the Elderly and Disabled Waiver Program. The Member entered the program on _____. Current services for this Member are listed below.

Based on specific criteria within the waiver, this member qualifies for
☐ Enhanced Case Management/ ☐ Traditional Case Management

Case Management involves Disease Management guidance.

This member has reported the following regarding being free of communicable disease.

_____

Please verify and return this letter ***if corrections are needed regarding accuracy of member self -report***.

_____

For your review, we have attached a list of current medications found during our most recent home visit.

Please contact our agency about questions you may have.

For more information on The Elderly and Disabled Waiver and other Georgia waivers, please visit our website at https://medicaid.georgia.gov/waiver-programs

Services: (list frequency for applicable services)

☐ Personal Support Service- _____
☐ Emergency Response System- 24 hour alert system
☐ Home Delivered Meals-_____
(include frequency and meal type … low sodium, renal, diabetic etc.)
☐ Adult Day Health- _____
☐ Home Delivered Services/Skilled Nursing Services- _____
☐ Alternative Living Service- (24 hour personal care home)
☐ Out of Home Respite- _____
☐ Enhanced Case Management
☐ Structured Family Care _____
☐ Consumer Direct

Sincerely,

Case Management Site info here with address and phone contact.

Enhanced Case Management DM Physician letter

Member Name- Member DOB-

Physician Name- Sent via fax: # Hand delivered: date ☐ NA

Sent via mail: address ☐ NA Sent via email: address ☐ NA

The Member above is active in the Elderly and Disabled Waiver Program. The Member entered the program on . Current services for this Member are listed below.

Based on specific criteria within the waiver, this member qualifies for
☐ Enhanced Case Management/ ☐ Traditional Case Management

Case Management involves Disease Management guidance.

This member has reported the following regarding being free of communicable disease.

Please verify and return this letter ***if corrections are needed regarding accuracy of member self -report***.

For your review, we have attached a list of current medications found during our most recent home visit.

Please contact our agency about questions you may have.

For more information on The Elderly and Disabled Waiver and other Georgia waivers, please visit our website at https://medicaid.georgia.gov/waiver-programs

Services: (list frequency for applicable services)

☐ Personal Support Service-
☐ Emergency Response System- 24 hour alert system
☐ Home Delivered Meals-
(include frequency and meal type … low sodium, renal, diabetic etc)
☐ Adult Day Health-
☐ Home Delivered Services/Skilled Nursing Services-
☐ Alternative Living Service- (24 hour personal care home)
☐ Out of Home Respite-
☐ Enhanced Case Management
☐ Structured Family Care
☐ Consumer Direct

Sincerely,
Case Management Site info here with address and phone contact.

Instructions
Enhanced Case Management DM Physician letter

Purpose: This form is used as a communication tool to the Member's Primary Care Physician to notify of entrance and ongoing placement into the EDWP as an Enhanced or Traditional Case Management member.

Who Complete/When Completed: Source and CCSP ECM submit the letter to the member's PCP initially and every 6 months. CCSP Traditional submit the letter to the member's PCP initially and annually if the Level of Care and Placement Instrument is signed by the agency's Medical Director.

Instructions:

1. Complete all applicable sections.
    i. At a minimum, the medication list provided to the physician should include name of the medication, dosage, units, frequency, route and prescriber to inform the Physician of all other prescribers the member is seeing.
2. Submit via mail, email, fax or hand delivery to the Member's Primary Care Physician
3. File original/copy (depending on submission type) in Member file/upload to the electronic data system formal notes if applicable.
4. The form is not intended for return by the Physician unless an update to communicable disease is indicated.

Date _____

Dear Dr. (Physician name) _____,

Based on criteria within the Elderly and Disabled Waiver, **(client's name)** _____, (DOB) **mm/dd/yyyy**, qualifies for Enhanced Case Management services. Criteria includes but is not limited to the presence of a chronic medical condition which requires medical oversight and long term care services to assist with performance of ADL/IADL care needs.

The Member entered the program on **(date of initial assessment)** and is receiving the following Home and Community Based Services within a plan of care.

- ☐ Personal Support Service _____
- ☐ Skilled Nursing Services _____
- ☐ Alternative Living Service _____
- ☐ Adult Day Health _____
- ☐ Home Delivered Meals _____
- ☐ Home Delivered Services _____
- ☐ Out of Home Respite _____ ☐ Emergency Response System

Observations noted during the recent home visit(s) **(Date of Last Home Visit)** include:

- ☐ Cognitive/Behavior issues/changes _____
- ☐ Nutritional Problems _____
- ☐ Clinical Problems/Treatments _____
- ☐ Skin Problems _____ ☐ Falls/Mobility _____
- ☐ Caregiver Concerns _____ ☐ Other (i.e. requests for referrals, DME, etc.)

_____

☐ See attached medication list for medications observed in the home during the last home visit.

Please contact me if you have questions.
Case Manager's Name
Case Manager Phone Number (ext)
Mailing Address
Zip Code

For more information on The Elderly and Disabled Waiver and other Georgia waivers, please visit our website at https://medicaid.georgia.gov/waiver-programs

Date Sent _____ fax: # _____ Mail (address) _____
Hand Delivered: Name of Recipient/title _____

Instructions
Enhanced Case Management Disease Management Physician letter

***Purpose*:** This form is used as a communication tool to the Member's Primary Care Physician to notify of entrance and ongoing placement of a client in the Enhanced Case Management

Who Complete/When Completed: Complete at initial assessment and every six months thereafter.

Instructions:

1. Complete all applicable sections.
    - Date – Date letter is mailed to physician
    - Date member entered the program (date of initial assessment)
2. Be sure all information is included is relevant to the client's medical care.
    - PSS – include frequency and units (2 hours/3 times week
    - SNS – include skill and frequency (med management LPN 1xwk)
    - ALS – include name of facility
    - ADH – include name of facility and frequency (Adult Day 4 half days per week)
    - HDM – 7 meals weekly
    - HDS – PT 3 times week x 2 weeks
    - OOH Respite – include facility, frequency, units (TC Healthcare 2nd Saturday and Sunday of the month every 2 months)
    - ERS
3. Document date of last home visit and observations of the following:
    - Cognition – oriented, alert, presence/absence of behaviors
    - Nutrition – diet followed in the home, compliance, tube feeding, other
    - Clinical problems/treatments – refer to abnormals or noncompliance with home monitoring for blood pressure, blood sugar, weight; note dialysis, chemotherapy, radiation, Home Health; surgery in the last 3 months, when applicable include edema, pain, member concerns
    - Skin problems – rash, burns, skin tears, surgical incisions, ulcers, wound care, other
    - Falls/mobility – changes in mobility, falls in last 3 months, injury
    - Caregiver concerns
    - Other – include need for referrals (hospice, home health, therapy, other) and DME requests.
4. Attach medication list from home visit (medication reconciliation)
5. Submit via mail, email, fax or hand delivery to the Member's Primary Care Physician
    - File original/copy (depending on submission type) in Member file/upload to the electronic data system formal notes if applicable.
6. The form is not intended for return by the Physician but may do so if needed.

Date Sent _____ fax: # _____ Mail (address) _____
Hand Delivered: Name of Recipient/title _____

EDWP
Traditional
+ Enhanced
CD PSS Forms

EDWP - Consumer Directed PSS Option

Consumer-Directed PSS gives eligible *consumers* the choice and control over who provides their EDWP Personal Support Services and how these services are delivered. The Consumer Direction Personal Support Services' option allows the consumer or their representative to *hire, train, supervise, discipline, and terminate* the home care worker.

Client Choice: All clients and/or their representative are offered the option of Consumer-Directed PSS and Financial Management Services at admission, quarterly review and/or reassessment to EDWP.

Self Determination ***Consumer Responsibility*** ***Client-Centered Focus***

Access & Client Eligibility

- Gateway staff informs callers of option and provides EDWP Brochure
- Enrolled in EDWP and receiving PSS services for six months or longer
- Current Medicaid eligibility based on age (65 or older), blindness or total disability
- Current physician approved Comprehensive Care Plan having utilized PSS or PSSX
- If pays a cost share, shows timely and total payment history
- Ability to show control over schedule and decisions
- Capable of directing own care or designating a representative to do same
- Cognitively aware and capable of performing employer tasks (i.e., interviewing, hiring, managing)
- Willingly accepts responsibility for cost effective use of Consumer- Directed PSS
- Client behavior is such that risk for all parties is limited

"Support Broker" (CC) Responsibilities

1. Inform client of option at admission, recert or review
2. Review participant agreement
3. Begin client training
4. Complete skills Inventory and Checklist
5. Support client or representative in process
6. Develop CD-PSS budget
7. Choose emergency "Back Up" EDWP provider agency
8. Assist in completion of Financial Management Services packet
9. Mentor /monitor monthly

"Employer" Responsibilities

1. Demonstrates control over daily activities
2. Demonstrates timely cost share payments
3. Willingly assumes responsibility of self-direction and signs participant agreement
4. Demonstrates no problematic behavior
5. Completes CD PSS training with CC

"Fiscal Intermediary" Responsibilities

1. Processes worker(s) time sheets, generates payroll
2. Calculates, withholds and pays employer taxes
3. Provides reports and tools to manage client's budget
4. Provides a one-time purchase Fax machine
5. Conducts background checks for potential workers (up to 5 annually)
6. Keeps info on CPR and First Aid for hired staff
7. Facilitates the purchase of benefits for workers (optional)
8. Manages Workers Compensation
9. Manages and applies cost share

"Employer" Responsibilities (cont'd)

6. Develops worker job description
7. Recruits, interviews, hires, trains, terminates worker if necessary
8. Develops "Back Up" plan
9. Schedules worker and submits time sheets

"Prospective Employee" Responsibilities/Qualifications

1. Complete and submit:
   I-9, W-4 and G-4,
   Background check forms,
   Application for employment,
   Direct Deposit if desired
   Submit a copy of:
   Social Security card,
   ID card (driver's license / passport)
2. Current First Aid certification
3. Current CPR certification
4. Ensure 18 years or older
5. Basic reading/math skills
6. Initial and annual physical exam with TB screen
7. Compliance with CD PSS service option

For more information

contact the State of Georgia EDWP

1-866-55 AGING

Revised 3 20 18

Elderly and Disabled Waiver Program
Consumer Directed Option for Personal Support Services

CLIENT PARTICIPATION AGREEMENT TERMS AND CONDITIONS

Client _____ Medicaid Number _____

Purpose:

It is the intent of this agreement to provide an assurance that consumers understand the expectations and requirements of the Consumer Directed Service option under the EDWP Traditional/Enhanced. The EDWP consumer must follow specific requirements in order to assure compliance with the Care Plan. Failure to follow these requirements may result in a return to the traditional option of Personal Support Services or termination from EDWP. Signing the agreement indicates that you understand the option requirements and will abide by the terms and conditions for participation in the Consumer Directed Service option as implemented by the Georgia Department of Community Health. The following does not intend to address all of the conditions of participation; therefore, please discuss any questions or concerns you may have with your care coordinator.

Eligibility for the Consumer Directed Personal Support Service option in EDWP, whether by the consumer or chosen representative, requires the following criteria:

1. Meets EDWP eligibility criteria
2. Enrolled in the EDWP for a minimum of six months
3. Current eligibility and receipt of Medicaid benefits categorically related to aged, blind, or totally disabled population
4. Demonstrated total and timely payment of all cost share, if applicable
5. Demonstrated ability to control daily schedule and decisions
6. Free of dementia or developmental disability diagnosis
7. Motivated to direct personal support services
8. Willing to assume responsibility for cost effective use of Personal Support Services within the established budget

9. Completion of training requirements for the Consumer Directed Service option by reviewing the training manual and demonstrates understanding by completing required enrollment documents

10. Signs Client Participation Agreement which outlines the roles and responsibilities of the Consumer who chooses to direct his/her Personal Support Services

General Understanding:

1. The EDWP Care Coordinator develops the Comprehensive Plan of Care and budget for Consumer Directed Personal Support Services (CD-PSS).

2. The EDWP Care Coordinator will assist you with understanding your roles and responsibilities as an employer of your personal support workers and to identify other resources for you.

3. The Care Coordinator brokers all services identified on the care plan with a EDWP enrolled provider of the consumer's choice with the exception of CD-PSS.

4. CD-PSS services must begin on the first day of the month.

5. The EDWP consumer/representative is responsible for advertising, interviewing, hiring, training, supervising, disciplining, and terminating the employee.

6. The EDWP consumer/representative is responsible for working with the Fiscal Intermediary (FI) service provider to submit all required documentation including a criminal background check to the FI prior to hiring any employee.

7. The EDWP consumer/representative is fully responsible for payment of all required employer paid state and federal taxes and understands that those taxes can and do change; changes do impact the consumer's budget for personal support services.

8. The EDWP consumer/representative is responsible for submitting employee timesheets by established FI due dates for employees to be paid timely.

9. Personal Support Services are not to exceed the established budget without prior approval from the care coordinator.

10. The monies for employee salaries, federal and state taxes and benefits for the personal support services employee(s) and the FI service provider will be deducted from the budgeted CD-PSS units.

NOTE: Reimbursement for wages in excess of 40 hours per week to a consumer directed PSS aide will automatically be paid at one and one/half times the

normal hourly rate from the member's budget, in accordance with current federal law on overtime pay for personal support services, unless the employee has been exempted from overtime as a live-in caregiver. Rev 01/2019.

11. The consumer/representative ensures his/her employee(s) meet requirements/qualifications for employment and reimbursement by Medicaid.

12. The consumer/representative will have the freedom of choice in selection of the Medicaid FI enrolled provider.

13. The consumer/representative will be responsible for staffing/scheduling employee(s) as well as developing back up plans should the primary employee not be available to provide care.

14. The consumer/representative will be responsible for developing a CD-PSS task list and training employee(s) on the performance of the required care tasks.

15. A member of the Department of Community Health Utilization Review team will make in-home visits as needed and required to review service provision and documentation.

Discharge of Consumers from EDWP:

Discharge from Consumer Direction may take place when any of the following occurs:

1. Client no longer meets EDWP eligibility

2. The Utilization Review team recommends discharge (10 day notice required)

3. The consumer has not received a waiver service for sixty (60) consecutive days

4. The consumer/representative demonstrates behavior that is disruptive, illegal, threatening to self or others

5. The consumer refuses to comply with treatment/interventions identified in the Comprehensive Care Plan

6. The consumer chooses to be discharged or enters a long term care facility

Discharge from Consumer Directed Services:

Consumers who remain eligible for EDWP will be transferred back to EDWP Enhanced/Traditional 'traditional' services for any of the following reasons:

1. Consumer/Representative requests to dis-enroll from Consumer Directed Services

2. Consumer/Representative failure to maintain maximum control over daily schedule and decisions

3. Consumer/Representative failure to pay total cost share to the FI by the required due date.

4. The consumer/representative exceeds personal support services budget without prior authorization from the care coordinator for two (2) consecutive months

5. Consumer/Representative use of the state back up plan more than twice for two (2) consecutive months.

6. Consumer/Representative failure to meet identified health and safety goals (Client Assessment Protocols) for two (2) consecutive quarters

Consumers who are moved back to traditional services will experience no lapse in service. A return to Enhanced/Traditional 'traditional' Option does not constitute a reduction in services. Personal Support Services will be brokered with a EDWP enrolled provider of the consumer's choice. After one year the consumer will be eligible to re-apply for the Consumer Directed Service option.

Terms of the agreement:

The term of this agreement is effective for one year from the approval date or the next reassessment whichever comes first and must be renewed annually at the time of reassessment. The renewal is a mutual written consent of the consumer and the care coordinator.

As a EDWP consumer who has chosen the Consumer Directed Personal Support Service option, I understand that I, or my designated representative, assume responsibility as EMPLOYER and all the related duties this requires. The option and processes have been explained to me and all of my questions have been answered.

I choose to direct my own Personal Support Services ☐

I choose a representative to direct my Personal Support Services ☐

Consumer

Signed _____

Print Name _____

Date _____

Chosen representative

Signed _____

Print Name_____

Date _____

Care Coordinator

Signed _____

Print name _____

Date _____

Instructions
Elderly and Disabled Waiver
Program CD-PSS

CLIENT AGREEMENT
TERMS AND CONDITIONS FOR PARTICIPATION

Purpose: This form is used to assure that consumers understand the conditions of participation, client and care coordination expectations, option requirements and discharge procedures of the Consumer Directed Service option under the Elderly and Disabled Waiver Program. By signing this form, the client or client representative chooses Consumer Directed Option for Personal Support Services (CD-PSS) and agrees to the conditions and requirements of CD-PSS and assumes responsibility as the Employer/Employer Representative.

Who Completes/When Completed: The care coordinator completes with the client/client representative prior to client's enrollment in CD-PSS and annually thereafter.

Instructions:

1. **General Information**

    a. Complete the form with the client name and Medicaid number

    b. Carefully review, with the client or client representative, all sections of the document.

    c. Ask questions and/or give examples to insure the client or client representative fully understands his/her rights and responsibilities under CD-PSS.

    d. Explain fully conditions of eligibility and discharge procedures which return the participant to the 'traditional' Option.

2. **Obtain Signatures**

    a. Document check box with client choice to self-direct or the client choice for an Employer/Representative to direct his/her care.

    b. Client signature is required as the first step to participation in CD-PSS.

    c. Print the Client/Employer name under his/her signature.

    d. Date document with current date.

e. When an Employer/Representative is chosen, obtain representatives signature, printed name of representative under signature and current date.

f. Care Coordinator signs, prints name and dates the form with the current date in the presence of the Employer/Employer Representative.

NOTE: This document must be reviewed and completed with signatures of all parties, printed names and dates prior to any enrollment activities into the CD-PSS.

Distribution: File original in care coordination agency's client record and provide a copy to the client/client representative for his/her records.

Elderly and Disabled Waiver Program
CD-PSS

EMPLOYEE TASK LIST

Assignment for _____ **Date**_____
Employee Name

Personal Care Tasks:	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Specific Instructions
BATHING								
Shower								
Tub bath								
Bed bath								
Sponge bath at sink								
Other:								
HAIR CARE								
Wash hair								
Set/style hair								
Brush/comb hair								
Cut hair								
Other:								
NAIL CARE								
Clean nails								
File nails								
Cut nails								
Other:								
DRESSING								
Lay out clothes								
Supervise/cue								
Partial assistance with dressing								
Full assistance with dressing								
Other:								
MOUTH CARE								
Brushing teeth								
Floss teeth								
Mouthwash								
Denture care								
Make dental appointments as requested								
Other:								
Other:								
Other:								
Other:								

Personal Care Tasks:	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Specific Instructions
FACE AND BODY CARE								
Shave face								
Shave body hair								
Apply lotion								
Apply/remove makeup								
Apply deodorant								
Other:								
SKIN CARE								
Check skin for irritation or breakdown								
Tell employer/representative of irritated skin areas or breakdown								
Skin treatments								
Other:								
CONTINENCE CARE								
Toileting schedule								
Catheter care								
Use of bedside commode								
Use of urinal								
Change briefs/diapers								
Clean urinary/ostomy equipment								
Bowel program								
Ostomy care								
Other:								
TRANSFERS								
Full assistance								
Partial assistance								
Wheelchair								
Shower/tub								
Toilet								
Use special equipment								
Car/van								
Other:								
WALKING								
Assist with walking								
Use special equipment								
Walking Other:								
POSITION IN BED/CHAIR								
Turn/freq								
Assist with weight shifts								
Check pressure reduction device								
Other:								
Other:								
Other:j								

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Specific Instructions
RANGE OF MOTION								
Exercises								
Other:								
NUTRITION								
Prepare meals/snacks								
Clean up after meals								
Clean out refrigerator								
Other:								
Other Tasks:								
MEDICAL								
Assist with medications								
Call in prescriptions								
Pick up prescriptions								
Make medical appointments								
Go with me to medical appointments								
Make transportation arrangements								
Order Medical supplies								
Special Needs:								
Special Needs:								
Other:								
HOUSEHOLD								
Laundry								
Ironing								
Dry cleaning								
Vacuum								
Sweep								
Dust								
Mop floors								
Clean toilet								
Clean oven/stove								
Empty trash								
Make bed								
Other Tasks:	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Specific Instructions**
Change bed linens								
General cleaning								
Grocery shopping								
Pay bills								
Other:								
Arrival time:								
Departure time								

Instructions
Elderly and Disabled
Waiver Program
CD-PSS

EMPLOYEE TASK LIST

Purpose: This form is used to direct and assign specific care tasks to assist participants in CD-PSS.

Who Completes/When Completed: The Client/Employer or Representative completes the form with the assistance of the care coordinator. Clients may choose to use the task list to develop an Employee job description prior to hiring his/her employee but the form must be completed prior to the employee first day of employment.

Instructions:

1. **General Information**

    a. Use the Comprehensive Care Plan-Client Assessment Protocols for the reference point to assist the client with identification of care needs

    b. Provide information, make suggestions and recommendations as needed to assist the client/representative with decisions regarding frequency and requirements for safety, health and welfare

NOTE: CD-PSS promotes client choice and independence, Care Coordinators support and mentor Client/Employers in decision making.

    c. Insure the client or client representative understands the task list is a contract agreement with his/her Employee

2. **Form Completion**

    a. Client/Employer completes form with the name of his/her Employee. If multiple workers are employed, complete a task list for each Employee

    b. Document the specific task, the day or days per week on which the task is required and any specific instructions.

EXAMPLE: Client requires assistance with bathing. The client is medically fragile, requests a shower one time per week and a bed bath three times per week. The client prefers the bath two hours after breakfast. Based on this information, the client checks the boxes to indicate a shower on Monday, bed baths on Wednesday and Friday and documents "bathe two hours after am meal".

Distribution: Employers retain the completed documents in the required Employee file folder maintained at the client/employer residence.

Recruitment Strategies

- Explore your needs and options, preferences and personalities desired
- Consider your goals
- Decide the kind and amount of assistance you will need to meet your goals
- Decide what tasks are needed and provide task descriptions (refer to provided task list and expand)
- Develop plan which outlines how tasks are accomplished
- Explore what you can do for yourself and what you need help with:
    - Meals-preparation, meal time, diet, meals at home or out and will the aide eat with you etc
    - Grooming- regular schedule, hair/make-up, clothes
    - Housekeeping- neat house, tasks done a certain way, certain product types to clean
    - Lifestyle- smoker, daily schedule/hours, needed outings, pets, specialized training
- Provide a detailed profile of yourself to strengthen aide's overall learning and cooperation (list personal goals and preferences)
- Develop a strategy for recruitment of prospective employees
    - Use agency : (HireMyCare.com)
    - Newspaper ad
    - Post opening at hospital or nursing home (with permission)
    - Seek resources with recruiting, screening and training
    - Establish clear qualifications
- Avoid discrimination based on age, race, gender or disability respecting ethnic and cultural diversity
- Evaluate employee qualifications and experience based on need
- Address confidentiality and privacy to honor both the client and employee
- Set boundaries and maintain limits, scheduling performance review meetings as needed

Hiring Process Preparation

- Recruiting (work with an agency or perform on own)
- Utilize job description and application for employment
- Advertise and recruit from areas of reliability (nursing schools/colleges, community volunteers, churches, and healthcare facilities, etc)
- Screen and interview applicants (consider back-up employees)
- Check references (Background checks provided by Fiscal Intermediary)
- Set up a work agreement including duties, pay rate, schedule and termination policy
- Orient and train staff

Conflict Mediation

- Provide coaching to deliver results
- Teach goal achievement and what priorities to work towards
- Delegate tasks
- Provide motivation with respect, appreciation and problem solving
- Mentor with feedback and continue to teach and improve skills of aide
- Evaluate and discuss your working relationship with open communication and constructive criticism
- Provide aide self-appraisal
- Display positive problem solving with good communication
- Be prepared to consider alternative ways of working
- *Seek help from a familiar but neutral source*

Elderly and Disabled Waiver Program
Consumer Directed Option for Personal Support Services

EMPLOYER/REPRESENTATIVE
SKILLS INVENTORY/TRAINING CHECK LIST

The following training sessions have been provided to me or my representative and I am able to successfully demonstrate knowledge of these activities:

ACTIVITY	*TRAINING DATE*	*EMPLOYER/ REPRESENTATIVE*	*CARE COORDINATOR*
Risks and Responsibilities of Consumer Direction			
Freedom of Choice of Providers			
Individual Rights			
Calculating my budget			
Developing a written job description			
Employee recruitment (hiring attendants)			
Hiring a certified attendant (employee)			
Training employee(s) prior to service delivery on the following: • **CPR** • **First Aid** • **Basic skills necessary to provide my care** • **Confidentiality regarding the services provided** • **Environmental/fire safety** **(All training must be documented in writing and maintained in the employee file)**			
Coaching and disciplining the employee (provide positive and negative feedback)			

Determining my employee's salary			
Paying my employee			
Terminating my employee			
Accessing community resources			
Developing a staffing plan and back up staffing plan			
Mediation, conflict management and problem solving skills			
Revising the care plan; reassessment and review schedules			
Risk Management Intervention: Incident reporting and Unexpected Activity to the Care Coordinator			
Returning to the Traditional Option			
Removal from Consumer Direction			
Miscellaneous:			

Date Completed:_____

EDWP Client:_____

EDWP Representative:_____

EDWP Care Coordinator/Support Broker:_____

Instructions
Elderly and Disabled Waiver
Program CD-PSS

SKILLS INVENTORY/TRAINING CHECK LIST

Purpose: This form is used to document adequate Employer/Employer Representative knowledge of the skills required to participate in CD-PSS and successful completion of Employer/Employer Representative training.

Who Completes/When Completed: The care coordinator completes with the client/client representative. The form will be completed incrementally as each activity has been successfully trained.

Instructions:

1. **General Information**

    a. Provide training and information for each activity listed on the form

    b. Provide referral information for additional resources. Clarify with examples

    c. Ask questions to insure the client or client representative understands his/her role as Employer and is fully prepared to successfully direct personal support services.

    NOTE: Resources for training are available in "Consumer Directed Option Manual, A Guide for the Consumer" developed by ShepherdCare 2005 and "Working Together: Consumer Personal Assistance Training" by Ripple, Kraus, Nelson, Chong, and Temkin.

2. **Obtain Signatures**

    a. Document, by activity, the date training was successfully completed

    b. Obtain client or representative signature of understanding

    c. Care Coordinator signature verifies client or representative has completed the training and is able and capable to perform the activity

    d. Date document when all activities on the form have been trained

    e. Client or Representative and Care Coordinator signatures at the bottom of the form confirm the required training for all activities is complete

NOTE: All training is completed and this document annotated with date(s) of completion and

Client or Representative and Care Coordinator signatures are required before the client is referred to a Fiscal Intermediary services provider for additional enrollment activities.

Distribution: File original in care coordination agency's client record and provide a copy to the client/client representative for his/her records.

Georgia Medicaid will not reimburse personal care services or any waiver services when services are provided by legally responsible relatives, i.e., spouses or parents of minor children, guardians or anyone with <u>any</u> power of attorney.

General Services Manual Section 1002/Pss Manual 1406/CC Manual 1872-1876

Relatives are not permitted to be employed as CD-PSS caregivers unless there is prior approval from the Department of Community Health for <u>extenuating circumstances. See Below***</u> **A review of relative submissions will include requests by DCH for documented proof of attempts to hire non-family first. Examples include: ads in church bulletins, web pages, care.com, local newspapers or newsletters.**

"Relative" is defined as a person who is related by blood **or legal adoption** within the third degree of consanguinity or by marriage. Third degree of consanguinity means mother, father, grandmother, grandfather, sister, brother, daughter, son, granddaughter, grandson, aunt, uncle, great aunt, great uncle, niece, nephew, grandniece, grandnephew, 1st cousins, 1st cousins once removed and 2nd cousins.

Relative Caregivers in EDWP Consumer Direction Option
***** Extenuating Circumstance Guidelines**
Adequate Justification Documentation

When reviewing relative requests for approval as a paid caregiver; reviewers will consider the following when determining if the waiver member meets criteria for extenuating circumstances:

Traditional CC Manual Sect 1875….. Please mark those applicable for consideration.

☐ Member lives in remote area and/or lack of qualified providers

☐ Member Communication Barriers
Examples: Inaccessibility of caregivers who speak member's native language
(Language or dialect rarely used in geographic area*) and/or Expressive/ReceptiveA phasia

☐ Member Aggressive or Dangerous Behaviors

☐ Medical Diagnosis and Treatment which requires unique/skilled care giving training for extenuating care needs

Member Communication Barriers

- ☐ Written documentation which identifies the member's language and confirms the that the member neither speaks nor understands another language (case notes or assessment document from member record)
- ☐ Written documentation which confirms the medical diagnosis and medical history related to member expressive/receptive aphasia. Case notes, MDS-HC, Care Plan and/LOC Placement Form can be submitted. Existing case notes or documentation of the aforementioned forms should document history of communication difficulties with providers as well as with care coordinator

Member Aggressive of Dangerous Behaviors

- ☐ Copies of existing case notes which document history and current occurrences of the behavior(s) and triggers resulting in the behavior(s), if applicable
- ☐ Copies of Incident Reports, MDS-HC or Service Plan which addresses aggressive or dangerous behavior
- ☐ Attestations from former providers (care coordination notes or CCNF are also acceptable), physicians and/or mental health providers

Medical Diagnosis and Treatments

- ☐ Copies of LOC Placement Instrument, MDS-HC and/or Service Plans which confirm medical dx and treatment
- ☐ Written attestation from member physician
- ☐ Copies of existing case notes which document difficulty/inability to staff a caregiver able to provide the high level of care for the member and documentation which demonstrates how care is currently provided to the member

Procedure for requesting a family member to become a paid aide in consumer direction…

1- Client must be an existing client in EDWP 'traditional' Enhanced/Traditional for 6 months.
2- Client/ representative sends a written request by mail, fax or email with appropriate documentation (see above) to the assigned Care Coordination Agency/Worker. The Care Coordinator will then process the request to the DCH/CCSP CC Specialist for the area.

The address is …. 2 Peachtree St NW, 37th Floor Atlanta Ga 30303 or
Carolyn.Porter@dch.ga.gov or Jill.Crump@dch.ga.gov

3- The DCH CC Specialist will review, request other documentation if necessary.
4- Once reviewed all documents will be sent to Tom Underwood/DCH for review and approval/denial. The specialist will notify the CC agency of the decision.

Care Coordination check list: CD PSS family caregiver request

- ☐ Client name/Harmony ID
- ☐ FI chosen
- ☐ Live-in paid caregiver- (alert the FI)
- ☐ 5588 to FI
- ☐ Policy reviewed with potential employer (1872-1876)
- ☐ Client in traditional x 6 mos or waiver letter request
- ☐ Medicaid approved
- ☐ Employer name
- ☐ Employee(s) Name(s)
    - (Can't be employer and employee) (Employee can't be POA/guardian)
- ☐ CC letter of approval/denial
- ☐ Physician letter
- ☐ Client/rep justification letter
- ☐ Submission of attempts to hire non-family
- ☐ Cd PSS budget cost
- ☐ Traditional cost…. List services, frequency and total pss budget
- ☐ Employee pay rate
- ☐ State back up traditional provider name
- ☐ Informal back up (paid/unpaid) (names/relation)
- ☐ Proxy review if medication administration will take place
- ☐ Dates of (2) Cd PSS trainings performed

EDWP Traditional + Enhanced General Forms

Name and address of the ADRC here or on letterhead

Member's Name

Member's Address

Date

Dear Applicant

Before we can refer you for a full assessment for the Elderly and Disabled Waiver Program (EDWP), the program you requested to provide help at home, you need to choose a case management agency. Please circle or mark an X beside the case management agency of your choice below. Please sign and date your choice and return it to us in the enclosed envelope. After we receive your choice, we will contact your chosen case management agency to request an assessment in your home to determine if you meet all the requirements for the program. They will contact you to schedule the assessment after the receipt of this completed form.

Thanks for returning your choice to us promptly.

Your Aging and Disability Resource Connection

Below are the case management agencies that serve County, your county of residence, for the EDWP. Please mark your choice by circling the name of the agency or marking an X next to it.

Your Signature: _____

Your Printed Name: _____

Date signed: _____

If not signed by the applicant, your relationship to the applicant: _____

Return this letter with your choice indicated above in the enclosed return envelope. Thank you!

For ADRC Use Only:

Date received :

Notes:

EDWP Case Management Member Choice Form Instructions

Purpose:

To determine client choice of Case Management Agency at screening level.

Who completes/When completed:

Initiated by the ADRC at the time of screening and processing for initial assessment to a Case Management Agency. Can be submitted to the ADRC by an outside agency during the referral process and would accompany the client waiver referral form. Client choice must be validated by ADRC staff at screening level. Form can be uploaded to the electronic data system and is also and kept on file at the ADRC for a minimum of 5 years.

The ADRC will confirm the choice via a mailed-in form, via e-mail or via a text message from the member that can be saved if this is possible, but the choice needs to be confirmed *in writing* to the ADRC before the member is referred for assessment.

*Member's choice of case management provider only needs to occur if the member was not referred for screening for CCSP/SOURCE by a case management agency. If the referral for waivered care is from the Case Management agency to the ADRC, the referral can be processed with a comment that the client is being referred back to the agency that made the referral.

Name and address of the ADRC here or on letterhead

Nombre del miembro

Dirección del miembro

Fecha

Estimado solicitante,

Antes de que podamos remitirlo a una evaluación completa para el Programa de Exención para Personas Mayores y Discapacitados (EDWP), el programa que ha solicitado para recibir ayuda en el hogar, usted necesita elegir una agencia de administración de casos. Encierre en un círculo o marque una X al lado de la agencia de administración de casos de su elección que se muestra abajo. Firme, fecha y envíe su elección en el sobre adjunto. Luego de recibir su elección, nos comunicaremos con la agencia de administración de casos que ha elegido para solicitar una evaluación en su hogar y determinar si usted cumple con todos los requisitos para el programa. Luego de recibir este formulario completado, la agencia se comunicará con usted para programar la evaluación.

Gracias por devolvernos su elección sin demora.

Su Conexión de Recursos para Personas Mayores y Discapacitadas de Georgia (Aging and Disability Resource Connection, ADRC)

Abajo se enumeran las agencias de administración de casos que sirven al Condado, su condado de residencia para el EDWP. Marque su elección encerrando en un círculo o colocando una X al lado del nombre de la agencia.

Su firma: _____

Su nombre en letra de molde: _____

Fecha de la firma: _____

Si no está firmada por el solicitante, indique su relación con el solicitante: _____

Devuelva esta carta con su elección indicada arriba, en el sobre de devolución adjunto. ¡Gracias!

For ADRC Use Only (Solo para uso de ADRC)

Date received:

Notes:

Name and address of the ADRC here or on letterhead

회원 이름:

회원 주소:

날짜

신청자 님께

가정에서 도움을 받을 수 있는 프로그램인 노인 및 장애자 면제 프로그램 (EDWP) 과 관련하여 귀하의 요청에 대한 전반적인 평가를 의뢰하기 전에, 우선 귀하는 케이스 관리 기관을 선택해야 합니다. 아래에서 선택하신 케이스 관리 기관 옆에 동그라미나 X 표시를 해주세요. 서명하고 날짜를 기입 한 후 동봉된 봉투에 넣어 보내 주세요. 귀하의 선택에 관한 편지을 받은 후, 저희는 선택된 케이스 관리 기관에게 연락하여 귀하의 모든 프로그램 요건 충족 여부에 관한 평가를 귀하의 집에서 실시하도록 요청합니다. 작성된 본 양식을 수령 한 후, 케이스 관리 기관이 평가 일정을 잡기 위해 연락드릴 것입니다.

선택과 관련해 신속하게 답신을 주셔서 감사합니다.

노령화 및 장애 자원 연결 ***(Aging and Disability Resource Connection, ADRC).***

다음은 귀하의 카운티에서 **EDWP** 를 제공하는 케이스 관리 기관들입니다. 기관 이름에 동그라미를 치거나 옆에 **X** 표시로 선택해 주세요.

귀하의 서명: _____

귀하의 이름(인쇄체): _____

서명 날짜: _____

신청자가 서명하지 않은 경우, 서명자의 신청자와의 관계: _____

선택한 기관 표시가 있는 이 편지를 동봉된 반송 봉투에 넣어 보내 주세요. 감사합니다.

For ADRC Use Only (ADRC 전용):

Date received:

Notes:

Name and address of the Case Management here or on letterhead

Member's Name

Member's Address

Date

Dear Member

You recently requested a new case management agency to manage your case under Georgia's Elderly and Disabled Waiver Program (EDWP), the program through which you receive help at home, or your circumstances have changed so that we must transfer your case to a new case management agency. Before we can refer you for a transfer assessment by the new case management agency, you need to choose a new case management agency. Please circle or mark an X beside the case management agency of your choice below. Please sign and date your choice and return it to us in the enclosed envelope. After we receive your choice, we will contact your chosen case management agency to request a transfer of your case to the new agency. They will contact you to schedule a home visit after the receipt of this completed form.

Thanks for returning your choice to us promptly.

Your Case Management Agency

Below are the case management agencies that serve County, your new/current county of residence, for the EDWP. Please mark your choice by circling the name of the agency or marking an X next to it.

Your Signature: _____

Your Printed Name: _____

Date signed: _____

If not signed by the applicant, your relationship to the applicant: _____

Return this letter with your choice indicated above in the enclosed return envelope. Thank you!

For Case Management Use Only:

Date received :

Notes:

EDWP Case Management Member Choice Form Instructions

Purpose:

To determine client choice of Case Management Agency for transfers and rebrokering.

Who completes/When completed:

Initiated by the Case Management agency at the time of transfer or rebrokering of case management. Form can be uploaded to the electronic data system and is also kept on file in the client record for a minimum of 5 years.

The Case Management will confirm the choice via a mailed-in form, via e-mail or via a text message from the member that can be saved if this is possible, but the choice needs to be confirmed *in writing* to the Case Management agency before the member is referred for transfer/rebrokering.

EDWP NOTIFICATION FORM

1. Mark (X) indicate the reason for sending: (CC to Provider ☐ Provider to CC ☐)

   ☐ Initial ☐ Change ☐ Complaint/Concern ☐ Transfer ☐ Discharge ☐ Other

2. To: Date:

3. From: Telephone:

4. Client Name: (Source ☐ CCSP ☐) Medicaid #:

   ☐ Mark if new address Client Address:

   City: Zip: County: Telephone:

5. SERVICES:

   ☐ PSS ☐ PSSX ☐ CD PSS ☐ SFC
   ☐ ERS
   ☐ ALS
   ☐ ADH ☐ HALF, ☐FULL ☐LEVEL I, ☐ LEVEL II
   ☐ HDM
   ☐ SNS ☐ RN, ☐ LPN
   ☐ HDS
   ☐ OHR
   COMMENTS:

6. Date your RN/Staff completed initial evaluation with client: *(Must be RN for ALS, ADH and PSS/X)*
   ☐ Services were accepted ☐ Services were not accepted – REASON:

7. Date services began:

8. Service Issues: (Check below and clarify in #14)

Request service increase	☐	Request service decrease	☐
Failure to pay cost share	☐	Client out of home	☐
Client termination	☐	Requested provider change	☐
Health/Safety Issue	☐	Request for information	☐
Other	☐		

   Fall/Incident (perform online incident report) ☐

9. Discharge (briefly describe actions leading up to need for discharge process):

10. Date discharge (30-day) letter sent Actual discharge date Last day of service

11. Are services continuing through 30-day notice? ☐ Yes ☐ No *Please enter final units below*

    FINAL UNITS PSS PSSX CD PSS SFC ADH ERS

    HDM ALS RN LPN OHR

12. INITIAL OR CURRENT SERVICES IN THE HOME:

13. FREQUENCY CHANGES REQUESTED:

14. Complaint/Concern/Other

15. ER/Hospital/Rehab visit- (Name/Date/Reason if known) (perform online incident report)

16. Sender name or signature: Title: Date: Email:

17. Recipient name or signature: Title: Date: Email:

18. Recipient response:

EDWP Notification Form

The EDWP Notification Form conveys information between the site and participating service providers. The form serves as documentation of interactions on behalf of individual EDWP members and may be initiated by either case management or service provider staff. The form confirms key exchanges (new admissions, service level changes, hospitalizations, etc.) but also should be used to identify issues that potentially jeopardize an EDWP member's ability to continue living in the community.

Instructions:

1. Indicate entity-initiating form (site or provider) with a check mark and provide explanation of reason for the communication.

2. Indicate the person/agency and date the form is being sent to.

3. Indicate the person/agency and phone number of the sender of the form.

4. Indicate the EDWP Member name and program served as well as Medicaid ID of the member. Provide Member address, county and phone info.

5. Indicate services delivered in the home by the provider sending the form or services of the provider the form is being sent to. Provide comments if applicable.

6. Service Provider to indicate dates of evaluation performed in the home and if services will be accepted or declined.

7. Provider to indicate date services began.

8. Indicate service issues, checking all that are applicable.

9/10. Indicate date of discharge, last day of service, reason and date of notification being sent.

11. Indicate specifics regarding discharge and units finalized.

12. Indicate current service frequency presently received.

13. Indicate frequency change information.

14. Indicate narrative as applicable re complaint/concern or other.

15. Indicate details re hospital/rehab/NH stay.

16. Indicate sender name, title, date and email information.

17. Indicate recipient name, title, date and email information.

18. Indicate recipient response as applicable.

NOTE: The agency receiving the form must acknowledge receipt in writing with signature and date. Return the form to the agency which generated the form with three (3) business days.

WAIVER TRANSFER FORM

1. **Prior Authorization Number:** **Expiration Date:**
2. Member Name (Last, First, Middle): DOB:

   Social Security Number: Medicaid #:

3. Other Contact Information:

4. **Member transfer from-**: Agency Name Provider ID

   Email contact Care Coordination/Contact Person Telephone

   Last Service Date

   Member Current Waiver type (CCSP/SOURCE/ICWP)

   Member street address City County State

   Zip Code Member phone number

5. **Member transfer to-** : Agency Name Provider ID

   Email contact Care Coordination/Contact Person Telephone

   New Waiver type (CCSP/SOURCE/ICWP)

   Member street address City County State

   Zip Code Member phone number

WAIVER TRANSFER FORM

Prior Authorization Number: _____ **Expiration Date:** _____

Member Name: _____ DOB:_____

Social Security Number: _____ Medicaid #: _____

Other Contact Information: _____

_____

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 NOW/COMP GAPP

Member street address _____

City _____ County_____ State _____

Zip Code _____ Member Phone Number _____

Member transfer to: Agency Name _____

Provider ID _____

Care Coordination/Contact Person _____

Email_____ Telephone _____

New waiver type (circle one) CCSP SOURCE NOW/COMP GAPP

Member new street address _____

City _____ County _____ State _____

Zip Code _____ Member Phone Number _____

WAIVER TRANSFER FORM

Instructions

Elderly and Disabled Waiver Program

Purpose: The waiver transfer form is used to transfer case records from one agency to another and also to notify Alliant of the transfer.

Who Completes/When Completed: The staff member completes the member transfer form. It accompanies the original case record of the last year of service to the receiving agency. Original agency is responsible for providing one year of copied records 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". Receiving agency uses those records for historical reference and picks up with policy by completing a home visit within 5 days of the transfer notification or arrival of client to the area. Copied records to include additional items from Harmony if receiving agency does not utilize Harmony.

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 Member transfer from information (Agency, provider ID, Email contact, telephone, last service date, current waiver type, member street address and phone information)

5. 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.

1. CCSP - interRAI MDS HC Assessment

Client:

Review Date:

InterRAI Assessment

MDS Assessment Type:

A. Identification Information

A.1. NAME

A1a. First name

A1b. Middle Initial

A1c. Last name (surname/family name)

A1d. Jr./Sr.

A.2. GENDER

Gender

A.3. BIRTHDATE

Birthdate (month, day, year)

A.4. MARITAL STATUS

Marital Status

A.5. NATIONAL NUMERIC IDENTIFIER [EXAMPLE - USA]

A5a. Social Security Number

A5b. Medicare number (or comparable railroad insurance number)

A5c. Medicaid number [Note: "+" if pending, "N" if not Medicaid recipient]

A.6. FACILITY / AGENCY PROVIDER NUMBER [EXAMPLE - USA]

Facility / Agency Provider Number

A.7. CURRENT PAYMENT SOURCES [EXAMPLE - USA]

Current Payment Sources [Note: Billing Office to indicate]

A.8. REASON FOR ASSESSMENT

Reason for Assessment

A.9. ASSESSMENT REFERENCE DATE

Assessment Reference Date = 3 Calendar Days prior to Assessment Date

Assessment Reference Date (month, day, year)

A.10. PERSON'S EXPRESSED GOALS OF CARE

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Enter primary goal
A.11. POSTAL / ZIP CODE OF USUAL LIVING ARRANGEMENT [EXAMPLE - USA]
Postal / Zip Code of Usual Living Arrangement
A.12. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT
Residential / Living Status at Time of Assessment
A.13. LIVING ARRANGEMENT
A13a. Lives
A13b. As compared to 90 DAYS AGO (or since last assessment), person now lives with someone new - e.g., moved in with another person, other moved in
A13c. Person or relative feels that the person would be better off living elsewhere
A.14. TIME SINCE LAST HOSPITAL STAY
Time since last hospital stay - Code for most recent instance in LAST 90 DAYS
Identification Information Notes
B. Intake and Initial History
B.1. DATE CASE OPENED (this agency)
Date Case Opened (this agency) (month, day, year)
B.2. ETHNICITY AND RACE [EXAMPLE - USA]
B2a. Ethnicity - Hispanic or Latino
Race
B.3. PRIMARY LANGUAGE [EXAMPLE - USA]
Primary Language
B.4. RESIDENTIAL HISTORY OVER LAST 5 YEARS - Code for all settings person lived in during 5 years prior to date case opened.
B4a. Long-term care facility - e.g., nursing home
B4b. Board and care home, assisted living
B4c. Mental health residence - e.g., psychiatric group home
B4d. Psychiatric hospital or unit
B4e. Setting for persons with intellectual disability
Intake and Initial History Notes
C. Cognition
C.1. COGNITIVE SKILLS FOR DAILY DECISION MAKING

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Making decisions regarding tasks of daily life - e.g., when to get up or have meals, which clothes to wear or activities to do
C.2. MEMORY / RECALL ABILITY - Code for recall of what was learned or known.
C2a. Short-term memory OK - Seems / appears to recall after 5 minutes
C2b. Procedural memory OK - Can perform all or almost all steps in a multitask sequence without cues
C2c. Situational memory OK - Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room)
C.3. PERIODIC DISORDERED THINKING OR AWARENESS - Note: Accurate assessment requires conversation with staff, family, or others who have direct knowledge of the person's behavior over this time.
C3a. Easily distracted - e.g., episodes of difficulty paying attention; gets sidetracked
C3b. Episodes of disorganized speech - e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought
C3c. Mental function varies over the course of the day - e.g., sometimes better, sometimes worse
C.4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING
Acute change in mental status from person's usual functioning - e.g., restlessness, lethargy, difficult to arouse, altered environmental perception
C.5. CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)
Change in decision making as compared to 90 days ago (or since last assessment)
Cognition Notes
D. Communication and Vision
D.1. MAKING SELF UNDERSTOOD (Expression)
Expressing information content - both verbal and nonverbal
D.2. ABILITY TO UNDERSTAND OTHERS (Comprehension)
Understanding verbal information content (however able; with hearing appliance normally used)
D.3. HEARING
Ability to hear (with hearing appliance normally used)
D.4. VISION
Ability to see in adequate light (with glasses or with other visual appliance normally used)
Communication and Vision Notes
E. Mood and Behavior
E.1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD - Code for indicators observed in last 3 days, irrespective of assumed cause
E1a. Made negative statements - e.g., "Nothing matters"; "Would rather be dead"; "What's the use"; "Regret having lived so long"; "Let me die"

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E1b. Persistent anger with self or others - e.g., easily annoyed, anger at care received
E1c. Expressions, including non-verbal, of what appear to be unrealistic fears - e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations
E1d. Repetitive health complaints - e.g., persistently seeks medical attention, incessant concern with body functions
E1e. Repetitive anxious complaints / concerns (non-health related) - e.g., persistently seeks attention / reassurance regarding schedules, meals, laundry, clothing, relationships
E1f. Sad, pained, or worried facial expressions - e.g., furrowed brow, constant frowning
E1g. Crying, tearfulness
E1h. Recurrent statements that something terrible is about to happen - e.g., believes he or she is about to die, have a heart attack
E1i. Withdrawal from activities of interest - e.g., long-standing activities, being with family / friends
E1j. Reduced social interactions
E1k. Expressions, including non-verbal, of a lack of pleasure in life (anhedonia) - e.g., "I don't enjoy anything anymore"
E.2. SELF-REPORTED MOOD
E2a. In the last 3 days, how often have you felt a little interest or pleasure in things you normally enjoy?
E2b. In the last 3 days, how often have you felt anxious, restless, or uneasy?
E2c. In the last 3 days, how often have you felt sad, depressed, or hopeless?
Not being able to stop or control worrying?
E.3. BEHAVIOR SYMPTOMS
E3a. Wandering - Moved with no rational purpose, seemingly oblivious to needs or safety
E3b. Verbal abuse - e.g., others were threatened, screamed at, cursed at
E3c. Physical abuse - e.g., others were hit, shoved, scratched, sexually abused
E3d. Socially inappropriate or disruptive behavior - e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through other's belongings
E3e. Inappropriate public sexual behavior or public disrobing
E3f. Resists care - e.g., taking medications / injections, ADL assistance, eating
Mood and Behavior Notes
F. Psychosocial Well-Being
F.1. SOCIAL RELATIONSHIPS
F1a. Participation in social activities of long-standing interest
F1b. Visit with a long-standing social relation or family member
F1c. Other interaction with long-standing social relation or family member - e.g., telephone, e-mail

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F1d. Conflict or anger with family or friends
F1e. Fearful of a family member or close acquaintance
F1f. Neglected, abused, or mistreated
F.2. LONELY
Says or indicates that he / she feels lonely
F.3. CHANGE IN SOCIAL ACTIVITIES IN LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO)
Decline in level of participation in social, religious, occupational, or other preferred activities
F.4. LENGTH OF TIME ALONE DURING THE DAY (MORNING AND AFTERNOON)
Length of time alone during the day (morning and afternoon)
F.5. MAJOR LIFE STRESSORS IN LAST 90 DAYS
e.g., episode of severe personal illness; death or severe illness of close family member / friend; loss of home; major loss of income / assets; victim of a crime such as robbery or assault; loss of driving license / car
Psychosocial Well-Being Notes
G. Functional Status
G.1. IADL SELF-PERFORMANCE AND CAPACITY
G1a. PERFORMANCE - Meal preparation - How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)
CAPACITY - Meal preparation - How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)
UNMET NEED - Meal preparation - How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)
G1b. PERFORMANCE - Ordinary housework - How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)
CAPACITY - Ordinary housework - How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)
UNMET NEED - Ordinary Housework - How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)
G1c. PERFORMANCE - Managing finances - How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored
CAPACITY - Managing finances - How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored
UNMET NEED - Managing finances - How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored
G1d. PERFORMANCE - Managing medications - How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)

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CAPACITY - Managing medications - How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)
UNMET NEED - Managing medications - How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)
G1e. PERFORMANCE - Phone Use - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)
CAPACITY - Phone Use - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)
UNMET NEED - Phone Use - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)
G1f. PERFORMANCE - Stairs - How full flight of stairs is managed (12-14 stairs)
CAPACITY - Stairs - How full flight of stairs is managed (12-14 stairs)
UNMET NEED - Stairs - How full flight of stairs is managed (12-14 stairs)
G1g. PERFORMANCE - Shopping - How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION
CAPACITY - Shopping - How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION
UNMET NEED - Shopping - How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION
G1h. PERFORMANCE - Transportation - How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)
CAPACITY - Transportation - How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)
UNMET NEED - Transportation - How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)
G.2. ADL SELF-PERFORMANCE
G2a. Bathing - How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed; arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR
LEVEL OF IMPAIRMENT - Bathing - How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed; arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR
UNMET NEED - Bathing - How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed; arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR

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G2b. Personal hygiene - How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS
LEVEL OF IMPAIRMENT - Personal hygiene - How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS
UNMET NEED - Personal hygiene - How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS
G2c. Dressing upper body - How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.
LEVEL OF IMPAIRMENT - Dressing upper body - How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc
UNMET NEED - Dressing upper body - How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.
G2d. Dressing lower body - How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.
LEVEL OF IMPAIRMENT - Dressing lower body - How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.
UNMET NEED - Dressing lower body - How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.
G2e. Walking - How walks between locations on same floor indoors
LEVEL OF IMPAIRMENT - Walking - How walks between locations on same floor indoors
UNMET NEED - Walking - How walks between locations on same floor indoors
G2f. Locomotion - How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair
LEVEL OF IMPAIRMENT - Locomotion - How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair
UNMET NEED - Locomotion - How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair
G2g. Transfer toilet - How moves on and off toilet or commode
LEVEL OF IMPAIRMENT - Transfer toilet - How moves on and off toilet or commode
UNMET NEED - Transfer toilet - How moves on and off toilet or commode
G2h. Toilet use - How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET

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LEVEL OF IMPAIRMENT - Toilet use - How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET
UNMET NEED - Toilet use - How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET
G2i. Bed mobility - How moves to and from lying position, turns from side to side, and positions body while in bed
LEVEL OF IMPAIRMENT - Bed mobility - How moves to and from lying position, turns from side to side, and positions body while in bed
UNMET NEED - Bed mobility - How moves to and from lying position, turns from side to side, and positions body while in bed
G2j. Eating - How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)
LEVEL OF IMPAIRMENT - Eating - How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)
UNMET NEED - Eating - How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)
G.3. LOCOMOTION / WALKING
G3a. Primary mode of locomotion
G3b. Timed 4-meter (13-foot) walk - Enter time in seconds, up to 30 seconds (30: 30 or more seconds to walk 4 meters, 77: Stopped before test complete, 88: Refused to do the test, 99: Not tested - e.g., does not walk on own)
G3c. Distance walked - Farthest distance walked at one time without sitting down in the LAST 3 DAYS (with support as needed)
G3d. Distance wheeled self - Farthest distance wheeled self at one time in the LAST 3 DAYS (includes independent use of motorized wheelchair)
G.4. ACTIVITY LEVEL
G4a. Total hours of exercise or physical activity in LAST 3 DAYS - e.g., walking
G4b. In the LAST 3 DAYS, number of days went out of the house or building in which he / she resides (no matter how short the period)
G.5. PHYSICAL FUNCTION IMPROVEMENT POTENTIAL
G5a. Person believes he / she is capable of improved performance in physical function
G5b. Care professional believes person is capable of improved performance in physical function
G.6. CHANGE IN ADL STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO
Change in ADL status as compared to 90 days ago, or since last assessment if less than 90 days ago

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G.7. DRIVING
G7a. Drove car (vehicle) in the LAST 90 DAYS
G7b. If drove in LAST 90 DAYS, assessor is aware that someone has suggested that person limits OR stops driving
G.8. DL SELF-PERFORMANCE
LEVEL OF IMPAIRMENT - Laundry - How do laundry including sorting, carrying, loading, unloading, folding, and putting away
UNMET NEED - Laundry - How do laundry including sorting, carrying, loading, unloading, folding, and putting away
LEVEL OF IMPAIRMENT - Transfer - How transfer (from/to) between bed and wheelchair, walker, etc.
UNMET NEED - Transfer - How transfer (from/to) between bed and wheelchair, walker, etc.
LEVEL OF IMPAIRMENT - Routine Health - How follow the directions of physicians, nurses or therapists, as needed for routine health care
UNMET NEED - Routine Health - How follow the directions of physicians, nurses or therapists, as needed for routine health care
LEVEL OF IMPAIRMENT - Being Alone - How be left alone
UNMET NEED - Being Alone - How be left alone
LEVEL OF IMPAIRMENT - Special Health - How follow directions of physicians, nurses or therapists as needed for specialized health care
UNMET NEED - Special Health - How follow directions of physicians, nurses or therapists as needed for specialized health care
Functional Status Notes
H. Continence
H.1. BLADDER CONTINENCE
Bladder continence
H.2. URINARY COLLECTION DEVICE (Exclude pads / briefs)
Urinary collection device (Exclude pads / briefs)
H.3. BOWEL CONTINENCE
Bowel continence
H.4. PADS OR BRIEFS WORN
Pads or briefs worn
Continence Notes
I. Disease Diagnoses
I.1. DISEASE DIAGNOSES - Musculoskeletal
I1a. Hip fracture during last 30 days (or since last assessment if less than 30 days)

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I1b. Other fracture during last 30 days (or since last assessment if less than 30 days)
I. Neurological
I1c. Alzheimer's disease
I1d. Dementia other than Alzheimer's disease
I1e. Hemiplegia
I1f. Multiple sclerosis
I1g. Paraplegia
i1h. Parkinson's disease
I1i. Quadriplegia
I1j. Stroke / CVA
I. Cardiac or Pulmonary
I1k. Coronary heart disease
I1l. Chronic obstructive pulmonary disease
I1m. Congestive heart failure
I. Psychiatric
I1n. Anxiety
I1o. Bipolar disorder
I1q. Depression
I1p. Schizophrenia
I. Infections
I1r. Pneumonia
I1s. Urinary tract infection in last 30 days
I. Other
I1t. Cancer
I1u. Diabetes mellitus
I.2. OTHER DISEASE DIAGNOSES
a. Other Disease Diagnoses
a. Disease Code
a. ICD Code
a. Add Another Other Disease Diagnoses

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Disease Diagnoses Notes
J. Health Conditions
J.1. FALLS
Falls
J.2. RECENT FALLS
Recent Falls
J.3. PROBLEM FREQUENCY - Balance
J3a. Difficult or unable to move self to standing position unassisted
J3b. Difficult or unable to turn self around and face the opposite direction when standing
J3c. Dizziness
J3d. Unsteady gait
J. Cardiac or Pulmonary
J3e. Chest pain
J3f. Difficulty clearing airway secretions
J. Psychiatric
J3g. Abnormal thought process - e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality
J3h. Delusions - Fixed false beliefs
J3i. Hallucinations - False sensory perceptions
J. Neurologica
J3j. Aphasia
J. GI Status
J3k. Acid reflux - Regurgitation of acid from stomach to throat
J3l. Constipation - No bowel movement in 3 days or difficult passage of hard stool
J3m. Diarrhea
J3n. Vomiting
J. Sleep Problems
J3o. Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep
J3p. Too much sleep - Excessive amount of sleep that interferes with person's normal functioning
J. Other
J3q. Aspiration
J3r. Fever

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J3s. GI or GU bleeding
J3t. Hygiene - Unusually poor hygiene, unkempt, disheveled
J3u. Peripheral edema
J.4. DYSPNEA (Shortness of breath)
Dyspnea (Shortness of breath)
J.5. FATIGUE
Inability to complete normal daily activities - e.g., ADLs, IADLs
J.6. PAIN SYMPTOMS
J6a. Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other nonverbal signs suggesting pain)
J6b. Intensity of highest level of pain present
J6c. Consistency of pain
J6d. Breakthrough pain - Times in LAST 3 DAYS when person experienced sudden, acute flare-ups of pain
J6e. Pain control - Adequacy of current therapeutic regimen to control pain (from person's point of view)
J.7. INSTABILITY OF CONDITIONS
J7a. Conditions/diseases make cognitive, ADL, mood, or behavior patterns unstable (fluctuating, precarious, or deteriorating)
J7b. Experiencing an acute episode, or a flare-up of a recurrent or chronic problem
J7c. End-stage disease, 6 or fewer months to live
J.8. SELF-REPORTED HEALTH
Ask: "In general, how would you rate your health?"
J.9. TOBACCO AND ALCOHOL
J9a. Smokes tobacco daily
J9b. Alcohol - Highest number of drinks in any "single sitting" in LAST 14 DAYS
Health Conditions Notes
K. Oral and Nutritional Status
K.1. HEIGHT AND WEIGHT [INCHES AND POUNDS - COUNTRY SPECIFIC]
K1a. Height (in.)
K1b. Weight (lb.)
K.2. NUTRITIONAL ISSUES
K2a. Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS

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K2b. Dehydrated or BUN / Cre ratio > 25 [Ratio, country specific]
K2c. Fluid intake less than four 8 oz cups per day (or less than 1,000 cc per day)
K2d. Fluid output exceeds input
K.3. MODE OF NUTRITIONAL INTAKE
Mode of nutritional intake
K.4. DENTAL OR ORAL
K4a. Wears a denture (removable prosthesis)
K4b. Has broken, fragmented, loose, or otherwise non-intact natural teeth
K4c. Reports having dry mouth
k4d. Reports difficulty chewing
Oral and Nutritional Status Notes
L. Skin Condition
L.1. MOST SEVERE PRESSURE ULCER
Most severe pressure ulcer
L.2. PRIOR PRESSURE ULCER
Prior pressure ulcer
L.3. PRESENCE OF SKIN ULCER OTHER THAN PRESSURE ULCER
Presence of skin ulcer other than pressure ulcer - e.g., venous ulcer, arterial ulcer, mixed venous-arterial ulcer, diabetic foot ulcer
L.4. MAJOR SKIN PROBLEMS
Major skin problems - e.g., lesions, 2nd or 3rd degree burns, healing surgical wounds
L.5. SKIN TEARS OR CUTS
Skin tears or cuts - Other than surgery
L.6. OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION
Other skin conditions or changes in skin condition - e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema
L.7. FOOT PROBLEMS
Foot problems - e.g., bunions, hammer toes, overlapping toes, structural problems, infections, ulcers
Skin Condition Notes
M. Medications
M.1. LIST OF ALL MEDICATIONS
List all active prescriptions, and any nonprescribed (over-the-counter) medications taken in the LAST 3 DAYS

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Number of Medications (code 0 for none or 9 if more than 9)
M.2. ALLERGY TO ANY DRUG
Allergy to any drug
M.3. ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN
Adherent with medications prescribed by physician
Medications Notes
N. Treatments and Procedures
N.1. PREVENTION
N1a. Blood pressure measured in LAST YEAR
N1b. Colonoscopy test in LAST 5 YEARS
N1c. Dental exam in LAST YEAR
N1d. Eye exam in LAST YEAR
N1e. Hearing exam in LAST 2 YEARS
N1f. Influenza vaccine in LAST YEAR
N1g. Mammogram or breast exam in LAST 2 YEARS (for women)
N1h. Pneumovax vaccine in LAST 5 YEARS or after age 65
N.2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS - Treatments
N2a. Chemotherapy
N2b. Dialysis
N2c. Infection control - e.g., isolation, quarantine
N2d. IV medication
N2e. Oxygen therapy
N2f. Radiation
N2g. Suctioning
N2h. Tracheostomy care
N2i. Transfusion
N2j. Ventilator or respirator
N2k. Wound care
N. Programs
N2l. Scheduled toileting program
N2m. Palliative care program

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N2n. Turning / repositioning program
N.3. FORMAL CARE - Days (A) and Total minutes (B) of care in last 7 days
N3a. (A) Home health aides - # of days
(B) Home health aides - Total Minutes in Last Week
N3b. (A) Home nurse - # of days
(B) Home nurse - Total Minutes in Last Week
N3c. (A) Homemaking services - # of days
(B) Homemaking services - Total Minutes in Last Week
N3d. (A) Meals - # of days
N3e. (A) Physical therapy - # of days
(B) Physical therapy - Total Minutes in Last Week
N3f. (A) Occupational therapy - # of days
(B) Occupational therapy - Total Minutes in Last Week
N3g. (A) Speech-language pathology and audiology services - # of days
(B) Speech-language pathology and audiology services - Total Minutes in Last Week
N3h. (A) Psychological therapy (by any licensed mental health professional) - # of days
(B) Psychological therapy (by any licensed mental health professional) - Total Minutes in Last Week
N.4. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT
N4a. Inpatient acute hospital with overnight stay
N4b. Emergency room visit (not counting overnight stay)
N4c. Physician visit (or authorized assistant or practitioner)
N.5. PHYSICALLY RESTRAINED
Physically restrained - Limbs restrained, used bed rails, restrained to chair when sitting
Treatments and Procedures Notes
O. Responsibility
O.1. LEGAL GUARDIAN [EXAMPLE - USA]
Legal guardian
Responsibility Notes
P. Social Supports
P.1. TWO KEY INFORMAL HELPERS
P1a. Relationship to primary helper

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P1a. Relationship to secondary helper
P1b. Lives with primary helper
P1b. Lives with secondary helper
P. AREAS OF INFORMAL HELP DURING LAST 3 DAYS
P1c. Primary IADL help
P1c. Secondary IADL help
P1d. Primary ADL help
P1d. Secondary ADL help
P.2. INFORMAL HELPER STATUS
P2a. Informal helper(s) is unable to continue in caring activities - e.g., decline in health of helper makes it difficult to continue
P2b. Primary informal helper expresses feelings of distress, anger, or depression
P2c. Family or close friends report feeling overwhelmed by person's illness.
P.3. HOURS OF INFORMAL CARE AND ACTIVE MONITORING DURING LAST 3 DAYS
Hours of informal care and active monitoring during last 3 days - For instrumental and personal activities of daily living in the LAST 3 DAYS, indicate the total number of hours of help received from all family, friends, and neighbors
P.4. STRONG AND SUPPORTIVE RELATIONSHIP WITH FAMILY
Strong and supportive relationship with family
Social Supports Notes
Q. Environmental Assessment
Q.1. HOME ENVIRONMENT
Q1a. Disrepair of the home - e.g., hazardous clutter; inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor; leaking pipes
Q1b. Squalid condition - e.g., extremely dirty, infestation by rats or bugs
Q1c. Inadequate heating or cooling - e.g., too hot in summer, too cold in winter
Q1d. Lack of personal safety - e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street
Q1e. Limited access to home or rooms in home - e.g., difficulty entering or leaving home, unable to climb stairs, difficulty maneuvering within rooms, no railings although needed
Q.2. LIVES IN APARTMENT OR HOUSE RE-ENGINEERED ACCESSIBLE FOR PERSONS WITH DISABILITIES
Lives in apartment or house re-engineered accessible for persons with disabilities
Q.3. OUTSIDE ENVIRONMENT

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Q3a. Availability of emergency assistance - e.g., telephone, alarm response system
Q3b. Accessibility to grocery store without assistance.
Q3c. Availability of home delivery of groceries
Q.4. FINANCES
Because of limited funds, during the last 30 days made trade-offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heating or cooling; necessary health care
Environmental Assessment Notes:
R. Discharge Potential and Overall Status
R.1. ONE OR MORE CARE GOALS MET IN THE LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)
One or more care goals met in the last 90 days (or since last assessment if less than 90 days)
R.2. OVERALL SELF-SUFFICIENCY HAS CHANGED SIGNIFICANTLY AS COMPARED TO STATUS OF 90 DAYS AGO
Overall self-sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days)
R.3. NUMBER OF 10 ADL AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION
Number of 10 ADL areas in which person was Independent prior to deterioration
R.4. NUMBER OF 8 IADL PERFORMANCE AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION
Number of 8 IADL performance areas in which person was Independent prior to deterioration
R.5. TIME OF ONSET OF THE PRECIPITATING EVENT OR PROBLEM RELATED TO DETERIORATION
Time of onset of the precipitating Event or problem related to deterioration.
Discharge Potential and Overall Status Notes
S. Discharge
S.1. LAST DAY OF STAY
Last day of stay (month, day, year)
S.2. RESIDENTIAL / LIVING STATUS AFTER DISCHARGE
Residential / Living status after discharge
Discharge Notes

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Provider Service Information

Date_____

Client's name_____Phone #_____

Street Address _____

County _____ City/Town_____Zip Code _____

Date of birth_____ Medicaid Number _____

If client unable to give information please list contact person below

Name_____ Relationship_____

Contact Phone number (H)_____(W) _____

Services currently in home _____

Other resources or services client may need _____

_____

Name/provider agency _____

Phone _____

Other pertinent information _____

_____

_____

_____

_____

_____

_____

Instructions

PROVIDER SERVICE INFORMATION FORM

Purpose: To provide information to the Area Agencies on Aging-Gateway Intake and Referral Unit to assure that individuals are contacted by the Gateway staff as quickly as possible. This form is a sample form for use by provider agencies when making referrals to the Gateway.

Who Completes/When Completed: An individual or agency outside EDWP, such as a hospital discharge planner or provider agency when referring an individual to Gateway.

Instructions:

1. Enter the name of the individual in need of services and a valid telephone number which assists AAA staff to contact the individual.
2. Enter the complete street address of the potential client.
3. Enter the county of residence, city or town, and zip code.
4. Enter the date of birth of the individual being referred.
5. Identify name and relationship to client for a family member or representative who can assist the Information and Referral staff at the Gateway.
6. Provide telephone number(s) for contact person.
7. Provide information about the best time to reach the contact.
8. Provide information about any services the client presently receives.
9. List, if known, other services or resources needed by the client.
10. Enter name of the individual completing the information form and the provider agency.
11. Provide a telephone number for the provider agency.
12. Enter the date the form is completed
13. List other information known about the individual that would expedite contact between the Gateway staff and the client.

DETERMINATION OF NEED- REVISED (DON-R)

Function	Level of Impairment	Unmet Need for Care	Comments
1. Eating			
2. Bathing			
3. Grooming			
4. Dressing			
5. Transferring			
6. Continence			
7. Managing Money			
8. Telephoning			
9. Preparing Meals			
10. Laundry			
11. Housework			
12. Outside Home			
13. Routine Health			
14. Special Health			
15. Being Alone			
Total 1-6 (ADL)			
Total 7-15 (IADL)			
Total 1-15 (ADL+ IADL)			

Instructions
Elderly and Disabled Waiver Program

TELEPHONE SCREENING

Purpose: The TS is a pre-screening tool to determine appropriateness for services based on the applicant's medical and financial status.

Who Completes/When Completed: The EDWP screening specialist completes within three business days of receiving the referral. This action may occur at the care coordination or at the AAA level.

Inform applicant of screening process before you begin.

Complete the Client Detail Report and Screening Detail found in the electronic data system.

Instructions for completion of the Determination Of Need-Revised (DON-R) Functional Assessment are outlined below.

DETERMINATION OF NEED - REVISED FUNCTIONAL ASSESSMENT (DON-R)

The Determination of Need (DON) defines the factors which help determine a person's functional capacity and any unmet need for assistance in dealing with these impairments. The DON-R allows for independent assessment of both impairment in functioning on Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) and the need for assistance to compensate for these impairments.

Assess both Column A Level of Impairment, and Column B Unmet Need for Care on all applicants. A minimum score of 15 is required in Column A Level of Impairment along with identified Unmet Need for Care in Column B, before a client is referred to care coordination for assessment. If the Level of Impairment score is less than 15 refer client for HCBS or other available resources.

The central question to determining the level of need for care is whether a person can perform activities of daily living (ADL). Table 1 presents the list of ADL included in the DON under two headings: ADL AND INSTRUMENTAL.

Table 1 - Activities of Daily Living Included in the Determination of Need (DON) Functional Assessment

ACTIVITIES OF DAILY LIVING (ADL)	INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)
Eating	Managing Money
Bathing	Telephone
Grooming	Preparing Meals

Dressing	Laundry
Transfer (In and Out of Bed/Chair)	Housework
Bowel/Bladder Continence	Outside Home
	Routine Health
	Special Health
	Being Alone

ITEM DEFINITIONS

1. EATING:

A. Is the client able to feed himself/herself?

Assess the client's ability to feed oneself a meal using routine or adapted table utensils and without frequent spills. Include the client's ability to chew, swallow, cut food into manageable size pieces, and to chew and swallow hot and cold foods/beverages. When a special diet is needed, do not consider the preparation of the special diet when scoring this item (see "preparing meals" and "routine health" items).

B. Is someone available to assist the client at mealtimes?

If the client scores at least (1) in Column A, evaluate whether someone (including telephone reassurance) is available to assist or motivate the client in eating.

2. BATHING

A. Is the client able to shower or bathe or take sponge baths for the purpose of maintaining adequate hygiene as needed for the client's circumstances?

Assess the client's ability to shower or bathe or take sponge baths for the purpose of maintaining adequate hygiene. Consider minimum hygiene standards, medical prescription, or health related considerations such as incontinence, skin ulcer, lesions, and frequent profuse nose bleeds. Consider ability to get in and out of the tub or shower, to turn faucets, regulate water temperature, wash and dry fully. Include douches if required by impairment.

B. Is someone available to assist or supervise the client in bathing?

If the client scores at least (1) in Column A, evaluate the continued availability of resources to assist in bathing. If intimate assistance is available but inappropriate and/or opposed by the client, consider the assistance unavailable.

3. GROOMING

A. Is the client able to take care of his/her personal appearance?

Assess client's ability to take care of personal appearance, grooming, and hygiene activities. Only consider shaving, nail care, hair care, and dental hygiene.

B. Is someone available to assist the client in personal grooming tasks?

If the client scores at least (1) in Column A, evaluate the continued personal assistance needed, including health professionals, to assist client in grooming.

4. DRESSING

A. Is the client able to dress and undress as necessary to carry out other activities of daily living?

Assess the client's ability to dress and undress as necessary to carry out the client's activities of daily living in terms of appropriate dress for weather and street attire as needed. Also include ability to put on prostheses or assistive devices. Consider fine motor coordination for buttons and zippers, and strength for undergarments or winter coat. Do not include style or color coordination.

B. Is someone available to assist the client in dressing and undressing?

If someone scores at least one (1) in Column A, evaluate whether someone is available to help dressing and/or undressing the client at the times needed by the client. If intimate assistance is available but inappropriate and/or opposed by the client, consider the assistance unavailable.

5. TRANSFER

A. Is the client able to get into and out of bed or other usual sleeping place?

Assess the client's ability to get into and out of bed or other usual sleeping place, including pallet or armchair. Include the ability to reach assistive devices and appliances necessary to ambulate, and the ability to transfer (from/to) between bed and wheelchair, walker, etc. Include ability to adjust the bed or place/remove handrails, if applicable and necessary. When scoring, do not consider putting on prostheses or assistive devices.

B. Is someone available to assist or motivate the client to get in and out of bed?

If the client scores at least one (1) in Column A, evaluate the continued availability of resources, (including telephone reassurance and friendly visiting) to assist or motivate the client in getting into and out of bed.

6. CONTINENCE

A. Is the client able to take care of bladder/bowel functions without difficulty?

Assess the client's ability to take care of bladder/bowel functions by reaching the bathroom or other appropriate facility in a timely manner. Consider the need for reminders.

B. Is someone available to assist the client in performing bladder/bowel functions?

If the client scores at least (1) in Column A, evaluate whether someone is available to assist or remind the client as needed in bladder/bowel functions.

NOTE: When using the MDS-HC, the DON question regarding continence is incorporated in the MDS-HC question for toilet use.

7. MANAGING MONEY

A. Assess the client's ability to handle money and pay bills. Include ability to plan, budget, write checks or money orders, exchange currency, and handle paper work and coins. Include the ability to read, write and count sufficiently to perform the activity. Do not increase score based on insufficient funds.

C. Is someone available to help the client with money management and money transactions?

If the client scores at least (1) in Column A, evaluate whether an appropriate person is available to plan and budget or make deposits and payments on behalf of the client. Consider automatic deposits, banking by mail, etc.

8. TELEPHONING

A. Is the client able to use the telephone to communicate essential needs?

Assess the client's ability to use a telephone to communicate essential needs. The client must be able to use the phone: answer, dial, articulate and comprehend. If the client uses special adaptive telephone equipment, score the client based on the ability to perform this activity with that equipment. Do not consider the absence of a telephone in the client's home. (Note: the use of an emergency response system device should not be considered.

B. Is some available to assist the client with telephone use?

If the client scores at least (1) in Column A, evaluate whether someone is available to help the client reach and use the telephone or whether someone is available to use the telephone on behalf of the client. Consider the reliability and the availability of neighbors to accept essential routine calls and to call authorities in an emergency.

9. PREPARING MEALS

A. Is the client able to prepare hot and/or cold meals that are nutritionally balanced or therapeutic, as necessary, which the client can eat?

Assess the client's ability to plan and prepare routine hot and/cold, nutritionally balanced meals. Include ability to prepare foodstuffs, to open containers, to use kitchen appliances, and to clean up after the meal, including washing, drying and storing dishes and other utensils in meal preparation. Do not consider the ability to plan therapeutic or prescribed meals.

B. Is someone available to prepare meals as needed by the client?

If the client scores at least one (1) in Column A, evaluate the continued availability of resources (including restaurants and home delivered meals) to prepare meals or supervise meal preparation for the client.

Consider whether the resources can be called upon to prepare meals in advance for reheating later.

10. LAUNDRY

A. Is the client able to do his/her laundry?

Assess the client's ability to do laundry including sorting, carrying, loading, unloading, folding, and putting away. Include the use of coins where needed and use of machines and/or sinks. Do not consider the location of the laundry facilities.

B. Is someone available to assist with the performing or supervising the laundry needs of the client?

If the client scores at least one (1) in Column A, evaluate the continued availability of laundry assistance, including washing and/or dry cleaning. If public laundries are used, consider the reliability of others to insert coins, transfer loads, etc.

11. HOUSEWORK

A. Is the client able to do routine housework?

Assess the client's ability to do routine housework. Include sweeping, scrubbing, and vacuuming floors. Include dusting, cleaning up spills, and cleaning sinks, toilets, bathtubs. Minimum hygienic conditions for client's health and safety are required. Do not include laundry, washing and drying dishes or the refusal to do tasks if refusal is unrelated to the impairment.

B. Is someone available to supervise, assist with, or perform routine household tasks for the client as needed to meet minimum health and hygiene standards?

If the client scores at least one (1) in Column A, evaluate the continued availability of resources, including private pay household assistance and family available to maintain the client's living space. When the client lives with others, do not assume the others will clean up for the client. This item measures only those needs related to maintaining the client's living space and is not to measure the maintenance needs of living space occupied by others in the same residence.

12. OUTSIDE HOME

A. Is the client able to get out of his/her home and to essential places outside the home?

Assess the client's ability to get to and from essential places outside the home. Essential places may include the bank, post office, mail box, medical offices, stores, and laundry if nearest available facilities are outside the home. Consider ability to negotiate stairs, streets, porches, sidewalks, entrance and exits of residence, vehicle, and destination in all types of weather. Consider the ability to secure appropriate and available transportation as needed, will increase the score. However, in scoring, do not consider the inability to afford public transportation.

B. Is someone available to assist the client in reaching needed destinations?

If the client scores at least one (1) in Column A, evaluate the continued availability of escort and transportation, or someone to go out on behalf of the client. Consider banking by mail, delivery services, changing laundromats, etc., to make destinations more accessible.

NOTE: When using the MDS-HC, the DON question regarding outside home is incorporated in the MDS-HC question for transportation.

13. ROUTINE HEALTH CARE

A. Is the client able to follow the directions of physicians, nurses, or therapists, as needed for routine health care?

Assess the client's ability to follow directions from a physician, nurse, or therapist, and to manipulate equipment in the performance of routine health care. Include simple dressings, special diet planning, monitoring of symptoms and vital signs (e.g., blood pressure, pulse, temperature and weight), routine medications, routine posturing and exercise not requiring services or supervision of a physical therapist.

B. Is someone available to carry out or supervise routine medical directions of the client's physician or other health care professionals?

If the client scores at least one (1) in Column A, evaluate the continued availability of someone to remind, supervise or assist the client in complying with routine medical directions. If the assistance needed involves intimate care, and the care giver is inappropriate and/or opposed by the client, consider the assistance unavailable.

14. SPECIAL HEALTH CARE

A. Is the client able to follow directions of physicians, nurses or therapists as needed for specialized health care?

Assess the client's ability to perform or assist in the performance of specialized health care tasks which are prescribed and generally performed by licensed personnel including physicians, nurses, and therapists. Include blood chemistry and urinalysis; complex catheter and ostomy care; complex or non-routine posturing/suctioning; tub feeding; complex dressings and decubitus care; physical, occupational and speech therapy; intravenous care; respiratory therapy; or other prescribed health care provided by a licensed professional. Score "0" for clients who have no specialized health care needs.

B. Is someone available to assist with or provide specialized health care for the client?

If the client scores at least one (1) in Column A, evaluate the continued availability of specially trained resources as necessary to assist with or perform the specialized health care task required by the client.

15. BEING ALONE

A. Can the client be left alone?

Assess the client's ability to be left alone and to recognize, avoid, and respond to danger and/or emergencies. Include the client's ability to evacuate the premises or alert others to the client's need for assistance, if applicable, and to use appropriate judgment regarding personal health and safety.

B. Is someone available to assist or supervise the client when the client cannot be left alone?
If the client scores at least one (1) in Column A, evaluate the continued availability of someone to assist or supervise the client as needed to avoid danger and respond to emergencies. Consider friendly visiting, telephone reassurance, and neighborhood watch programs.

ADL's refer to those activities and behaviors that are the most fundamental self-care activities to perform and are an indication of whether the person can care for his or her own physical needs.

IADL's are the more complex activities associated with daily life. (They are applications of the ADL's.) Information regarding both ADL and IADL are essential to evaluating whether a person can live independently in the community.

The DON-R Functional Assessment is a unique measure of functional assessment in that it differentiates between impairment in functional capacity and the need for care around a particular functional capacity. Furthermore, it is an ordinal scale with clearly defined meanings for each level of unmet need for care and each functional activity. Because of its ordinal nature, it permits quantification of scores so that changes in scores in subscales for ADL's and IADL's and for Total Impairment represent actual changes in impairment, and changes in scores for unmet need for care in ADL's, IADL's and Total Unmet Need for Care represent actual changes in unmet need for care.

Ask if client has a medical/health problem/diagnosis with functional impairment. Take the following action as appropriate:

1. If answer is "no", inform applicant of EDWP ineligibility and right to appeal. If applicant agrees, complete TS and refer client to other resources as appropriate.

2. If applicant's answer is yes, continue screening process answering each area with appropriate number (0-3).

Some general comments about the DON-R are provided to assist in the completion of the instrument.

The "Case Comments" space to the right of Column B in the functional status section is used to:

- Note special reasons for impairment or unmet need.

- Describe the type of service, caregiver support or assistive devices that decreases the client's unmet need.

- Record the primary care giver's name or other pertinent information.

Column Rules:

Use the following criteria to decide when to stop asking questions for a particular Functional Status item or when to skip Column B:

1. Ask each Functional Status item, starting with Column A, Level of Impairment.

2. If Column A, "level of impairment" is scored "0", score Column B "0".

3. If Column A is scored greater than "0", ask Column B, Unmet Need for Care.

Column A: Level of Impairment

Each one of the ADLs and IADLs needs to be discussed in terms of level of impairment. How the assessor mentions functional impairment is not as important as encouraging the client to report difficulties with the activity. Sample questions could include:

- Are you able to do...?
- How much difficulty do you have in doing...?

NOTE: If an applicant is living in a personal care home or nursing home, determine Impairment Level using Column A of the DON-R.

The objective is to gather sufficient information to determine the most appropriate score.

Answers to these questions should address the degree of unmet need for care if discharge occurs.

Score 0 - Performs or can perform all essential components of the activity, with or without an assistive device, such that:

- No significant impairment of function remains; or
- Activity is not required by the client (IADLs: medication management, routine and special health only); or
- Client may benefit from but does not require verbal or physical assistance.

Score 1 - Performs or can perform most essential components of the activity with or without an assistive device, but some impairment of function remains such that client requires some verbal or physical assistance in some or all components of the activity.

This includes clients who:

- Experience minor, intermittent fatigue in performing the activity; or
- Take longer than would be required for an unimpaired person; or
- Require some verbal prompting to complete the task **Score 2** - Cannot perform most of the essential components of the activity, even with an assistive device, and /or requires a great deal of verbal or physical assistance to accomplish the activity.

This includes clients who:

- Experience frequent fatigue or minor exertion in performing the activity; or
- Take an excessive amount of time to perform the activity; or

- Must perform the activity much more frequently than an unimpaired person; or
- Require frequent verbal prompting to complete the task.

Score 3 - Cannot perform the activity and requires someone else to perform the task, although applicant may be able to assist in small ways; or requires constant verbal or physical assistance.

Column B: Unmet Need for Care

In scoring this column, the idea is both to obtain information from the applicant about his or her perceptions regarding need for care and to use observational skills to determine the impact on the applicant should care or assistance not be provided, or a caregiver is unable to continue providing care at the current level. The availability of an appropriate caregiver also needs to be assessed.

Assess the degree to which the caregiver feels overwhelmed or burdened by the caregiving situation. The Zarit burden scale or the Caregiver Hassels Scale are formal assessments that may be used to assess caregiver burden.

Questions that might be asked of applicants and caregivers are:

- Do you feel burdened by providing care to your family member or friend?
- How often do you feel this way: frequently (daily), occasionally (weekly), sometimes (monthly), rarely (less than monthly?
- How long will you be willing/able to provide care at the current level?

Questions that might be asked of applicants and caregivers are:

- Can you tell me if you are getting enough help in meeting your needs with...?
- Do you think you need more help with...?

If the applicant is living in a personal care home or nursing home, score the applicant according to the care he would receive if discharged. To determine the future need for care, include the following questions:

a. Who will/would provide care in the home if the person was discharged?
b. How much care will the person need?
c. How much can the person do for him/herself?
d. How often will assistance be provided/available?
e. How long would this plan last?

NOTE: Answers to these questions should address the degree of unmet need for care if discharge occurs. Observe the applicant's mobility, level of clutter, personal appearance, unpaid bills, forgetfulness, etc., to assess the level of risk to health or safety if current levels of assistance are not maintained, or if additional assistance is not added.

Score 0 - The applicant's need for assistance is met to the extent that the applicant is at no risk to health or safety if additional assistance is not acquired; or the applicant has no need for assistance; or additional assistance will not benefit the applicant.

Score 1 - The applicant's need for assistance is met most of the time, or there is minimal risk to the health and safety of the applicant if additional assistance is not acquired.

Score 2 - The applicant's need for assistance is not met most of the time, or there is moderate risk to the health and safety of the applicant if additional assistance is not acquired.

Score 3 - The applicant's need for assistance is seldom or never met; or there is severe risk to the health:

and safety of the applicant that would require acute medical intervention if additional assistance is not acquired.

Comments - Ask applicant "If you don't get EDWP services, what will happen" and record the answer in applicant's own words.

Distribution: Export the file from the electronic data system to the care coordinator for initial assessment

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the four CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The four licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	CareSource 1-855-202-1058 www.caresource.com
Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All four CMOs are State-wide.**

The Department of Community Health has contracted with four CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan
- WellCare of Georgia

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child

920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged

243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged

428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com	866-231-1821 www.wellcare.com

Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact DXC at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Use of the Medicaid Management Information System (MMIS) web portal:

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. DXC will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to DXC in error:

DXC will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing

Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- Saves time
- Increases efficiency
- Eliminates duplication of data needed for multiple CMOs
- Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

HP provider reps will provide training and assistance as needed. Providers may contact HP for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to DXC in error:

DXC will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:

Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia

Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy**: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.	WellCare runs claims payment cycles up to six (6) times each week for **clean** claims. For further information, please refer to the WellCare website, the WellCare provider manual, or contact Customer Service at 866-231-1821

How often can a patient change his/her PCP?

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
Anytime	Members can change their PCP one (1) time	Within the first 90 days of a member's	Members can change PCPs for any reason

	per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.	within the first 90 days of their enrollment. After the first 90 days, members may change PCPs once every six months.

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month.	PCP changes made between the 1st and 10th of the month will go into effect right away. Changes made after the 10th of the month will take effect at the beginning of the next month

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
800-454-3730	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633	866-300-1141 ProspectiveProviderGA@WellCare.com

https://providers.amerigroup.com/pages/ga-2012.aspx		www.pshpgeorgia.com	or https://www.wellcare.com/en/Georgia/Become-a-Provider

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	PBM	BIN #	PCN
Amerigroup Community Care	ESI	003858	MA
CareSource	CVS Caremark	004336	MCAIDADV Group: RX0835
Peach State Health Plan	US Script (PBM) Caremark (Claims Processor)	004336	MCAIDADV
WellCare of Georgia	Caremark	004336	MCAIDADV

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through DXC by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. DXC will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes	Yes, you may also use the WellCare subscriber ID

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates: Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
1 (800) 454-3730	1 (855) 202-1058 1(866) 930-0019 (fax)	1 (866) 399-0929	1 (866) 231-1821 1 (866) 455-6558 (fax)

ABBREVIATIONS/ACRONYMS

AAA	Area Agency on Aging
ADH	Adult Day Health
ADL	Activities of Daily Living
ADH	Adult Day Health
AHS	Alliant Health Solutions
ALJ	Administrative Law Judge
ALAS	Atlanta Legal Aid Society
ALS	Alternative Living Services
AOA	Administration on Aging, U.S. Department of Health & Human Services
APS	Adult Protective Services
CC	Care Coordinator
CCC	Community Care Communicator, Form 5590
CCNF	Community Care Notification Form, Form 6500
CD-PSS	Consumer Directed Option for Personal Support Services
CCP	Comprehensive Care Plan

CMS	Centers for Medicare and Medicaid Services
CSBG	Community Services Block Grant
DCH	Department of Community Health
DFCS/DFACS DHS	Division of Family and Children Services and county Departments of Family and Children Services, both part of DHS Georgia Department of Human Resources
EDWP	Elderly and Disabled Waiver Program
ERS	Emergency Response System
ELAP	Elderly Legal Assistance Program
FBR	Federal Benefit Rate
FFP	Federal Financial Participation
FI	Fiscal Intermediary Services
SFY	State Fiscal Year
GLSP	Georgia Legal Services Program Home
HDM	Delivered Meals
HDS	Home Delivered Services
HHA	Home Health Aide or Home Health Agency
HHS	U. S. Department of Health and Human Services
IADL	Instrumental Activities of Daily Living
IT	Information Technology
LOC	Level of Care

LOS	Length of Stay
LSO	Legal Services Office
LTCO	Long Term Care Ombudsman
MAO	Medical Assistance Only
MFP	Money Follows the Person Grant
NAPIS	National Aging Program Information System
NSI	Nutrition Screening Initiative
OAA	Older Americans Act
OBRA	Federal Omnibus Budget Reconciliation Act
OCGA	Official Code of Georgia
OC	Options Counselor
OSAH	Office of State Administrative Hearings
OTC	Over the Counter Medications
OT	Occupational Therapy
PAR	Prior Authorization Request
PMAO	Pending Medicaid Assistance Only
PRN	Medical term which means as needed
PSA	Personal Support Aide

PSA	Planning and Service Area
PT	Physical Therapy
RC	Respite Care
RN	Registered Nurse
SAF	Service Authorization Form
SFY	State Fiscal Year (July 1 through June 30)
SNS	Skilled Nurse Services
SSN	Social Security Number
ST	Speech Therapy
SSW	Social Services Worker
TSI	Telephone Screening Instrument
TC	Transition Coordinator (MFP)
UR	Utilization Review

GLOSSARY

Abuse:	Any intentional or grossly negligent act or series of acts of intentional or grossly negligent omission to act which causes injury to a client, including but not limited to assault or battery, failure to provide treatment or care, or sexual harassment of the client. Abuse may be mental, verbal, sexual, or physical.
Adverse Action:	Denial of entrance into, termination or reduction of services from EDWP.
DXC Computer Services:	Current fiscal agent of DMA, responsible for EDWP claims processing.
Aggregate Cost:	Average cost for providing EDWP to all EDWP clients during a fiscal year.
Anniversary Date:	Date EDWP client initially receives a EDWP waivered service which is reimbursed by Medicaid. Defined by Services Begin Date on the client's SAF.
Applicant:	Consumer who indicates a desire to participate in the EDW Program.
Area Agency on Aging:	Gateway through which aging programs are funded and integrated. There is one AAA for each designated Planning and Service Area.
Authorized Representative:	Individual designated by the client to represent his or her interests; may be an attorney, paralegal, friend, or family member.
Care Coordinator:	Care coordinators are either registered nurses or social services workers employed by the AAA or its subcontract agency. They screen, assess, reassess clients and coordinate and evaluate EDWP client service delivery. Care coordinators implement care plans, arrange for clients to receive services and evaluate effectiveness of services and interventions in meeting care plan goals.
Caregiver:	Individual primarily responsible for the care of another person.
Care Plan:	Treatment and service order plan developed for a EDWP-eligible client to improve or maintain client's functional ability.

Centers for Medicare and Medicaid Services (CMS):	Federal agency that oversees Medicare and Medicaid.
Community Care Services Program (CCSP):	Title XIX Medicaid waivered community-based services available to functionally impaired persons as an alternative to care in a nursing facility. Traditional/Enhanced- EDWP
Consumer Directed Option Personal Support Services (CD-PSS):	Service delivery option in which EDWP client or his/her representative assumes all responsibilities for hiring and training a qualified employee and schedules services within within the framework and budget of the comprehensive care plan.
Cost Share (client liability):	Financial liability assigned to each Medical Assistance Only (MAO) client calculated by the county Department of Family And Children Services (DFCS).
Critical Incident:	Incidents of serious injury and/or unexpected death or elopement.
Deauthorization:	Automated procedure which compares EDWP Medicaid waivered services authorized monthly by the care coordinator to EDWP provider payment data from the Department of Medical Assistance (DMA). Deauthorization reduces amount authorized on the SAF to equal the amount billed and paid.
DFCS/DFACS:	State Division of Family & Children Services and county Departments of Family & Children Services, both part of DHR.
DHR:	The Department of Human Resources is the state agency responsible for the delivery of health and social services. There are 5 divisions: Aging Services, Public Health, Mental Health/ Developmental Disabilities/Addictive Diseases, Family and Children Services and Rehabilitation Services.
DMA:	Division of Medical Assistance, within the Georgia Department of Community Health. Jointly funded, federal/state healthcare assistance program serving primarily low income individuals;

	children, pregnant women, the elderly, blind and disabled.
DMA-6:	Form entitled "Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for Mentally Retarded". Used to request from the Georgia Medical Care Foundation (GMCF) pre-admission approval of a level of care certification needed for admission to a Medicaid nursing facility.
DMA-613:	Form used to screen a client's mental health status. Needed for admission to a Medicaid nursing facility.
Diagnostic Related Group:	A diagnostic group used for reimbursement purposes by the DMA and medical insurance companies.
Exploitation:	Unjust or improper use of another person or the person's property Through undue influence, coercion, harassment, duress, deception, false representation, false pretense, or other similar means for one's own profit or advantage
Elopement:	A cognitively impaired person who is missing from home, ADH or ALS facility.
Fair Hearing:	Process that occurs when an applicant/client appeals an adverse action.
Final Appeal:	Review of an adverse decision in a EDWP case by the DHR Legal Services Office (LSO). Consists of a review of the entire initial hearing record and any additional material submitted at the time of the hearing request. The LSO may provide for taking of additional testimony, argument, or evidence in a final appeal review.
Fiscal Intermediary:	Medicaid approved financial services provider, provides fiscal support for consumer participating in CD-PSS.
Fiscal Year:	Funding and reporting period of twelve months. State fiscal year (SFY) begins July 1 and ends June 30. Federal fiscal year (FFY) begins October 1 and ends September 30.
Formal Support Services:	Services paid by Medicare, Medicaid, insurance and other government fund sources.
Functionally Impaired:	Condition of having physical or cognitive limitations that restrict an individual's capacity to live independently.

Home Delivered Services:	Skilled services provided to EDWP clients, including home health aides, skilled nursing, physical, occupational, and speech therapies and medical social services.
Homebound:	Designation of an individual whose medical or mental ability is impaired to the point that the client EDWP applicant/client cannot leave home without assistance. An individual does not have to be bedridden to be considered homebound. However, the client's home must be the most appropriate setting to provide the services necessary to meet the medical needs of the patient.
Initial Care Plan:	First treatment and order plan developed for a new client entering the EDWP for the first time or after reinstatement.
Informal Support Services:	Services provided by family, friends or church organizations.
Information Technology:	Section of DCH responsible for the electronic data system
Lead Agency:	A local AAA under contract with the DCH, to manage care coordination of EDWP within a PSA, unless managed by the independent CC agency.
Level of Care:	Determination based on the same medical criteria the DMA uses to determine individual Intermediate LOC certification for a nursing facility and cannot exceed 12 months without re-determination. A care coordinator (RN) has the authority to make this determination in the EDWP.
Length of Stay:	1. Period of time a person is certified for a level of care. 2. Period of time a client is enrolled in a program. 3. Clients meet LOS requirement when they have received 32 consecutive days in case management.
Medical Assistance Only:	Medicaid benefits for individuals who are not eligible for cash assistance such as SSI.
Manual Transmittal:	Care coordination manual revisions produced by DCH and numbered sequentially with date displayed in footer at the bottom of the page.
Minimum Data Set:	A comprehensive assessment of nursing home residents to measure physical, functional and cognitive loss. It is a federal mandate for

	facilities participating in Medicaid or Medicare programs.
Mistreatment:	Any behavior or practice that has the potential to or results in any type of individual exploitation.
MDS-HC	Minimum Data Set-Home Care, a comprehensive, standardized instrument for evaluating the needs, strengths, and preferences of elderly clients in home care agencies. Compatible with the congressionally mandated MDS used in nursing homes.
Neglect:	Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.
Non-skilled Services:	Services not required to be administered by skilled nurses or skilled rehabilitation personnel, (e.g., administration of eye drops and ointments are usually non-skilled services).
Nutrition Screening Initiative (NSI):	A form used to determine if a client is at nutritional risk.
Older Americans Act:	Federal law for the provision of services to people 60 years of age or older.
Personal Support Aide:	Person providing Personal Support Service that may include a combination of basic personal care activities, respite care and homemaking services to EDWP clients.
Physician:	A doctor of medicine or doctor of osteopathy fully licensed to practice medicine.
Planning and Service Area: (PSA):	Designated by the Division of Aging Services (DAS) designates areas of the state. In each area the DAS designates an AAA to plan, coordinate and advocate for regional community service systems.
Potential Medical Assistance Only:	Individuals who appear to meet all financial criteria for MAO but have not been determined eligible for Medicaid by DFCS.
Primary Diagnosis:	The primary or most important reason for the care provided.
Referral Source:	Agencies or individuals that refer individuals for EDWP

services.

Secondary Diagnosis:	An additional medical condition which may affect client's health status but is not used by the care coordinator to determine client's appropriateness for the EDWP.
Serious Injury:	Bodily injury that involves a substantial risk of death, unconsciousness, extreme physical pain, sexual assault, violence, protracted and obvious disfigurement or impairment.
Service Episode:	Period of Medicaid-reimbursed, EDWP services which start with a Services Begin Date and stop with a Services End Date.
Skilled Services:	Services required to be administered by skilled nurses or therapists (e.g., administration of intravenous feedings, intramuscular injections are usually skilled services).
State Emergency Back-Up Plan:	Services provided by approved personal support services provider; required for participation in CD-PSS. Provide services in situations when the consumer's back up plan fails.
Social Services Block Grant (SSBG):	Funds used by DFCS and Division of Aging Services contractors to provide various social services to individuals.
Supplemental Security Income (SSI):	A federally administered cash assistance program based on financial need for low income individuals who are aged, blind or disabled; funded by Title XVI of the Social Security Act.
Title III:	Section of the Older Americans Act which provides various social and health related services to individuals 60 years of age and older.
Title XIX:	Section of the Social Security Act which funds Medicaid; includes funding for waivered services for in the EDWP.
Unduplicated Clients:	Number of clients who received a EDWP, Medicaid waivered service reimbursed by Medicaid during a state fiscal year
Unexpected Death:	Death that occurs as a result of homicide, suicide, accident or suddenly when client in apparent good health.

Utilization Review (UR):	A review conducted by the Division of Medical Assistance to determine the medical necessity for continued care, and the effectiveness of that care, for each EDWP client.
Waiting List:	The AAA or care coordination agency establishes a waiting list for clients waiting for initial assessments when EDWP funds are not available for additional clients.
Waivered Services:	Services specifically designated for the EDWP and reimbursable by Medicaid. Waivered services include: Adult Day Health, Alternative Living Services, Case Management, Emergency Response System, Home Delivered Meals, Home Delivered Services, Medical Social Services, Personal Support Services/Consumer Directed Option for Personal Support, Fiscal Intermediary Services (Consumer Directed Option), and Out-Of-Home Respite Care.

TRANSFER FORM- SUPPLEMENT CHECKLIST- SEND TO DCH WAIVER UNIT

Medicaid ID of member Transfer form attached? Yes ☐ No ☐

Reason for transfer?

Type of transfer-

SOURCE to SOURCE ☐ SOURCE to CCSP ☐ SOURCE to ICWP ☐

CCSP to CCSP ☐ CCSP to SOURCE ☐ CCSP to ICWP ☐

ICWP to ICWP ☐ ICWP to SOURCE ☐ ICWP to CCSP ☐

SOURCE to CCSP OR ICWP to CCSP ☐ Date referred to the AAA?

Referred by ☐ phone ☐ fax ☐ email ☐ online

Has the member chosen the new case management site, or will the AAA provide the member choice follow up?

LOC Transfer form uploaded to Alliant? Yes ☐ No ☐ Date uploaded

List all providers (by name) that you contacted via EDWP form/call/fax/email to alert them to stop/transfer care.

Name EDWP Form ☐ Call ☐ Fax ☐ Email ☐ last day they served the member

Name EDWP Form ☐ Call ☐ Fax ☐ Email ☐ last day they served the member

Name EDWP Form ☐ Call ☐ Fax ☐ Email ☐ last day they served the member

Name EDWP Form ☐ Call ☐ Fax ☐ Email ☐ last day they served the member

If HDM is listed above, please indicate the last date of their billing, last date of consumption.

Was the *Service* PA/SAF/Auth Service ended? Yes ☐ No ☐ End date?

Name of Case Management Agency to receive the transfer?
Date agency was notified of transfer? Staff member (name) contacted?
Date paper file sent to new agency?

Instructions: Do not upload this form to Alliant.
This form is completed by the Case Management that member is discharging from.
Send this form **and** the Alliant transfer form to carolyn.porter@dch.ga.gov, donna.elrod@dch.ga.gov and jill.crump@dch.ga.gov.
The form is not necessary if the transfer is to the same Case Management agency.

SOURCE DOCUMENTS

(not shared with CCSP)

SOURCE Screening Form

SCREENER_____REFERRAL DATE_____

SCREENING DATE_____

NAME_____DOB_____/_____/_____

SEX M_____ F_____ SSN_____-_____-_____

MEDICAID YES/ NO MEDICAID NUMBER_____

SSI: YES_____ NO_____

IF NO, IS MONTHLY INCOME SSI LEVEL OR BELOW? _____

MEDICARE NUMBER _____

ADDRESS:_____PHONE _____

HOUSING: ALONE_____ WITH RELATIVE/FRIEND_____ HOSPITAL _____

PERSONAL CARE HOME _____NURSING HOME ____ OTHER_____

PHYSICIAN _____
DATE OF LAST VISIT_____
DIAGNOSES _____
INITIAL CALLER _____
REFERRED BY _____
REFERRAL/SCREENING NOTES
_____
_____
_____
_____

PRIMARY CAREGIVER RELATIONSHIP _____
PHONE ( ) _____-_____
STREET ADDRESS _____
City _____ State_____ Zip_____
WILLING TO USE SOURCE PCP _____ YES _____ NO
REFERRED FOR SOURCE ASSESSMENT _____ YES _____ NO
NOT ELIGIBLE REASON _____

REFERRED FOR OTHER SERVICES _____

OTHER_____

SOURCE PROGRAM PARTICIPATION

DATE

DEAR

WELCOME TO THE SOURCE PROGRAM. THE SOURCE MULTIDISCIPLINARY TEAM REVIEWED YOUR SITUATION AND RECOMMENDED COMMUNITY –BASED SERVICES THROUGH SOURCE.

SERVICES WILL BEGIN AFTER THE PROVIDERS LISTED BELOW HAVE VISITED YOU.
SOMEONE FROM THE FOLLOWING AGENCY(S) WILL BE CONTACTING YOU.

1.
Provider Agency

Contact Person

Telephone #

2.
Provider Agency

Contact Person

Telephone #

3
Provider Agency

Contact Person

Telephone #

4.
Provider Agency

Contact Person

Telephone #

AS A PARTICIPANT IN THE SOURCE PROGRAM:

YOU WILL NOT LOSE ANY MEDICAL ASSISTANCE BENEFITS THAT YOU ARE CURRENTLY RECEIVING BY PARTICIPATING IN THE SOURCE PROGRAM.

YOU MAY WITHDRAW FROM SOURCE AT ANY TIME.

PLEASE CONTACT THE CASE MANAGER LISTED BELOW OR YOU MAY HAVE SOMEONE CALL ON YOUR BEHALF IF YOU HAVE QUESTIONS OR NEED ADDITIONAL INFORMATION.

CASE MANAGER

TELEPHONE NUMBER

SOURCE PROGRAM PARTICIPATION

DATE / /

DEAR_____

WELCOME TO THE SOURCE PROGRAM. THE SOURCE MULTIDISCIPLINARY TEAM REVIEWED YOUR SITUATION AND RECOMMENDED COMMUNITY –BASED SERVICES THROUGH SOURCE.

SERVICES WILL BEGIN AFTER THE PROVIDERS LISTED BELOW HAVE VISITED YOU.
SOMEONE FROM THE FOLLOWING AGENCY(S) WILL BE CONTACTING YOU.

1._____
Provider Agency

_____
Contact Person

_____
Telephone #

2._____
Provider Agency

_____
Contact Person

_____
Telephone #

3._____
Provider Agency

_____
Contact Person

_____
Telephone #

4._____
Provider Agency

_____
Contact Person

_____
Telephone #

AS A PARTICIPANT IN THE SOURCE PROGRAM:

YOU WILL NOT LOSE ANY MEDICAL ASSISTANCE BENEFITS THAT YOU ARE CURRENTLY RECEIVING BY PARTICIPATING IN THE SOURCE PROGRAM.

YOU MAY WITHDRAW FROM SOURCE AT ANY TIME.

PLEASE CONTACT THE CASE MANAGER LISTED BELOW OR YOU MAY HAVE SOMEONE CALL ON YOUR BEHALF IF YOU HAVE QUESTIONS OR NEED ADDITIONAL INFORMATION.

CASE MANAGER _____

TELEPHONE NUMBER_____

RN Review and Signature Form

MDS-HC Participants
SOURCE Program

Participant	Agency	Relationship to Applicant	Date

RN Who Reviewed MDS HC for Consistency & Completeness: (Printed) :	RN signature	Date:

Appendix T needs to be signed and dated by R.N. SOP is within 10 business days of completion of the MDS-HC and uploaded with packet to AHS

Rev. 04/11 Note: Remember when assessing LOC with the Multi Data Set – Home Care (MDS-HC) that the target population for SOURCE are physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance in the performance of the activities of daily living (ADLs) and instrumental activities of daily living (IADLs); these individuals must meet the Definition for Intermediate Nursing Home LEVEL OF CARE.)

interRAI Home Care (HC)©

[CODE FOR LAST 3 DAYS, UNLESS OTHERWISE SPECIFIED]

SECTION A. IDENTIFICATION INFORMATION

1. NAME

a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)

2. GENDER
1. Male 2. Female

3. BIRTHDATE
Year — Month — Day

4. MARITAL STATUS
1. Never married
2. Married
3. Partner / Significant other
4. Widowed
5. Separated
6. Divorced

5. NATIONAL NUMERIC IDENTIFIER [EXAMPLE - USA]

a. **Social Security number**

b. **Medicare number (or comparable railroad insurance number)**

c. **Medicaid number**
[Note: "+" if pending, "N" if not a Medicaid recipient]

6. FACILITY / AGENCY PROVIDER NUMBER

7. CURRENT PAYMENT SOURCES [EXAMPLE - USA]
[Note: Billing Office to indicate]
0. No 1. Yes

a. **Medicaid**
b. **Medicare**
c. **Self or family pays for full cost**
d. **Medicare with Medicaid co-payment**
e. **Private insurance**
f. **Other per diem**

8. REASON FOR ASSESSMENT
1. First assessment
2. Routine reassessment
3. Return assessment
4. Significant change in status reassessment
5. Discharge assessment, covers last 3 days of service
6. Discharge tracking only
7. Other—e.g., research

9. ASSESSMENT REFERENCE DATE
2 0 — — —
Year Month Day

10. PERSON'S EXPRESSED GOALS OF CARE
Enter primary goal in boxes at bottom

11. POSTAL / ZIP CODE OF USUAL LIVING ARRANGEMENT [EXAMPLE - USA]

12. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT
1. Private home / apartment / rented room
2. Board and care
3. Assisted living or semi-independent living
4. Mental health residence—e.g., psychiatric group home
5. Group home for persons with physical disability
6. Setting for persons with intellectual disability
7. Psychiatric hospital or unit
8. Homeless (with or without shelter)
9. Long-term care facility (nursing home)
10. Rehabilitation hospital / unit
11. Hospice facility / palliative care unit
12. Acute care hospital
13. Correctional facility
14. Other

13. LIVING ARRANGEMENT

a. **Lives**
1. Alone
2. With spouse / partner only
3. With spouse / partner and other(s)
4. With child (not spouse / partner)
5. With parent(s) or guardian(s)
6. With sibling(s)
7. With other relatives
8. With non-relative(s)

b. **As compared to 90 DAYS AGO (or since last assessment), person now lives with someone new—e.g., moved in with another person, other moved in**
0. No 1. Yes

c. **Person or relative feels that the person would be better off living elsewhere**
0. No
1. Yes, other community residence
2. Yes, institution

14. TIME SINCE LAST HOSPITAL STAY
Code for most recent instance in LAST 90 DAYS
0. No hospitalization within 90 days
1. 31 to 90 days ago
2. 15 to 30 days ago
3. 8 to 14 days ago
4. In the last 7 days
5. Now in hospital

SECTION B. INTAKE AND INITIAL HISTORY

[Note: Complete at Admission/First Assessment only]

1. DATE CASE OPENED (this agency)
2 0 — — —
Year Month Day

2. ETHNICITY AND RACE [EXAMPLE - USA]
0. No 1. Yes

ETHNICITY
a. **Hispanic or Latino**

RACE
b. **American Indian or Alaska Native**
c. **Asian**
d. **Black or African American**
e. **Native Hawaiian or other Pacific Islander**
f. **White**

3. PRIMARY LANGUAGE [EXAMPLE - USA]
1. English
2. Spanish
3. French
4. Other

4. RESIDENTIAL HISTORY OVER LAST 5 YEARS
Code for all settings person lived in during 5 YEARS prior to date case opened [Item B1]
0. No 1. Yes

a. **Long-term care facility**—e.g., nursing home
b. **Board and care home, assisted living**
c. **Mental health residence—e.g.,** psychiatric group home
d. **Psychiatric hospital or unit**
e. **Setting for persons with intellectual disability**

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SECTION C. COGNITION

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING
Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do
0. *Independent*—Decisions consistent, reasonable, and safe
1. *Modified independence*—Some difficulty in new situations only
2. *Minimally impaired*—In specific recurring situations, decisions become poor or unsafe; cues / supervision necessary at those times
3. *Moderately impaired*—Decisions consistently poor or unsafe; cues / supervision required at all times
4. *Severely impaired*—Never or rarely makes decisions
5. *No discernable consciousness, coma [Skip to Section G]*

2. MEMORY / RECALL ABILITY
Code for recall of what was learned or known
0. Yes, memory OK 1. Memory problem
a. **Short-term memory OK**—Seems / appears to recall after 5 minutes
b. **Procedural memory OK**—Can perform all or almost all steps in a multitask sequence without cues
c. **Situational memory OK**—Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room)

3. PERIODIC DISORDERED THINKING OR AWARENESS
(Note: Accurate assessment requires conversations with staff, family or others who have direct knowledge of the person's behavior over this time)
0. Behavior not present
1. Behavior present, consistent with usual functioning
2. Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)
a. **Easily distracted**—e.g., episodes of difficulty paying attention; gets sidetracked
b. **Episodes of disorganized speech**—e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought
c. **Mental function varies over the course of the day**—e.g., sometimes better, sometimes worse

4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING—*e.g., restlessness, lethargy, difficult to arouse, altered environmental perception*
0. No 1. Yes

5. CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)
0. Improved 2. Declined
1. No change 8. Uncertain

SECTION D. COMMUNICATION AND VISION

1. MAKING SELF UNDERSTOOD (Expression)
Expressing information content—both verbal and non-verbal
0. *Understood*—Expresses ideas without difficulty
1. *Usually understood*—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
2. *Often understood*—Difficulty finding words or finishing thoughts AND prompting usually required
3. *Sometimes understood*—Ability is limited to making concrete requests
4. *Rarely or never understood*

2. ABILITY TO UNDERSTAND OTHERS (Comprehension)
Understanding verbal information content (however able, with hearing appliance normally used)
0. ***Understands***—Clear comprehension
1. ***Usually understands***—Misses some part / intent of message BUT comprehends most conversation
2. ***Often understands***—Misses some part / intent of message BUT with repetition or explanation can often comprehend conversation
3. ***Sometimes understands***—Responds adequately to simple, direct communication only
4. ***Rarely or never understands***

3. HEARING
Ability to hear (with hearing appliance normally used)
0. ***Adequate***—No difficulty in normal conversation, social interaction, listening to TV
1. ***Minimal difficulty***—Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet [2 meters] away)
2. ***Moderate difficulty***—Problem hearing normal conversation, requires quiet setting to hear well
3. ***Severe difficulty***—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
4. ***No hearing***

4. VISION
Ability to see in adequate light (with glasses or with other visual appliance normally used)
0. ***Adequate***—Sees fine detail, including regular print in newspapers / books
1. ***Minimal difficulty***—Sees large print, but not regular print in newspapers / books
2. ***Moderate difficulty***—Limited vision; not able to see newspaper headlines, but can identify objects
3. ***Severe difficulty***—Object identification in question, but eyes appear to follow objects; sees only light, colors, shapes
4. ***No vision***

SECTION E. MOOD AND BEHAVIOR

1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD
Code for indicators observed in last 3 days, irrespective of the assumed cause [Note: Whenever possible, ask person]
0. Not present
1. Present but not exhibited in last 3 days
2. Exhibited on 1-2 of last 3 days
3. Exhibited daily in last 3 days
a. **Made negative statements**—e.g., *"Nothing matters; Would rather be dead; What's the use; Regret having lived so long; Let me die"*
b. **Persistent anger with self or others**—e.g., easily annoyed, anger at care received
c. **Expressions, including non-verbal, of what appear to be unrealistic fears**—e.g., fear of being abandoned, being let alone, being with others; intense fear of specific objects or situations
d. **Repetitive health complaints**—e.g., persistently seeks medical attention, incessant concern with body functions
e. **Repetitive anxious complaints / concerns (non-health related)**—e.g., persistently seeks attention / reassurance regarding schedules, meals, laundry, clothing, relationships
f. **Sad, pained, or worried facial expressions**—e.g., furrowed brow, constant frowning
g. **Crying, tearfulness**
h. **Recurrent statements that something terrible is about to happen**–e.g., believes he or she is about to die, have a heart attack
i. **Withdrawal from activities of interest**—e.g., long-standing activities, being with family / friends
j. **Reduced social interactions**
k. **Expressions, including non-verbal, of a lack of pleasure in life (anhedonia)**—e.g., *"I don't enjoy anything anymore"*

2. SELF-REPORTED MOOD
0. Not in last 3 days
1. Not in last 3 days, but often feels that way
2. In 1-2 of last 3 days
3. Daily in the last 3 days
8. Person could not (would not) respond
Ask: "In the last 3 days, how often have you felt..."
a. ***Little interest or pleasure in things you normally enjoy?***
b. ***Anxious, restless, or uneasy?***
c. ***Sad, depressed, or hopeless?***

3. BEHAVIOR SYMPTOMS
Code for indicators observed, irrespective of the assumed cause
0. Not Present
1. Present but not exhibited in last 3 days
2. Exhibited on 1-2 of last 3 days
3. Exhibited daily in last 3 days
a. **Wandering**—Moved with no rational purpose, seemingly oblivious to needs or safety
b. **Verbal abuse**—e.g., others were threatened, screamed at, cursed at
c. **Physical abuse**—e.g., others were hit, shoved, scratched, sexually abused
d. **Socially inappropriate or disruptive behavior**—e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through other's belongings
e. **Inappropriate public sexual behavior or public disrobing**
f. **Resists care**—e.g., taking medications / injections, ADL assistance, eating

SECTION F. PSYCHOSOCIAL WELL-BEING

1. SOCIAL RELATIONSHIPS

[Note: Whenever possible, ask person]

0. Never
1. More than 30 days ago
2. 8 to 30 days ago
3. 4 to 7 days ago
4. In last 3 days
8. Unable to determine

a. **Participation in social activities of long-standing interest**

b. **Visit with a long-standing social relation or family member**

c. **Other interaction with long-standing social relation or family member**—e.g., telephone, e-mail

d. **Conflict or anger with family or friends**

e. **Fearful of a family member or close acquaintance**

f. **Neglected, abused, or mistreated**

2. LONELY

Says or indicates that he / she feels lonely

0. No 1. Yes

3. CHANGE IN SOCIAL ACTIVITIES IN LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO)

Decline in level of participation in social, religious, occupational or other preferred activities

IF THERE WAS A DECLINE, person distressed by this fact

0. No decline
1. Decline, not distressed
2. Decline, distressed

4. LENGTH OF TIME ALONE DURING THE DAY (MORNING AND AFTERNOON)

0. Less than 1 hour
1. 1-2 hours
2. More than 2 hours but less than 8 hours
3. 8 hours or more

5. MAJOR LIFE STRESSORS IN LAST 90 DAYS—*e.g., episode of severe personal illness; death or severe illness of close family member/friend; loss of home; major loss of income / assets; victim of a crime such as robbery or assault; loss of driving license/car*

0. No 1. Yes

SECTION G. FUNCTIONAL STATUS

1. IADL SELF PERFORMANCE AND CAPACITY

Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0. *Independent*—No help, setup, or supervision
1. *Setup help only*
2. *Supervision*—Oversight / cuing
3. *Limited assistance*—Help on some occasions
4. *Extensive assistance*—Help throughout task, but performs 50% or more of task on own
5. *Maximal assistance*—Help throughout task, but performs less than 50% of task on own
6. *Total dependence*—Full performance by others during entire period
8. *Activity did not occur*—During entire period [DO NOT USE THIS CODE IN SCORING CAPACITY]

	PERFORMANCE	CAPACITY
a. **Meal preparation**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)		
b. **Ordinary housework**—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)		
c. **Managing finances**—How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored		
d. **Managing medications**—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)		
e. **Phone use**—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)		
f. **Stairs**—How full flight of stairs is managed (12-14 stairs)		
g. **Shopping**—How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION		
h. **Transportation**—How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)		

2. ADL SELF-PERFORMANCE

Consider all episodes over 3-day period.

If all episodes are performed at the same level, score ADL at that level. If any episodes at level 6, and others less dependent, score ADL as a 5.

Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2-5.

0. *Independent*—No physical assistance, setup, or supervision in any episode
1. *Independent, setup help only*—Article or device provided or placed within reach, no physical assistance or supervision in any episode
2. *Supervision*—Oversight / cuing
3. *Limited assistance*—Guided maneuvering of limbs, physical guidance without taking weight
4. *Extensive assistance*—Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
5. *Maximal assistance*—Weight-bearing support (including lifting limbs) by 2+ helpers —OR— Weight-bearing support for more than 50% of subtasks
6. *Total dependence*—Full performance by others during all episodes
8. *Activity did not occur during entire period*

a. **Bathing**—How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR

b. **Personal hygiene**—How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS

c. **Dressing upper body**—How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.

d. **Dressing lower body**—How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.

e. **Walking**—How walks between locations on same floor indoors

f. **Locomotion**—How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair

g. **Transfer toilet**—How moves on and off toilet or commode

h. **Toilet use**—How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET

i. **Bed mobility**—How moves to and from lying position, turns from side to side, and positions body while in bed

j. **Eating**—How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)

3. LOCOMOTION / WALKING

a. **Primary mode of locomotion**

0. Walking, no assistive device
1. Walking, uses assistive device—e.g., cane, walker, crutch, pushing wheelchair
2. Wheelchair, scooter
3. Bedbound

b. **Timed 4-meter (13 foot) walk**

[Lay out a straight unobstructed course. Have person stand in still position, feet just touching start line]

Then say: "When I tell you begin to walk at a normal pace (with cane/walker if used). This is not a test of how fast you can walk. Stop when I tell you to stop. Is this clear?" Assessor may demonstrate test.

Then say: "Begin to walk now" Start stopwatch (or can count seconds) when first foot falls. End count when foot falls beyond 4-meter mark.

Then say: "You may stop now"

Enter time in seconds, up to 30 seconds.
30. 30 or more seconds to walk 4-meters
77. Stopped before test complete
88. Refused to do the test
99. Not tested—e.g., does not walk on own

interRAI

c. **Distance walked**–Farthest distance walked at one time without sitting down in the LAST 3 DAYS (with support as needed)
0. Did not walk
1. Less than 15 feet (under 5 meters)
2. 15-149 feet (5-49 meters)
3. 150-299 feet (50-99 meters)
4. 300+ feet (100+ meters)
5. 1/2 mile or more (1+ kilometers)

d. **Distance wheeled self**–Farthest distance wheeled self at one time in the LAST 3 DAYS (includes independent use of motorized wheelchair)
0. Wheeled by others
1. Used motorized wheelchair / scooter
2. Wheeled self less than 15 feet (under 5 meters)
3. Wheeled self 15-149 feet (5-49 meters)
4. Wheeled self 150-299 feet (50-99 meters)
5. Wheeled self 300+ feet (100+ meters)
8. Did not use wheelchair

4. ACTIVITY LEVEL

a. **Total hours of exercise or physical activity in LAST 3 DAYS**—e.g., walking
0. None
1. Less than 1 hour
2. 1-2 hours
3. 3-4 hours
4. More than 4 hours

b. In the LAST 3 DAYS, number of days went out of the house or building in which he/she resides (no matter how short the period)
0. No days out
1. Did not go out in last 3 days, but usually goes out over a 3-day period
2. 1-2 days
3. 3 days

5. PHYSICAL FUNCTION IMPROVEMENT POTENTIAL
0. No 1. Yes

a. **Person believes he / she is capable of improved performance in physical function**

b. **Care professional believes person is capable of improved performance in physical function**

6. CHANGE IN ADL STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO
0. Improved
1. No change
2. Declined
3. Uncertain

7. DRIVING

a. **Drove car (vehicle) in the LAST 90 DAYS**
0. No 1. Yes

b. **If drove in LAST 90 DAYS, assessor is aware that someone has suggested that person limits OR stops driving**
0. No, or does not drive 1. Yes

SECTION H. CONTINENCE

1. BLADDER CONTINENCE
0. *Continent*—Complete control; DOES NOT USE any type of catheter or other urinary collection device
1. *Control with any catheter or ostomy over last 3 days*
2. *Infrequently incontinent*—Not incontinent over last 3 days, but does have incontinent episodes
3. *Occasionally incontinent*—Less than daily
4. *Frequently incontinent*—Daily, but some control present
5. *Incontinent*—No control present
8. *Did not occur*—No urine output from bladder in last 3 days

2. URINARY COLLECTION DEVICE (Exclude pads / briefs)
0. None
1. Condom catheter
2. Indwelling catheter
3. Cystostomy, nephrostomy, ureterostomy

3. BOWEL CONTINENCE
0. ***Continent***—Complete control; DOES NOT USE any type of ostomy device
1. ***Control with ostomy***—Control with ostomy device over last 3 days
2. ***Infrequently incontinent***—Not incontinent over last 3 days, but does have incontinent episodes
3. ***Occasionally incontinent***—Less than daily
4. ***Frequently incontinent***—Daily, but some control present
5. ***Incontinent***—No control present
8. ***Did not occur***—No bowel movement in the last 3 days

4. PADS OR BRIEFS WORN
0. No 1. Yes

SECTION I. DISEASE DIAGNOSES

Disease code
0. Not present
1. Primary diagnosis/diagnoses for current stay
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment

1. DISEASE DIAGNOSES

MUSCULOSKELETAL
a. **Hip fracture during last 30 days (or since last assessment if less than 30 days)**
b. **Other fracture during last 30 days (or since last assessment if less than 30 days)**

NEUROLOGICAL
c. **Alzheimers disease**
d. **Dementia other than Alzheimers disease**
e. **Hemiplegia**
f. **Multiple sclerosis**
g. **Paraplegia**
h. **Parkinson's disease**
i. **Quadriplegia**
j. **Stroke / CVA**

CARDIAC OR PULMONARY
k. **Coronary heart disease**
l. **Chronic obstructive pulmonary disease**
m. **Congestive heart failure**

PSYCHIATRIC
n. **Anxiety**
o. **Bipolar disorder**
p. **Depression**
q. **Schizophrenia**

INFECTIONS
r. **Pneumonia**
s. **Urinary tract infection in last 30 days**

OTHER
t. **Cancer**
u. **Diabetes mellitus**

2. OTHER DISEASE DIAGNOSES

	Diagnosis	Disease Code	ICD code
a.			
b.			
c.			
d.			
e.			
f.			

[Note: Add additional lines as necessary for other disease diagnoses]

SECTION J. HEALTH CONDITIONS

1. FALLS
0. No fall in last 90 days
1. No fall in last 30 days, but fell 31-90 days ago
2. One fall in last 30 days
3. Two or more falls in last 30 days

2. RECENT FALLS
[Skip if last assessed more than 30 days ago or if this is first assessment]
0. No
1. Yes
[blank] Not applicable (first assessment, or more than 30 days since last assessment)

3. PROBLEM FREQUENCY
Code for presence in last 3 days
0. Not present
1. Present but not exhibited in last 3 days
2. Exhibited on 1 of last 3 days
3. Exhibited on 2 of last 3 days
4. Exhibited daily in last 3 days

BALANCE

a. **Difficult or unable to move self to standing position unassisted**

b. **Difficult or unable to turn self around and face the opposite direction when standing**

c. **Dizziness**

d. **Unsteady gait**

CARDIAC OR PULMONARY

e. **Chest pain**

f. **Difficulty clearing airway secretions**

PSYCHIATRIC

g. **Abnormal thought process**—e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality

h. **Delusions**—Fixed false beliefs

i. **Hallucinations**—False sensory perceptions

NEUROLOGICAL

j. **Aphasia**

GI STATUS

k. **Acid reflux**—Regurgitation of acid from stomach to throat

l. **Constipation**—No bowel movement in 3 days or difficult passage of hard stool

m. **Diarrhea**

n. **Vomiting**

SLEEP PROBLEMS

o. **Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep**

p. **Too much sleep**—Excessive amount of sleep that interferes with person's normal functioning

OTHER

q. **Aspiration**

r. **Fever**

s. **GI or GU bleeding**

t. **Hygiene**—Unusually poor hygiene, unkempt, disheveled

u. **Peripheral edema**

4. DYSPNEA (Shortness of breath)

0. Absence of symptom
1. Absent at rest, but present when performed moderate activities
2. Absent at rest, but present when performed normal day-to-day activities
3. Present at rest

5. FATIGUE

Inability to complete normal daily activities—e.g., ADLs, IADLs

0. ***None***
1. ***Minimal***—Diminished energy but completes normal day-to-day activities
2. ***Moderate***—Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
3. ***Severe***—Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
4. ***Unable to commence any normal day-to-day activities***—Due to diminished energy

6. PAIN SYMPTOMS

[Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]

a. **Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other non-verbal signs suggesting pain)**

0. No pain
1. Present but not exhibited in last 3 days
2. Exhibited on 1-2 of last 3 days
3. Exhibited daily in last 3 days

b. **Intensity of highest level of pain present**

0. No pain
1. Mild
2. Moderate
3. Severe
4. Times when pain is horrible or excruciating

c. **Consistency of pain**

0. No pain
1. Single episode during last 3 days
2. Intermittent
3. Constant

d. **Breakthrough pain**—Times in LAST 3 DAYS when person experienced sudden, acute flare-ups of pain

0. No 1. Yes

e. **Pain control**—Adequacy of current therapeutic regimen to control pain (from person's point of view)

0. No issue of pain
1. Pain intensity acceptable to person; no treatment regimen or change in regimen required
2. Controlled adequately by therapeutic regimen
3. Controlled when therapeutic regimen followed, but not always followed as ordered
4. Therapeutic regimen followed, but pain control not adequate
5. No therapeutic regimen being followed for pain; pain not adequately controlled

7. INSTABILITY OF CONDITIONS

0. No 1. Yes

a. **Conditions / diseases make cognitive, ADL, mood or behavior patterns unstable** (fluctuating, precarious, or deteriorating)

b. **Experiencing an acute episode, or a flare-up of a recurrent or chronic problem**

c. **End-stage disease, 6 or fewer months to live**

8. SELF-REPORTED HEALTH

Ask: "In general, how would you rate your health?"

0. Excellent
1. Good
2. Fair
3. Poor
8. Could not (would not) respond

9. TOBACCO AND ALCOHOL

a. **Smokes tobacco daily**

0. No
1. Not in last 3 days, but is usually a daily smoker
2. Yes

b. **Alcohol**—Highest number of drinks in any "single sitting" in LAST 14 DAYS

0. None
1. 1
2. 2-4
3. 5 or more

SECTION K. ORAL AND NUTRITIONAL STATUS

1. HEIGHT AND WEIGHT [INCHES AND POUNDS– COUNTRY SPECIFIC]

Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in LAST 30 DAYS.

a. **HT (in.)** ☐☐ b. **WT (lb.)** ☐☐☐

2. NUTRITIONAL ISSUES

0. No 1. Yes

a. **Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS**

b. **Dehydrated or BUN / Cre ratio>25** [Ratio, country specific]

c. **Fluid intake less than 1,000 cc per day (less than four 8 oz cups/day)**

d. **Fluid output exceeds input**

3. MODE OF NUTRITIONAL INTAKE

0. ***Normal***—Swallows all types of foods
1. ***Modified independent***—e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
2. ***Requires diet modification to swallow solid food***—e.g., mechanical diet (e.g., puree, minced, etc.) or only able to ingest specific foods
3. ***Requires modification to swallow liquids***—e.g., thickened liquids
4. ***Can swallow only pureed solids —AND— thickened liquids***
5. ***Combined oral and parenteral or tube feeding***
6. ***Nasogastric tube feeding only***
7. ***Abdominal feeding tube***—e.g., PEG tube
8. ***Parenteral feeding only***—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
9. **Activity did not occur**—During entire period

4. DENTAL OR ORAL
0. No 1. Yes

a. **Wears a denture (removable prosthesis)**
b. **Has broken, fragmented, loose, or otherwise non-intact natural teeth**
c. **Reports having dry mouth**
d. **Reports difficulty chewing**

SECTION L. SKIN CONDITION

1. MOST SEVERE PRESSURE ULCER
0. No pressure ulcer
1. Any area of persistent skin redness
2. Partial loss of skin layers
3. Deep craters in the skin
4. Breaks in skin exposing muscle or bone
5. Not codeable, e.g., necrotic escher predominant

2. PRIOR PRESSURE ULCER
0. No 1. Yes

3. PRESENCE OF SKIN ULCER OTHER THAN PRESSURE ULCER—*e.g., venous ulcer, arterial ulcer, mixed venous-arterial ulcer, diabetic foot ulcer*
0. No 1. Yes

4. MAJOR SKIN PROBLEMS—*e.g., lesions, 2nd or 3rd degree burns, healing surgical wounds*
0. No 1. Yes

5. SKIN TEARS OR CUTS—*Other than surgery*
0. No 1. Yes

6. OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION—*e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema*
0. No 1. Yes

7. FOOT PROBLEMS—*e.g., bunions, hammertoes, overlapping toes, structural problems, infections, ulcers*
0. No foot problems
1. Foot problems, no limitation in walking
2. Foot problems limit walking
3. Foot problems prevent walking
4. Foot problems, does not walk for other reasons

SECTION M. MEDICATIONS

1. LIST OF ALL MEDICATIONS

List all active prescriptions, and any non-prescribed (over the counter) medications taken in the LAST 3 DAYS

[Note: Use computerized records if possible; hand enter only when absolutely necessary]

For each drug record:
a. **Name**

b. **Dose**—A positive number such as 0.5, 5, 150, 300.
[Note: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg)]

c. **Unit**—Code using the following list:
gtts (Drops) **mEq** (Milli-equivalent) **Puffs**
gm (Gram) **mg** (Milligram) **%** (Percent)
L (Liters) **ml** (Milliliter) **Units**
mcg (Microgram) **oz** (Ounce) **OTH** (Other)

d. **Route of administration**—Code using the following list:
PO (By mouth/oral) **REC** (Rectal) **ET** (Enteral Tube)
SL (Sublingual) **TOP** (Topical) **TD** (Transdermal)
IM (Intramuscular) **IH** (Inhalation) **EYE** (Eye)
IV (Intravenous) **NAS** (Nasal) **OTH** (Other)
Sub-Q (Subcuteneous)

e. **Freq**—Code the number of times per day, week, or month the medication is administered using the following list:
Q1H (Every hour) **5D** (5 times daily)
Q2H (Every 2 hours) **Q2D** (Every other day)
Q3H (Every 3 hours) **Q3D** (Every 3 days)
Q4H (Every 4 hours) **Weekly**
Q6H (Every 6 hours) **2W** (2 times weekly)
Q8H (Every 8 hours) **3W** (3 times weekly)
Daily **4W** (4 times weekly)
BED (At bedtime) **5W** (5 times weekly)
BID (2 times daily) **6W** (6 times weekly)
(includes every 12 hrs) **1M** (Monthly)
TID (3 times daily) **2M** (Twice every month)
QID (4 times daily) **OTH** (Other)

f. **PRN**
0. No 1. Yes

g. **Computer-entered drug code**

	a. Name	b. Dose	c. Unit	d. Route	e. Freq.	f. PRN	g. ATC or NDC code
1.							
2.							
3.							
4.							
5.							

[NOTE: Add additional lines, as necessary, for other drugs taken]
[Abbreviations are Country Specific for Unit, Route, Frequency]

2. ALLERGY TO ANY DRUG
0. No known drug allergies 1. Yes

3. ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN
0. Always adherent
1. Adherent 80% of time or more
2. Adherent less than 80% of time, including failure to purchase prescribed medications
8. No medications prescribed

SECTION N. TREATMENT AND PROCEDURES

1. PREVENTION
0. No 1. Yes

a. **Blood pressure measured in LAST YEAR**
b. **Colonoscopy test in LAST 5 YEARS**
c. **Dental exam in LAST YEAR**
d. **Eye exam in LAST YEAR**
e. **Hearing exam in LAST 2 YEARS**
f. **Influenza vaccine in LAST YEAR**
g. **Mammogram or breast exam in LAST 2 YEARS (for women)**
h. **Pneumovax vaccine in LAST 5 YEARS or after age 65**

2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 3 DAYS)
0. Not ordered AND did not occur
1. Ordered, not implemented
2. 1-2 of last 3 days
3. Daily in last 3 days

TREATMENTS
a. **Chemotherapy**
b. **Dialysis**
c. **Infection control**—e.g., isolation, quarantine
d. **IV medication**
e. **Oxygen therapy**
f. **Radiation**
g. **Suctioning**
h. **Tracheostomy care**
i. **Transfusion**
j. **Ventilator or respirator**
k. **Wound care**

PROGRAMS
l. **Scheduled toileting program**
m. **Palliative care program**
n. **Turning / repositioning program**

3. FORMAL CARE
Days (A) and Total minutes (B) of care in last 7 days

Extent of care/treatment in LAST 7 DAYS (or since last assessment or admission, if less than 7 days) involving:

	(A) # of Days	(B) Total Minutes in last week
a. **Home health aides**		
b. **Home nurse**		
c. **Homemaking services**		
d. **Meals**		
e. **Physical therapy**		
f. **Occupational therapy**		
g. **Speech-language pathology and audiology services**		
h. **Psychological therapy (by any licensed mental health professional)**		

4. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT
Code for number of times during the LAST 90 DAYS (or since last assessment if LESS THAN 90 DAYS)

a. **Inpatient acute hospital with overnight stay** ☐☐
b. **Emergency room visit (not counting overnight stay)** ☐☐
c. **Physician visit (or authorized assistant or practitioner)** ☐☐

5. PHYSICALLY RESTRAINED—*Limbs restrained, used bed rails, restrained to chair when sitting*
0. No 1. Yes ☐

SECTION O. RESPONSIBILITY

1. LEGAL GUARDIAN [EXAMPLE--USA]
0. No 1. Yes ☐

SECTION P. SOCIAL SUPPORTS

1. TWO KEY INFORMAL HELPERS

a. **Relationship to person**

1. Child or child-in-law
2. Spouse
3. Partner / significant other
4. Parent / guardian
5. Sibling
6. Other relative
7. Friend
8. Neighbor
9. No informal helper

Helper 1 ☐ 2 ☐

b. **Lives with person**
0. No
1. Yes, 6 months or less
2. Yes, more than 6 months
8. No informal helper

Helper 1 ☐ 2 ☐

AREAS OF INFORMAL HELP DURING LAST 3 DAYS
0. No 1. Yes 8. No informal helper

Helper 1 ☐ 2 ☐

c. **IADL help** ☐☐
d. **ADL help** ☐☐

2. INFORMAL HELPER STATUS
0. No 1. Yes

a. **Informal helper(s) is unable to continue in caring activities**—e.g., decline in health of helper makes it difficult to continue ☐
b. **Primary informal helper expresses feelings of distress, anger, or depression** ☐
c. **Family or close friends report feeling overwhelmed by person's illness** ☐

3. HOURS OF INFORMAL CARE AND ACTIVE MONITORING DURING LAST 3 DAYS
For instrumental and personal activities of daily living in the LAST 3 DAYS, indicate the total number of hours of help received from all family, friends, and neighbors ☐☐☐

4. STRONG AND SUPPORTIVE RELATIONSHIP WITH FAMILY
0. No 1. Yes ☐

SECTION Q. ENVIRONMENTAL ASSESSMENT

1. HOME ENVIRONMENT
Code for any of following that make home environment hazardous or uninhabitable (if temporarily in institution, base assessment on home visit)
0. No 1. Yes

a. **Disrepair of the home**—e.g., hazardous clutter, inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor, leaking pipes ☐
b. **Squalid Condition**—e.g., extremely dirty, infestation by rats or bugs ☐
c. **Inadequate heating or cooling**—e.g., too hot in summer, too cold in winter ☐
d. **Lack of personal safety**—e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street ☐
e. **Limited access to home or rooms in home**—e.g., difficulty entering or leaving home, unable to climb stairs, difficulty maneuvering within rooms, no railings although needed ☐

2. LIVES IN APARTMENT OR HOUSE RE-ENGINEERED ACCESSIBLE FOR PERSONS WITH DISABILITIES
0. No 1. Yes ☐

3. OUTSIDE ENVIRONMENT
0. No 1. Yes

a. **Availability of emergency assistance**—e.g., telephone, alarm response system ☐
b. **Accessibility to grocery store without assistance** ☐
c. **Availability of home delivery of groceries** ☐

4. FINANCES
Because of limited funds, during the last 30 days made trade offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care
0. No 1. Yes ☐

SECTION R. DISCHARGE POTENTIAL AND OVERALL STATUS

1. ONE OR MORE CARE GOALS MET IN THE LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)
0. No 1. Yes ☐

2. OVERALL SELF-SUFFICIENCY HAS CHANGED SIGNIFICANTLY AS COMPARED TO STATUS OF 90 DAYS AGO (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)
0. Improved [Skip to Section S]
1. No change [Skip to Section S]
2. Deteriorated ☐

CODE FOLLOWING THREE ITEMS IF "DETERIORATED" IN LAST 90 DAYS - OTHERWISE SKIP TO SECTION S

3. NUMBER OF 10 ADL AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION ☐☐

4. NUMBER OF 8 IADL PERFORMANCE AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION ☐

5. TIME OF ONSET OF THE PRECIPITATING EVENT OR PROBLEM RELATED TO DETERIORATION
0. Within last 7 days
1. 8 to 14 days ago
2. 15 to 30 days ago
3. 31 to 60 days ago
4. More than 60 days ago
8. No clear precipitating event ☐

SECTION S. DISCHARGE

[Note: Complete Section S at Discharge only]

1. LAST DAY OF STAY
2 0 ☐☐ — ☐☐ — ☐☐
Year Month Day

2. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT
1. Private home / apartment / rented room
2. Board and care
3. Assisted living or semi-independent living
4. Mental health residence—e.g., psychiatric group home
5. Group home for persons with physical disability
6. Setting for persons with intellectual disability
7. Psychiatric hospital or unit
8. Homeless (with or without shelter) ☐☐
9. Long-term care facility (nursing home)
10. Rehabilitation hospital / unit
11. Hospice facility / palliative care unit
12. Acute care hospital
13. Correctional facility
14. Other
15. Deceased

SECTION T. ASSESSMENT INFORMATION

SIGNATURE OF PERSON COORDINATING / COMPLETING THE ASSESSMENT

1. **Signature (sign on above line)**
2. **Date assessment signed as complete**
2 0 ☐☐ — ☐☐ — ☐☐
Year Month Day

MEDICATION LIST

Client Name:				Date:	
Med Name	Dosage	Route	Frequency	Indication	Physician

	• Problems identified that need reported to the MD?

Carepath

Member _____ **Medicaid #** _____ **Date:**_____

SOURCE Service Prior Authorization Number _____

SOURCE Service Dates _____ to _____

Service Options Using Resources In Community Environments

CAREPATH

Circle what the patient has:

1) a documented cognitive problem (with cognitive loss)–
2) a documented physical problem

Disease (s) that require DM Letter to PCP? _____

SOURCE Case Manager _____**Signature** _____ **Date**_____

SOURCE Case Mgmt Sprvsr_____**Signature**_____ **Date**_____

SOURCE Medical Director _____**Signature** _____**Date**_____

Care Path additions: Document Reason for Care Path changes and signatures as needed below for members who have Care Path changes but don't require a full reevaluation.

Carepath

Member _____ Medicaid # _____ Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Member resides in community, maintaining maximum control possible over daily schedule and decisions. **Sentinel events are discussed with appropriate parties and process improvement that will assist member to reside safely are documented and put into action.** **GOALS:** **A. Member/caregiver contributes to the design and implementation of community-based services plan. Key member responsibilities:** • **Accept services as planned with manager;** • **Provide accurate information on health status and service delivery; and** • **Maintain scheduled contact with case manager.** **B. Member keeps scheduled medical appointments.** **C. Support services are delivered in a manner satisfactory to SOURCE members, informal caregivers and Case Managers.** **Key provider performance areas:** • **Reliability of service** • **Competency and compatibility of staffing;** • **Responsiveness to member concerns and issues; and** • **Coordination with Case Manager.**	**Stabilize chronic conditions** and promptly treat episodic/acute illness through long-term management by a Practitioner /Case Manager team. The team will monitor risk factors for institutionalization, responding with medical and support services provided at the time, setting and intensity of greatest effectiveness. PCP: _____ Case Mgr._____ **Practitioner *role:*** Evaluate and treat episodic /acute illness Manage chronic disease, including: Risk factor modification/monitoring of key clinical indicators Coordination of ancillary services Education for members/informal caregivers Medication review and management Communicate with Case Manager as needed Review support service plans Refer/coordinate/authorize specialist visits, hospitalizations and ancillary services Promote wellness, including immunizations, health screenings, etc. ***SOURCE Case Manager role:*** Maintain contact with member, for ongoing evaluation: Monthly by phone or visit (minimum) Quarterly by visit (minimum) PRN as needed Educate members on patient responsibilities Encourage/assist member in keeping all medical appointments Communicate with PCP twice a year using the ECM Disease Management Physician letter; Encourage/assist member in obtaining routine immunizations, preventive screenings, diagnostic studies and lab work Coordinate with informal caregivers and paid providers of support services Educate or facilitate education on chronic conditions Educate member on Emergency Preparedness Assist members in ALL issues jeopardizing health status or community residence NOTES: _____ _____ (Providers and units/schedules listed on Member Version)	**GOALS:** 1st review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____ 2nd review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____ 3rd review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____ 4th review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____

Carepath

Member _____ **Medicaid #** _____ **Date:** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
A member's diet will be balanced and appropriate for maintaining a healthy body mass and for dietary management of chronic conditions **GOALS:** **A. SOURCE member's body mass supports functional independence and does not pose a critical health risk OR progress is made toward this goal (PCP, ADH or other report).** **B. Meals are generally balanced and follow appropriate diet recommended by PCP (observed by Case Manager or provider, self- or caregiver report).**	**MEMBER EDUCATION:** ___ Practitioner or staff ___SOURCE educational material ___other _____ **MEAL PREPARATION:** ___self-care (total) ___assistance by informal caregiver(s)_____ ___SFC ___home delivered meals ___ALS (alternative living service) ___ PSS aide (includes G-tube) **MEAL PREPARATION SCHEDULE: (Indicate SELF, INF, HDM, PSS or ALS):** Mon _____B _____L _____S Thurs ____B_____L_____S Tues _____B_____L_____S Fri _____B_____L_____S Wed _____B_____L_____S Sat _____B_____L_____S Sun _____B_____L_____S NOTES: _____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	**GOALS:** 1st review period (__/__/__): A. __met __not met B. __met __not met 2nd review period (__/__/__): A. __met __not met B. __met __not met 3rd review period (__/__/__): A. __met __not met B. __met __not met 4th review period (__/__/__): A. __met __not met B. __met __not met

Carepath

Member _____ Medicaid # _____ Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Member's skin will be maintained in healthy condition, avoiding breakdowns and decubiti. GOALS: **Member has no skin breakdowns or decubiti requiring clinical intervention/wound care.**	**MEMBER/CAREGIVER EDUCATION:** ___Practitioner staff ___SOURCE educational material ___other _____ **MONITOR SKIN for integrity:** ___PCP ___self-care ___informal caregiver _____ ___SFC ___ADH ___specialist _____ ___PSS aide/PSS RN every 62 days ___ALS ___skilled nursing provider: _____ Dates of Service: Assistance required: ___turning/repositioning (see page_____) ___continence (see page _____) ___nutrition (see page____) NOTES: _____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

Carepath

Member _____ **Medicaid #** _____ **Date:** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Key clinical indicators and lab values will regularly fall within parameters acceptable to PCP or treating specialist. **NOTE: Key clinical indicators and lab values deemed applicable are determined and monitored for each member by the PCP, according to the member's diagnosis and current medical condition. The CM role is to assist the member in carrying out PCP orders, to facilitate achieving this goal.** **The PCP will advise on any additional monitoring required for each member.** **Additional monitoring required, if applicable:** **___blood glucose** **___blood pressure** **___weight (as indicator of illness, for CHF patients, etc.)** **___labs** **___other_____** **____LMP_____** last menses for women of child bearing age	**MEMBER/CAREGIVER EDUCATION:** ___Practitioner/staff ___SOURCE educational material ___other_____ **MONITOR CLINICAL INDICATORS:** ____PCP (OV) **ADDITIONAL MONITORING REQUIRED:** ___self-care ___ASSISTANCE REQUIRED ___informal caregiver_____ ___ADH ___PSS aide ___ALS ___RN provider: _____ ___SFC ___other _____ _____ NOTES:_____ _____ _____ (Providers and units/schedules listed on Member Version)	**GOALS:** 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

Carepath

Member _____ Medicaid # _____ Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Member/caregiver understands and adheres to medication regimen (self- or caregiver report, physician/RN report or observation by Case Manager). **Sentinel events around medications are discussed with appropriate responsible parties.**	**MEMBER/CAREGIVER EDUCATION:** ___Practitioner/staff ___SOURCE educational material ___other_____ **MEDICATION ADMINISTRATION/MANAGEMENT:** ___self-care ___informal caregiver _____ ___ADH/DHC ___SFC ___ALS ___PSS aides (cueing) ___RN provider_____ Dates of Service: **OBTAINING MEDICATIONS:** ___self-care ___informal caregiver ___pharmacy delivery _____ ___other_____ **PHARMACY:** _____ NOTES: _____ _____ (Providers and units/schedules listed on Member Version)	**GOALS:** 1st review period (___/___/___): ____ met _____ not met Sentinel events? _____ 2nd review period (___/___/___): _____ met _____ not met Sentinel events? _____ 3rd review period (___/___/___): _____ met _____ not met Sentinel events? _____ 4th review period (___/___/___): _____ met _____ not met Sentinel events? _____

Carepath

Member _____ **Medicaid #** _____ **Date:** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Regular performance of ADLs and IADLs is not interrupted due to cognitive or functional impairments. **GOALS:** **No observations by Case Managers or reports from mbr. /caregiver/other providers identifying problems with ADLs, IADLs and/or patient safety.** **Sentinel events are discussed with appropriate parties (exclude falls).**	**___ASSISTANCE REQUIRED:** (S=SELF; INF=informal support; PSS=PSS aide; HDM=home delivered meals; ALS=alternative living service): _____bathing _____dressing _____eating _____transferring _____toileting/continence _____turning/repositioning _____errands _____chores _____financial mgt. _____meal prep. **__informal caregiver(s)** _____ **___SFC** **___home delivered meals** **___ADH** **___ALS** **___ERS** **___incontinence Carepath** **___PSS aide** Total hours/week: _____ Indicate no. of hours: Monday _____AM _____PM Thursday _____AM _____PM Tuesday _____AM _____PM Friday _____AM _____PM Wednesday _____AM _____PM Saturday _____AM _____PM Sunday _____AM _____PM NOTES: _____ _____ _____ (Providers and units/schedules listed on Member Version)	**GOALS:** 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

Carepath

Member _____ **Medicaid #** _____ **Date:** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Problem behavior will not place the Member at risk of social isolation, neglect or physical injury to themselves or others. Diagnosis: ___depression _____substance abuse ___bi-polar disorder ___schizophrenia ___Alzheimer's ___ other dementia ___other _____ **GOALS:** **A. Residential arrangements remain stable.** **B. Mental health conditions or cognitive impairment will be adequately managed by informal or paid caregivers. Indicators of inadequately managed behavior include:** • **hospitalization for condition** • **discussion of potential institutionalization** • **increased level of caregiver stress** • **physical danger to self or others posed by behavior** • **discharge from a program or service due to behavior** **Examples of problem or symptomatic behavior:** **wandering impaired memory substance abuse** **profoundly impaired judgment** **physical aggression** **suicide attempts or threats** C. **Sentinel events around behavior are discussed with appropriate parties and process improvement that will assist member to reside safely are documented and put into action.**	**ROUTINE AND PRN MONITORING AND EVALUATION** by Practitioner for signs of changes in mental status **MEMBER/CAREGIVER EDUCATION:** ___Practitioner ___other_____ __**ongoing management of condition** by mental health professional provider: _____schedule_____ ___**supervision** by informal caregiver(s): _____ ___**supervision** by SFC ___**ALS** for supervision and monitoring ___**PSS** aides for supervision and monitoring ___**day program** for supervision and monitoring of mental status when or if informal support is unavailable provider: _____ schedule: M T W Th F NOTES: _____ _____ _____ (Providers and units/schedules listed on Member Version)	**GOALS:** 1st review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____ 2nd review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____ 3rd review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____ 4th review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____

Carepath

Member _____ **Medicaid #** _____ **Date:** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS :
Transfers and mobility will occur safely. GOALS: **Member has no falls due to unsuccessful attempts to transfer.** **Sentinel events around falls are discussed with responsible parties.**	**MEMBER/CAREGIVER EDUCATION:** __Practitioner/staff __SOURCE educational material __PCP is notified. Member gait, balance assessed, medication reviewed. __other_____ **ASSISTANCE REQUIRED:** ___**informal caregiver(s)** to provide assistance with transfers and mobility: _____ ___**SFC** ___**PSS aide** for assistance if/when informal support is unavailable ___**ALS** ___**ADH program** for assistance if/when informal support is unavailable ___**Adaptive equipment** as indicated, with training as required (specify): _____ _____ _____ ___**Home modifications** as indicated (specify): _____ _____ NOTES: _____ _____ _____ _____ Providers and units/schedules listed on Member Version)	Goals: 1st review period (___/___/___): _ met _ not met Sentinel events? _____ 2nd review period (___/___/___): _ met _ not met Sentinel events? _____ 3rd review period (___/___/___): _ met _ not met Sentinel events? _____ 4th review period (___/___/___): _ met _ not met Sentinel events? _____

Carepath

Member _____ **Medicaid #** _____ **Date:** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Informal caregivers will maintain a supportive role in the continued community residence of the SOURCE member. **GOALS:** **No reports or other indicators of caregiver exhaustion (self-report, observed by case manager, etc.).**	___**Ongoing SOURCE case management/support service plan** ___**Referral to support group** _____ ___**In-home respite** Extended Personal Support (EPS) schedule: _____ ___**Out-of-home respite** provider: _____ schedule: _____ ___**ADH** for respite purposes for informal caregiver NOTES:_____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

Carepath

Member _____ **Medicaid #** _____ **Date:**_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
GOALS: Member's discharge planning needs will be assessed on the day of admission with continued assessment occurring quarterly.	CM will assess discharge planning needs of member/responsible party including preparation for education and/or referral needs for ordered services.	**GOALS:** 1st review period (___/___/____): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met 4th review period (___/___/____): _ met _ not met

Carepath

Member _____ **Medicaid #** _____ **Date:**_____

		1st review period (___/___/___): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met 4th review period (___/___/___): _ met _ not met

MEMBER VERSION

Member: _____ Medicaid Number: _____ Date: _____

Welcome to SOURCE

Our goals are helping you:

Stay as healthy as possible

AND

Continue living in your own home.

Your SOURCE Case Manager:

_____

SOURCE 24-hour Phone: _____

Your Doctor:

_____Phone: _____

Preferred hospital (name, location)

_____

For Emergencies, please dial 911

Hurricane, Tornado, or other Natural Disaster evacuation and/or support plan (local shelter, family/friend support, other):

_____

_____

_____

_____

_____

Good Nutrition

Proper Meals

_____

_____

Healthy Skin

Checking skin for problems _____

_____

Keeping It Under Control

_____ Blood Pressure _____Blood Sugar

_____ Weight _____ Unsafe Behavior

Monitoring each: YOUR DOCTOR

Others: _____

_____

Notes: _____

_____

Member signature: _____Date_____

Case Manager signature: _____Date____

MEMBER VERSION

Member: _____ Medicaid Number: _____ Date: _____

Taking Medicines Properly

Current medications: Contact your case manager or doctor's office.

Drug Store: _____

Picking up medicines: _____

Help with taking medicines: _____

Getting Up, Down and Around Safely

Equipment _____

Help from another person _____

Taking Care of My Home and Myself

Cleaning _____

Errands _____

Laundry _____

Bathing _____

Dressing _____

Other support _____

Current SOURCE Support Services

_____

_____

_____

_____

_____

Notes: _____

_____

_____

* Refer to Discharge Planning Checklist for available resources following discharge from waivered services

MEMBER VERSION

Member: _____ Date: _____

Welcome to SOURCE!

Our goals are helping you:

Stay as healthy as possible
AND
Continue living in your own home.

Your SOURCE CASE MANAGER:

_____

SOURCE 24-hour Phone: _____

Your SOURCE DOCTOR:

_____ Phone: _____

Hospital for emergencies:

- - -

Besides treating you when you're sick, your SOURCE doctor will give you ADVICE and TREATMENT in the areas listed on this sheet, areas that are very important for your good health. Also listed are any people who may be helping you with each.

Please call the SOURCE 24-hour phone line before going to the emergency room, unless it is a life-threatening emergency.

Name _____ Date _____

GOOD NUTRITION

Proper meals

_____

_____

HEALTHY SKIN

Checking skin for problems _____

_____

KEEPING IT UNDER CONTROL

____ Blood pressure ____ Blood sugar
____ Weight ____ Unsafe behavior

Monitoring each: YOUR SOURCE DOCTOR

Others: _____

_____

NOTES: _____

_____

Member signature/date_____

Case Manager signature/date_____

MEMBER VERSION

Member: _____ Date: _____

TAKING MEDICINES PROPERLY

Current medications: Contact your case manager or doctor's office.

Drug store used _____

Picking up medicines _____

Help with taking medicines _____

_____

GETTING UP, DOWN AND AROUND SAFELY

EQUIPMENT_____

_____

HELP from another person _____

_____

GETTING HELP IN AN EMERGENCY

Plan for getting help in an emergency:

MEDICAL CALL 911 FIRE CALL 911

HURRICANE OR OTHER NATURAL DISASTER:

_____

TAKING CARE OF MY HOME AND MYSELF

CLEANING

_____

_____

ERRANDS_____

LAUNDRY

_____

BATHING/DRESSING _____

_____

OTHER SUPPORT

_____

_____

SOURCE SUPPORT SERVICES

_____ _____

_____ _____

_____ _____

NOTES:

_____

_____

MEMBER VERSION

Member: _____ Date: _____

CARE PATH VARIANCE REPORT

Carepath Variance Report

SOURCE Member: _____

Year/Quarter:_____**Date:** _____

__Comm __Skin __Clin __ Meds __I/ADLs

__Trans/MOB

__Nutr'n __Behavior __Inf Support __Incontinence

Corrective Action Taken:

Year/Quarter_____**Date:** _____

__Comm __Skin __Clin __Meds __I/ADLs

__Trans/MOB__

__Nutr'n __Behavior __Inf Support __Incontinence

Corrective Action Taken:

CARE PATH VARIANCE REPORT

Year/Quarter_____Date: _____

__Comm __Skin __Clin __Meds __I/ADLs

__Trans/MOB

__Nutr'n __Behavior __Inf Support __Incontinence

Corrective Action Taken:

Year/Quarter_____Date: _____

__Comm __Skin __Clin __Meds __I/ADLs

__Trans/MOB

__Nutr'n __Behavior __Inf Support __Incontinence

Corrective Action Taken:

SOURCE
HOUSING, INCONTINENCE CAREPATHS

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
Member will reside in housing that is safe, affordable and accessible. Issues identified: ___substandard physical structure ___unaffordable not accessible ___geographic isolation ___family/household dynamics other _____ **GOALS:**	___Member preference is to explore relocating to a new home. ___Member preference is to remain in existing home and explore repair options as feasible. **___SOURCE RELOCATION ASSISTANCE:** ___Assess Member's own circumstances, preferences and financial resources for housing. ___Identify a contact person – if available – to explore housing options on behalf of the Member, if applicable. ___Offer list of housing resources maintained by ___For Members with inadequate informal support, review available options. ___Complete application process (gathering necessary documentation).		**MEASURES:** _____ 1st review period (/ /): _ met _ not met _____ 2nd review period (/ / _): _ met _ not met 3rd review period (___/ / ___): _ met _ not met

No reports or observations of the above. .	___Follow-up on application once submitted (review waiting list if applicable, contact regularly to check) ___Relocation checklist: ___security deposit ___utilities ___transfer ___new service (deposit) ___change of address with Social Security, DFCS, etc. ___notification of providers		

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
Member will reside in housing that is safe, affordable and accessible. (CONT'D, Page 2)	Moving arrangements: ___family/informal support ___PSS aide; provider _____ Date moved: _____ Date refused to relocate: _____ ___**HOME REPAIR, renter:** ___Broadly describe nature of repairs needed: ___structural ___electrical ___plumbing ___infestation ___heating/cooling ___major accessibility modifications ___other_____		**MEASURES:** 1st review period (___/___/___): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met

	___Identify informal support to provide assistance, if available. _____ ___Provide SOURCE resources to informal support. ___Obtain permission to contact landlord if applicable, if no informal support available for this assistance.		

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
Member will reside in safe, affordable and accessible housing. (CONT'D, page 3)	___Identify and contact landlord, describing nature of need repairs. ___One-month follow-up ___repairs acceptable____/____/____ ___repairs in progress____/____/____ ___no repairs initiated____/____/____ ___Notify appropriate authority: ___City Inspection Department___/___/___ (structural, plumbing, wiring) ___Health Department___/_ /___ (infestation, sewage) ___Fire Department___/___/___ (electrical, wiring, smoke alarms) ___One month follow-up with Member ___repairs in progress/completed ___repairs not initiated ___Re-contact appropriate authority		**MEASURES:** 1st review period (___/___/____): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met

	Final disposition: ___repairs made ___repairs not made ___Member preference is to relocate (see relocate plan)__ ___Member preference is to remain in home under present conditions		

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
Member will reside in safe, affordable and accessible housing. (CONT'D, page 4)	___**HOME REPAIRS, owner:** ___Review Member/family personal resources for home repair ___If unavailable, identify a family member capable of pursuing other options for Member ___Provide SOURCE collection of local resource information. ___Broadly describe nature of repair work needed ___structural ___electrical ___plumbing ___infestation ___heating/cooling ___major accessibility modifications ___other_____		**MEASURES:** 1st review period (___/___/___): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met

	___Explore available funding from other sources: _____		

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	Quarterly Reviews
Member will reside in safe, affordable and accessible housing. (CONTD, page 5)	__One month follow-up ___repairs acceptable / /__ ___repairs in progress / /___ ___no repairs initiated / /__ ___Re-contact appropriate funding source __Final disposition: __repairs made __ repairs not made ___Member preference is to relocate (see "Relocation" section) ___Member preference is to remain in home under present conditions		**MEASURES:** 1st review period (_/_/_) : __met __not met 2nd review period (_/_/_): __met __not met 3rd review period (_/_/_) : __met __not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE	FUNDING	QUARTERLY REVIEWS
Member's incontinence will be managed to promote skin integrity and adequate personal hygiene. **GOALS:** **A. Member has no skin breakdowns or decubiti requiring clinical intervention/wound care** **B. Member maintains acceptable personal hygiene (no perceptible odor, etc., and no reports by Member or caregiver/provider/PCP).** **C. Member has no infections/complications OR frequency of infections decreased for persons with catheter.**	___**paper continence products** supplier:____Member/informal caregiver ___Community Benefits ___assistance by informal caregiver ___ assistance by PSS aide provider: schedule: ___ **catheterization** ___ in-and-out ___assistance by informal caregiver ___ assistance by LPN/RN provider: schedule: ___in-dwelling ___assistance by informal caregiver/SFC ___assistance by RN/LPN provider: schedule: ___external ___assistance by informal caregiver		**MEASURES:** 1st review period (___/___/___):_ A. A. __met _ not met B. __met _ not met C _ met _ not met 2nd review period (___/___/___) A. met _ not met B. _ met _ not met C. _ met _ not met 3rd review period (___/___/___):

	___assistance by PSS aide provider: schedule: ___SFC ___ostomy ___Member/caregiver education ___SOURCE PCP ___SOURCE RN ___self-care Assistance required: ___assistance by informal caregiver ___assistance by PSS aide provider: schedule: ___assistance by LPN/RN provider: schedule: ___Assistance by SFC		A. __ met _ not met B. __ met _ not met C. __ met _ not met 4th review period (___/___/___): A. __ met _ not met B. __ met _ not met C. __ met _ not met

Monthly Contact Assessment

Member Name:

Assessment Visit Date

Case Management Worker

Call Type: To client/caregiver ☐ From client/caregiver ☐ To/from provider ☐

Contact Name:

Relation (if caregiver):

Topic(s) of Discussion: choose all applicable-

☐ Caregiver issue ☐ Client Complaint/Concern ☐ DME Issues

☐ ERS transmitter monthly test requirement ☐ Fall(s) ☐ Family Issue ☐ Home Environment Issue

☐ Hospitalization(s) ☐ Emergency Room-no admission ☐ Medical Appointment Compliance

☐ Non-waivered services ☐ Provider Complaint/Concern ☐ Service Issue/Service Changes

☐ Support System changes(s) ☐ Other

Issues/Problems addressed/discussed

SOURCE QUARTERLY CONTACT

Use this form for Case Management **Quarterly Contact Sheet.** May use this form **or Quarterly Alternate** for **quarterly reviews**. Review these areas with member or member's caregiver each month. See section 1302

Member Name _____DOB_____ PCP:_____

Services Receiving _____

Significant Diagnosis:_____

Column A	Column B	Column C
PROCESS **See Policy 1302**	**1st 2nd 3rd 4th (circle quarter)** **QUARTERLY OBJECTIVES** **Circle Variances**	**MONITORING/CASENOTES** **√: if GM goals met. CN: see case notes. NA: not applicable**
Quarterly Contacts **Circle Specifics below:**	**I have Reviewed with the member:** **Community Services:**	*Quality Service Level provided? Complaints?*
	Medical Appts and Dates: **☐ PCP or ☐ Specialist**	Document reason and outcome of appt i.e. new diagnosis, meds, referrals etc. or NO APPTs
	Emergency Room Visit or Hospitalizations	*Document number, reason , outcome if any of these occurred*
Quarterly _____ DATE **Other** _____	**Diet and Nutrition Goals:**	*Weight stable, feeding problems, following diet*
	Skin Integrity Goals:	*Details for any skin openings or decubiti: ie stable, worsening, new*
	Clinical Goals	*Is blood pressure, blood sugar or other within goal?*
	ADL/IADL Goals	*Any disruptions in ADL or IADL maintenance?*
Home Visit or Phone or Other_____	**Transfer and Mobility Goals**	*Any falls or concerns with Transfers or Mobility?*
_____Copies of Advance Directives received, if applicable	**Behavioral Goals:**	*Any problem behaviors?*
	Care Giver Support Goals	*Informal caregivers maintained in member's life?*
Any Variances Yes No **Document # of Variances (In Quarter) ___**	**Incontinence Goals:** **☐ Ostomy or Catheter**	*Incontinence issues including supplies*
	Medications **(update list from chart)**	*Adherence issue? Problems?*
	Disease Management (DM) (Does member Have or Need DM with PCP)	*Is Intervention needed? What will be done?*
Any Incidents this /Quarter? Yes No **# of Incidents**	**Notes** (*include resolution of last month's variances, if any, teaching done on DM*)**:**	
	Appropriate follow up actions/ interventions needed:	

Section D

SOURCE QUARTERLY CONTACT

CM Signature and Date	Member Signature and Date (if face to face)
CM Supervisor Signature and Date (quarterly)	

Case Management Agency Monthly Report

1.Agency Name: _____ 2.Report Month: _____

3.Submitted by: _____ 4. Today's Date/ Year:_____

Provide member counts for the report month as follows:

5. Previous Month Total Members: _____
6. Members Admitted during report month: _____
7. Members Discharged during report month:_____
8. Current Active Members: _____

8a. Unduplicated Members with yearly "Flu Shot" _____
8b Total members who received "flu shot" (add 8a + any members from previous months as applicable. _____
9. Unduplicated total _____
10. Reason(s) Discharged (include number for each)-

Nursing Facility: _____
Deceased: _____
Moved out of Service Area: _____
Hospice: _____
Member Choice: _____
Non-Compliance: _____
Lost SSI/Related Eligibility: _____
Lost Level Of Care_____
Other (specify):

Wait List Data:

11. Total Number on the Wait List: _____
12. Wait List Report by DON-R Score:

DON-R Score	# Members on WL	DON-R Score	# Members on WL

Programmatic report is due to: Department of Community Health, Division of Medicaid, SOURCE Program Specialist no later than the 15th of the month following the report month. EPCMM agencies with multiple locations will complete one programmatic report.

Instructions for SOURCE monthly report:

The purpose of the report is to keep track of how many active members your SOURCE site currently serves (members locked into your site), how many unduplicated members the Site has served to date, track the reason why members discharge from the program, and track the number of members in process to receive service.

Instructions:

1. **Agency Name**

   Insert the SOURCE case agency name here.

2. **Report month.**

   The month the data gathered and submitted for the report. Member information gathered in April would equal an April Report Month.

3. **Submitted by**

   Who is responsible for this data or who compiled the report.

4. **Today's Date and Year**

   The date the report is submitted.

5. **Previous month total**

   Represents the current number of members active on the previous month report.

6. Members Admitted during report month

Number of new members who became locked into your site during the month. (This includes anyone locked in during the report month who were retro locked back to a previous month.)

7. Members Discharged during report month

If you sent in a discharge and DCH closed the span.

8. **Current Active Members**

Active members equal #5 + #6 - #7. (Number of members locked into your site as of the last day of the report month)

8a. Members unduplicated who received influenza vaccine the month of the report in that SFY.

8b. All members who received influenza vaccine for this season. Season starts July of the calendar year to June 30th of next calendar year.

9. Unduplicated total equals #5 (previous month total) + #6 (members admitted during report month)

10. Reason(s) Discharged (include number for each

Self-explanatory Numbers must equal number discharged.

Wait List Data (WL)

11. Total Number on Wait List:

Anyone screened during the report month and any members pending lock in from previous months. If score is less than 15, there is no need to put on the waiting list.

12. Wait List Report by DON-R Score

The agency may devise a span of scores to group member data on this list or report by individual score.

	Column1	2021 July	august	sept	oct	nov	december	2022 Jan	feb	march	april	may	june	Totals	Column2
	Prior Mo Undup													0	
5	Prev Mon Tot Membr													0	
6	Mmbr admit drng report Mo													0	
7	Mem D/C During Rprt Mon													0	
8	Current Activ. Mem													0	
8a	Mem with flu shot (RESTART JULY)													0	
8b	Total members with flu shot														
9	Undup total														
10	Reasons Discharged													Totals	
a	Rehab													0	
b	Nursing Facility													0	
c	Deceased													0	
d	Moved out of Area													0	
e	Hospice													0	
f	Member Choice													0	
g	Non-compliance													0	
h	Lost Elig or SSI													0	
i	Lost Level of Care													0	
j	Other (specify)													0	
	Unabe to locate													0	
	Other Waiver													0	
	Nonapproved PCH													0	
	Needs too Great													0	
	Transfer to another SOURCE													0	
	(total)														
	SPECIFICS : (write in short term: ie transf.														

11	Wait List Report by DON-R Score:	Members July 2021	Members Aug	Members Sept	Members Oct	Members Nov	Members Dec	Members Jan 2022	Members Feb	Members Mar	Members Apr	Members May	Members Jun		
	0-14														
	15-24														
	25-34														
	35-44														
	45-54														
	55-64														
	65-74														
	>74														
12	Total on wait list														
	Case Managers	2021 July	august	sept	oct	nov	december	1-Jan	feb	march	april	may	june	Total	
	New Case Managers														
	Prior Month Staff														
	Total Case Managers														
	CM Certification														
	New CM Training														

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

SOURCE Admission Wait List

Date

SOURCE Site Name

Location *(if reporting by site)*

			Determination of Need - Revised			
Applicant Last Name	First Name	Medicaid #	Level of Impairment	Unmet Need for Care	Total Score	DON-R Date

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

SOURCE Admission Wait List

DATE:

SOURCE Site Name **Location** *(if reporting by site)*

			Determination of Need - Revis		
Applicant Last Name	First Name	Medicaid #	Level of Impairment	Unmet Need for Care	Total Score

ed

DON-R Date	PA Number	Date Uploaded	Status

EDWP Modified Reassessment

Section A. Identification Date of Visit_____

Member Name: _____ DOB _____ Medicaid number _____

Place of Assessment: ☐ Home ☐ Hospital ☐ Nursing Home ☐ ALS/PCH ☐ other _____

Section B. Reason for evaluation

☐ Discharged from Nursing Facility ☐ Discharge from institutional stay (mental health) ☐ Internal Transfer

☐ External Transfer ☐ Change in function (cognitive or physical) ☐ Other _____

Section C. Diagnoses (if applicable, include diagnosis relevant to nursing facility or institutional stay and/or change in function)

1. _____ 2. _____ 3. _____

Section C. Carepath Goals

Community	Service Recommended	Provider	Frequency/Units
Nutrition/Weight	Ordered diet: _____ ☐ Weight gain (90 days) ☐ Weight Loss (90 days)		
Skin Care	☐ No skin breakdown ☐ Decubitus ulcer/stage and location _____ ☐ Other wound/ulcer (specify) and location _____ ☐ Wound care provider and frequency _____		
Clinical Indicators	☐ Self-monitoring ☐ BP ☐ Blood sugar ☐ Weight ☐ Other _____ ☐ Assisted monitoring ☐ Dialysis ☐ Chemotherapy/radiation ☐ Oxygen Nursing Facility admit date_____ discharge date _____		
Medication	☐ Self-monitoring ☐ Compliant ☐ Noncompliant ☐ Needs assistance ☐ Medication list updated		
ADL/IADL Performance (S-Self; INF-informal support; PSS)	____ bathing __dressing ____ eating ____ transferring _____ toileting ____ walking _____ managing finances _____ errands ____ meal prep _____ laundry _____ shopping _____ transportation		
Transfers	☐ cane ☐ walker ☐ wheelchair ☐ bedbound ☐ other _____ ☐ fall in 30 days ☐ fall in 90 days ☐ fall with injury in 90 days _____		
Problem Behavior	☐ Alzheimer's ☐ Dementia ☐ mental health ☐ substance abuse ☐ depression ☐ Other _____		
Informal Support/Caregiver	☐ indicators present for caregiver burnout ☐ adequate caregiver support/name _____		
Other – Continence, Housing, Hospice, other	☐ UTI/other urinary related infection ☐ Urinary Incontinence ☐ Bowel Incontinence ☐ Request to move ☐ Dual enrollment hospice/provider _____		

Additional information (i.e. home health, PT, OT, ST, etc.)

_____

_____

_____

Member signature _____ **Date** _____

LPN/RN Signature _____ **Date** _____

Supervisor Signature _____ **Date** _____

MEMBER CHOICE OF PROVIDER FORM

Member:_____ Date: _____

Issues Noted	Services Recommended	Provider	Frequency	Participant Feedback

_____ _____

Member Signature Date

_____ _____

Case Manager Signature Date

SOURCE Referral Form

SOURCE Member _____ Date _____

Social Security No._____ Medicaid No._____

Address_____ Phone No._____

_____ Medicare No._____

_____

Diagnosis Code _____

SOURCE **Service Prior Authorization Number** _____

Service Prior Authorization Effective Date _____ Expiration Date _____

Directions to home_____

Primary Contact and Relationship_____

Primary Contact Phone Number _____

Primary Contact Address _____

Services Requested:

Adult Day Health_____

Provider _____Frequency_____

Level 1 Full Day_____ Level II Full Day_____
Level 1 Partial Day_____ Level II Partial Day_____
Physical Therapy_____
Speech Therapy_____

Alternative Living Service_____ Provider_____

Group Model_____ Family Model_____

Respite Services_____

Provider _____Frequency_____

Out of Home Respite (12 hours) _____
Out of Home Respite (8 hours maximum, 3 hours minimum)_____

Structured Family Caregiving _____

Provider _____

Member Medicaid Number _____

Personal Support Services (PSS) _____**Extended Personal Support Services (EPS)**_____

Provider _____

PSS Frequency_____

EPS Frequency _____

Emergency Response System_____

Provider_____

Installment_____ Monitoring Monthly_____

Home Delivered Meals_____

Provider _____ Frequency _____

Comments: _____

Medicaid Home Health (75 units of service)_____

Provider _____

Skilled Nursing Visit_____
Physical Therapy Visit_____
Occupational Therapy Visit_____
Medical Social Services_____
Home Health Aide_____

Level of Care is approved through _____

Services to Begin: _____

Member is under administrative review. Please continue services until: _____

Comments:

SOURCE Site _____
Case Manager Signature/Title_____ Date_____

DISCHARGE PLANNING CHECKLIST

Assessment Date _____

Member's name: _____ DOB: _____ Date of Admission to Waiver: _____

	Discharge Planning	Yes	No	Comments/other
1.	Is member able to participate in discharge planning process? If no, provide rational in comments.			
2.	Is caregiver assisting with discharge planning if client is unable to assist?			Name and relationship to member:
	Backup Care			
3.	Can member safely be left alone? If yes, check appropriate time in comments.			☐ < 1 hour ☐ > 2 hours, but less than 8 ☐ 1-2 hours ☐ 8 hours or more
4.	Is there an alternate plan for support in absence of the formal caregiver? List name, phone number, address, time alternate plan/support available			☐ _____ days ☐ ____ months ☐ _____ weeks ☐ Indefinite/flexible
5.	Is alternate support available to provide nighttime care? List name and phone number if different than number 4.			
6.	Does the member have emergency placement available in the event the home had to be evacuated quickly? List name, phone number, address.			
	Member Preferences for Care Following Discharge from Waivered Services			
7.	Family (formal support) – Name (first, last)			Care Provided (circle all that apply) ADL support IADL support
	Location of care (circle all that apply) Member's home Family's home			Other: (address if other than member's home)
8.	Nursing Home (Name and contact number)			County
9.	Community Resources (check yes/no if needed after discharge and include contact information)	**Yes**	**No**	Contact Information
	Food			
	Emergency Shelter			
	Personal Support (ADL\IADL care needs)			
	Transportation			
10.	Private Arrangements/Friends/Church/other assisting with care needs			Contact information (phone number)
	a.			
11.	Services received and requiring a physician's order upon discharge in order to continue: (home health, rehabilitation, referrals, other)			Contact Information: phone number/address
	a.			
	Follow Up			
12.	MD name and phone number	MD address:		

Other discharge resources/plans/instructions

Date Copy of DC Plan Given to Member _____ ☐ Mail ☐ Hand Deliver ☐ Other_____

Date of Follow Up (if applicable) Pending Discharge _____ RV Date pending