

PART II

POLICIES AND PROCEDURES
for
INDEPENDENT CARE WAIVER SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAID

April 1, 2023

Policy Revisions Record
Part II Policies and Procedures Manual for Independent Care Waiver Services

2022-2023

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added D=Deleted M=Modified	(Revision required by Regulation, Legislation, etc.)
4/1/2023	902.2, C, 2	Added EVV Non-compliance consequences	A	Policy
4/1/2023	604.1, B, 8	Added Member Responsibility to allow in person case management visits	A	Policy
4/1/2023	Appendix B	Revised Rights and Resp Form- added member responsibility to allow in person visits	M	Policy
4/1/2023	Appendix F-1	Added Informed Consent Form	A	Policy
4/1/2023	902.1, I, t	Added CM responsibility to obtain a signed Informed Consent form at in-person visits	A	Policy
4/1/2023	Appendix W	Removed Relative Caregiver Request Form	D	Policy
4/1/2023	1002.3, C, 1	Revised Relative Caregiver requirements	M	Policy
4/1/2023	902.1	Reorganized Case Management Section	M	Policy
4/1/2023	702.4 Waiting List	Added Waiting List Procedure	A	Procedure
4/1/2023	702.3, A, 2	Added Screening Tool is the DON-R	A	Procedure
4/1/2023	701, D	Removed Cognitively alert requirement	M	Policy
4/1/2023	602.4, E	Updated Mailing Address	M	Procedure
1/1/2023	Appendix D	Updated Participant Assessment Form	M	Policy
1/1/2023	902.10, 6	Updated Respite Levels of Service	M	Policy
1/1/2023	Appendix D-1	Updated Personal Needs Allotment Form	M	Policy
1/1/2023	602.2	Updated Provider Enrollment procedures	M	Policy
1/1/2023	Appendix A-1	Added Provider Enrollment Checklist	A	Procedure
1/1/2023	Appendix A-2	Added Standard Assurance Forms	A	Policy
10/1/2022	Appendix H-1	Revised Carepath- New Goals added	M	Policy
10/1/2022	902.5 F	Modified Home Modification Policy	M	Policy
10/1/2022	902.2 G	Added PSS Monitoring Requirement	A	Policy
10/1/2022	902.2	PSS not allowed in PCH	A	Policy
10/1/2022	902.12-F	Revised Enhanced CM educ requirement	M	Policy
10/1/2022	902.1 2-E	Revised CM experience requirement	M	Policy
10/1/2022	902.1 t Specific Resp	Revised CM Visit Requirement	M	Policy
10/1/2022	1002.3 A	Revised claims not allowed while in facility	M	Policy
7/1/2022	701, B	Age requirement aligned with the Waiver	M	Policy
7/1/2022	902.2, G	Added PSS Travel regulation	A	Policy
7/1/2022	902.2, 3, A	Clarified PSS required training	M	Policy
4/1/2022	702.3	Clarified Selection Procedures, added use of LOC screening tool score for waiting list priority	M	Policy
4/1/2022	902.9, G	Added section- location of ADH must be separate from ALS	A	Policy
4/1/2022	902.5, F	Added Home mod rental agreement and exclusion of provider owned homes	A	Policy
4/1/2022	902.5, A	Updated Environmental Mod definition	M	Policy
1/1/2022	Appendix O -1	Added Public Health Emergency temporary rate increase table	M	Policy

1/1/2022	902.1 Specific Resp	Removed reference to an AHS social worker	M	Policy
1/1/2022	902.2 E	Clarified GChex requirement for PSS employees	M	Policy
1/1/2022	Appendix V	Edited Waiver transfer form	M	Policy
1/1/2022	703 F	Removed reference to an AHS social worker	M	Policy
1/1/2022	703 D	Removed reference to an AHS social worker	M	Policy
1/1/2022	1004	Added PSS Rounding Rules	A	Policy
10/01/2021	702.3, B	Added to Selection procedures that AHS may request medical records to determine LOC	A	Policy
10/01/2021	Appendix O	Removed outdated rate codes	M	Policy
10/01/2021	Appendix H-2	Revised title to Equipment sheet	M	Policy
10/01/2021	Appendix P, Employer Eligibility Requirements, 9, H	Added CD employee physical and TB screening requirement	A	Policy
10/01/2021	902.2, C	Added GA Lifeline information	A	Informational
10/01/2021	Appendix Z	Added Form – Member Acknowledgement of Receipt of Forms	A	Policy
10/01/2021	902.1, Specific Responsibilities, z	Added CM responsibility to obtain the Member Acknowledgement of receipt of forms	A	Policy
10/01/2021	Appendix E	Added DMA – 6 revised 8/11/21	M	Policy
7/1/2021	Appendix P	Added EVV requirement. Removed references to paper timesheet requirements	M	Policy
7/1/2021	Appendix P-1	Added use of EVV requirement. Removed references to paper timesheet reporting	M	Policy
7/1/2021	Appendix P-2	Removed reference to timesheet	M	Policy
7/1/2021	Appendix C-1	Removed reference to timesheet	M	Policy
7/1/2021	1002.3	Removed reference to timesheet	M	Policy
7/1/2021	602.1, O	Added Incident Report Training requirement for new providers	A	Policy
7/1/2021	902.7, H, 1	Clarified replacement of ERS equipment responsibility	M	Policy
7/1/2021	902.8, E, 5	Changed “psychologist or psychiatrist” to “practitioner”	M	Policy
7/1/2021	Appendix Q	Removed old GA Families flyer, added new flyer	M	Policy
4/1/2021	902.2 C	Added EVV requirement to PSS	A	Policy
4/1/2021	1001	Added EVV requirement for PSS reimbursement	A	Policy
4/1/2021	902.2 D Note	Added Note to address use of personal cars by PSS staff	A	Policy
4/1/2021	Appendix M	Replaced NEMT Appendix with current release	M	Policy
4/1/2021	Appendix H-4	Added Case Management document checklist	A	Policy

PREFACE

Independent Care Waiver Services

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

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

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

PART II

POLICIES AND PROCEDURES

FOR

INDEPENDENT CARE WAIVER SERVICES

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PART II - CHAPTER 600

ICWP SERVICE OVERVIEW

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

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

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

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

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

- A) To provide quality services, consistent with the needs of the individual member, which are effective in developing, improving and maintaining the member's independence to live actively, safely and successfully in the community.
- B) To provide cost effective services to assist individuals in living as independently as possible in the home and community.
- C) To involve the member or member's representative in the provision and decision-making process regarding member care.
- D) To demonstrate compassion for those served by treating members with dignity and respect while providing quality services.

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

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

601.1 Structures and Administration of the Program

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

- 7/11 A) The Division of Medicaid is responsible for the overall coordination, administration, and quality assurance of the program. The Division is responsible for enrollment and reimbursement to providers for services provided to those members who have applied and been approved for the Program. The Division conducts utilization reviews of providers to assure that only authorized and appropriate ICWP/TBI services are delivered.
- 7/11

Rev. 04/11

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

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

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- D) The Healthcare Facility Regulation Division (HFR), in the Department of Community Health, licenses and monitors private home care providers.
- E) Alliant Health Solutions is under contract with DMA to assess applicants, maintain the waiting list and authorize reimbursement to Medicaid providers. . Alliant Health distributes information about enrollment, reviews enrollment packets for submission requirements and trains Medicaid providers in the billing process.

- F) The Case Manager arranges, coordinates, and monitors the delivery of services to the ICWP/TBI member. The case manager also provides the member and member representative with resource information regarding home and community living. The member's Physician, familiar with the specific health and service needs of a member, provides the required medical information, and consults with the case manager and Alliant Health as requested.
- G) Service Providers enrolled in ICWP/TBI deliver services as ordered on the care plan developed by Alliant Health and the case manager. By sharing information with the case manager, service providers are a vital component of the member's care team.

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

601.2 Services of the Program

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

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

7/11

- A) Case Management assists eligible members in gaining and coordinating access to needed medical, social, educational and other needed services. Case management is the focal point for service planning and delivery through the ICWP/TBI.
An Application to enroll as a case manager will be denied if the Division determines that the potential for conflict of interest exists.
Case managers are required to be available to members seven days a week, twenty-four hours a day. If a case manager is temporarily unavailable to a member due to a planned or an unforeseen event, an alternative plan must be made so that another case manager is accessible at all times. The case manager's absence not of a short duration is not considered temporary. The case manager's absence due to employment, extended absences for other reasons does not meet program requirements. If the case manager becomes unable to provide case management services, the case manager must notify the Division so that members can select another case manager.
- B) Adult Day services provide specialized treatment techniques for members with traumatic brain injuries in congregate community based settings. Adult Day Services provide training to reduce inappropriate and/or maladaptive behaviors and behaviors which prevent effective use of community resources.
- C) Behavior Management services provide individualized interventions designed to decrease the member's severe maladaptive behavior, which, if not modified, decreases the individual's ability to remain in the community.

- D) Respite Care services provide temporary relief for the individual(s) normally providing care.
- E) Skilled Nursing provides treatments and health care procedures ordered by a physician, monitors the member's health care condition and trains other Independent Care service providers in areas within the scope of nursing such as dietary practices, sanitation and use of emergency medical services.
- F) Counseling services assist members with developmental or physical disabilities in understanding their capabilities and limitations and addresses problem of adjustment in their interpersonal relationships.
- G) Environmental Modification services provide physical adaptations to the home, specified in the Individual Plan of Care, which are necessary to ensure the health, welfare and safety of the member, or which enable the member to function with greater independence in the home and, without which, the member could require institutionalization. Medicaid does not reimburse for modification to rental property.
- H) Personal Emergency Response System provides two-way verbal and electronic communication with a central monitoring station seven (7) days a week, 24 hours a day to geographically and socially isolated members and lessens the need for 24 hours of care.
- I) Personal Support Services (PSS) provide personal care tasks such as assistance with eating, bathing, dressing, personal hygiene, preparation of meals, light housekeeping tasks, and other activities of daily living.
- J) Specialized Medical Equipment and Supplies provides services for devices, controls, or appliances, specified in the Individual Plan of Care, which enable members to increase their abilities to perform activities of daily living or to perceive, control, and communicate with the environment in which they live. Ceiling track is not covered Medicaid equipment.
- K) Consumer Directed Care Option (personal Support Services) allows individuals to direct their own care, by hiring training and terminating their care givers. A care giver must assist or provide care for the member as define under personal support services.
- L) Financial Support Services/ Fiscal Intermediary (FI) Services are provided to assure that consumers' funds outlined in the Plan of Care are managed and distributed as intended.
- M)

602. Conditions of Participation

All Medicaid providers must comply with the requirements in Part I of the Policies and Procedures for Medicaid and PeachCare For Kids Manual.

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

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

602.1 General Conditions

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

A) Legal Right to Perform Business in the State Of Georgia

1. Authorization Document – The service provider, if incorporated, must submit a copy of its Annual Corporate Registration from the Office of the Secretary of State, and its current business license or other proof of legal authorization to conduct business in the state of Georgia.
2. Licensure – If state or local law requires licensure of the agency, organization, facility or staff for the service the agency wishes to provide, the service provider must submit proof of licensure to the DMA, upon application and annually thereafter. The service provider must post current licensure in a conspicuous location open to public view. Licensure requirements for each service are included in Chapter 900.

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

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

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

C) Management Capacity – The enrolling entity must have operated in its current business form and provided services for individuals with physical disabilities and/or traumatic brain injuries for at least three (3) years AND an individual with an ownership stake must have three years management experience in a health care facility (hospital, nursing home, home health company, or hospice). A resume and a list of references are required at the time of application.

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

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

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

- a. Scope of services offered;
- b. Admission and discharge criteria;
- c. Supervision of services;
- d. Care of members in an emergency, disaster plan;
- e. Clinical records management, including progress notes and retention of records;
- f. Administrative/Personnel records and supervision;
- g. Use and maintenance of supplies and equipment (if applicable); and
- h. Coordination of member care with physicians, case managers, and other service providers

G) Performance Policies and Procedures - The service provider must assure that policies and procedures exist to assure:

- a. Coverage if staff fail to report to duty; and
- b. Quality of service performance.

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

I) Business Hours/Business Location - The service provider must be open for business during normal business hours to ensure access by members during waking hours (generally 8 a.m. to 5 p.m. or 9 a.m. to 6 p.m.) to agencies,

organizations and businesses with which services must be arranged, brokered, coordinated or planned for members.

10/11 In addition, telephone coverage must be provided a minimum of 8 hours per day Monday through Friday during normal business hours to ensure access by members, agencies, businesses and the general public. Telephones must be answered during business hours in a professional manner by identifying the business and the individual who is answering the telephone, unless absence from the office requires the use of an automated answering machine, voice mail, or answering service.

10/11 An automated answering machine or any other answering device which answers during business or non-business hours must identify the business.. The answering device must inform the caller of a secondary contact such as a cell phone or pager or must allow for a message to be left and inform the caller of the approximate time to expect a returned telephone call . Any ICWP provider not in compliance with these procedures does not meet requirements for answering the telephone in a professional manner.

7/13 Providers of ICWP services, except case management, must operate their ICWP business at a location that is designed for business use. For example, in a business office park, business district or free-standing location designated for business separate from the provider's home. The business location must be conducive to conducting routine program management activities with employees, agencies, organizations or others with which coordination of care or services must be arranged or planned. This includes employee orientation and training, in-service education and other types of training and personnel matters. If the ICWP Case Manager provider employs case managers, they too must meet business location requirements as reflected above. Business operations of the ICWP is not permitted in the provider's home nor any other site that does not meet requirements as reflected above.

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

- a. Case Management
- b. Personal Support Services
- c. Personal Emergency Response System
- d. Respite Care Services
- e. Skilled Nursing

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

K) Response Time – Case managers and service providers must respond to calls from members/representatives and/or families requesting assistance, within 30 minutes of the contact in emergency situations. For routine requests, case managers and service providers must respond to calls from members/representatives and/or families requesting assistance within 24 hours.

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

- a. Prohibit individuals with a prior conviction on charges of abuse, neglect, mistreatment, or financial exploitation from performing direct member care duties;
- b. Require all critical and non-critical incidents, as outlined in Section 604.2, to be reported within 24 hours or one (1) business day of the incident or discovery of the incident to the Department. Notify all appropriate parties in accordance with state law. Investigate the incident with involvement of appropriate parties while taking immediate steps to protect the waiver participant's health, safety and welfare. Submit the Follow-Up and Interventions Report to the Department within seven (7) business days of submitting the incident report. Participate in regulatory agency investigations, when applicable and take appropriate a corrective action if alleged violation is verified.

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

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

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

Newly enrolled providers must review the DCH HCBS Incident report system information and instructions that are posted on the DCH website:

<https://medicaid.georgia.gov/programs/all-programs/waiver-programs/hcbs->

[incident-reporting-system-resources](#). Completion of this review and familiarity with this system must be in place before providing services to ICWP members. Newly enrolled Case Managers must send their contact information that is to be used in the incident report system to the ICWP program specialist.

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

- P) Guardianship- ICWP providers may not serve as a legal guardian and/or power of attorney for ICWP members.
- Q) Insurance Coverage--The applicant must submit proof that the provider agency has at least \$1,000,000 in general liability insurance coverage. In addition, Private Home Care providers must submit proof of their agency's worker's compensation insurance coverage. Proof of liability insurance is required at enrollment, expansion and annual re-validation.

4/1/19

602.2 Enrollment Procedures

- A. Private Home Care Providers who want to provide Personal Support Services are limited to the month of January to complete an application. All other providers can apply at any time.
- B. Before completing an online application potential providers must review all of these items:
1. Part I Medicaid and Peachcare for Kids Policies and Procedure Manual
 2. Part II Independent Care Services Policies and Procedures Manual or Part II Independent Care Services Alternative Living Services Policies and Procedures Manual
 3. Appendix A-1. This chart lists all the documents and information that potential providers must provide for each specialty at enrollment. Review the chart and prepare to upload all the documents per your specialty into the online application. If all the documents are not provided at the time of the application your application will be considered incomplete and will be withdrawn.
- C. Providers applying to be a Fiscal Intermediary please see Appendix P-1.
- D. Complete an online application on the MMIS website at www.mmis.georgia.gov. Select the tab labeled "Provider Enrollment" and use the enrollment wizard. Select Facility > Home and Community Based Services > ICWP > select your specialty. Providers may submit applications and track progress of an application via the Internet. Gainwell Technologies will acknowledge in writing the receipt of enrollment application.
- E. After completing the online application potential providers must email the Application Tracking Number (ATN) to the ICWP inbox at

ICWP.documents@dch.ga.gov and attach the documents or information listed in Appendix A-1 per specialty.

F. The application and documentation will be reviewed by the credentialing verification organization. If approved by CVO, the Provider Enrollment Team will review the application and documents for eligibility. If all the documents required for each specialty (Appendix A-1) are not provided, the application will be withdrawn. If the documents are provided, but the applicant does not qualify, the application will be denied. Gainwell Technologies will send notification of application disposition.

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

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

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

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

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

Providers must send a detailed resume at the time of submitting the application.

7/11

NOTE:

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

602.4 Changes in Enrollment Data

A) Change in Ownership or Legal Status or Buy Out

Any enrolled service provider or case manager undergoing a change (including, but not limited to, dissolution, incorporation, re-incorporation, reorganization, change of ownership of assets, merger or joint venture) so that, as a result, the provider becomes a different legal entity, must furnish written notice to the Department of

Community Health, Healthcare Facility Regulation Division if licensure is applicable, ICWP/TBI members and case managers, at least thirty (30) days prior to the change. (See Section D for addresses.) The successor provider must submit a new application for enrollment as a provider of the service under the ICWP.

NOTE:

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

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

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

B) Change in Provider Data

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

- 1) Correct address of the agency/business location;
- 2) Correct street address of the service location, if different from above;
- 3) Current phone number(s); and
- 4) Name of contact person(s).

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

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C) Termination of Provider Number/Enrollment in ICWP/TBI

1) Provider-Initiated Termination

- A) A provider (including case managers) seeking to terminate enrollment in the ICWP/TBI must provide written notice to the Department of Community Health, and the Alliant Health Solutions no less than sixty (60) calendar days prior to the

termination date, stating it intends to terminate participation in the ICWP. (See Section D for addresses.)

- B) Alliant Health will notify case managers of the service provider's intent to terminate enrollment.

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

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

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

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

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

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

2) Termination of Provider Number/Enrollment by the DCH

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

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

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

**Department of Community Health /Division of Medicaid
Attention: ICWP/TBI Program Specialist
2 Martin Luther King Jr Drive, SE
Floor 19
Atlanta, Georgia 30334**

and

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

Also report to the change to HFRD if permitted by HFRD

Department of Community Health, Healthcare Facility Regulation Division
2 Martin Luther King Jr Drive, SE
Floor 17
Atlanta, Georgia 30334

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

602.5 Records Management

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

A) Records Retention

- 1) The provider must maintain current clinical records for active members and organize the clinical records for easy reference and review. For discharged members, the provider must maintain the clinical record for a minimum of five (5) years from the last date of service. This policy applies even if the provider ceases operation. (Refer to Part I, Medicaid/PeachCare for Kids Policies and Procedures manual.)
- 2) In accordance with 45 CFR Part 17, the state and federal governments shall have access to any pertinent books, documents, papers, and records for the purpose of making audit examinations, excerpts, and transcripts. The provider must retain records for five (5) years after submission of the final claim for payment. If any litigation, claim, or audit is initiated before the expiration of the five-year period, the provider must retain records until all litigation, claims, or audit findings involving the records are resolved.

B) Destruction of Records

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

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

603. Adverse Actions

603.1 Conditions of Adverse Action

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

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

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

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

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

- 1) Utilization review reports or other audits conducted by the Department of Community Health.
- 2) Reviews and site visits conducted by HFR within the Department of Community Health.
- 3) Reports from members, member representatives or member families, case managers, and other providers.

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

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

If the service provider experiences temporary staffing problems and is

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

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

- C) Failure to Maintain Quality of Care – Care and/or services provided are of such poor quality that the health, safety or welfare of members is placed at risk.
- D) Failure to Maintain Current Licensure – Failure of service provider personnel to maintain current licenses required by Georgia law.
- E) Failure to Act on Charges of Abuse, Neglect of Care or Exploitation of Members – Failure of a service provider to take measures to report and/or stop identified known abuse, neglect or exploitation of members.
- F) Failure to Respond to an Adverse Action – Failure of a service provider to submit a timely plan of corrective action or any other reports or documentation as requested or required by the DCH.
- G) Refusal of Access to Member and Member Records – Failure of a case manager, service provider or its subcontractor(s) to permit staff or contracted personnel acting on behalf of the state of Georgia access to members, member records or other documentation required by participation in the ICWP/TBI.
- H) Falsification of Records or Other Acts of Fraud/Abuse
- I) Inappropriate Charging – Willful overcharging of member services and billing for services that have not been rendered.
- J) Failure to Refund Fees – Failure of a service provider to refund fees to members within thirty (30) calendar days after a determination that a member is due a refund. (Retroactive Medicaid eligibility and/or other reasons may cause a provider to owe refunds to a member.)
- K) Failure to Notify Prior to Termination – Failure of a provider to provide required notice prior to termination of services. Providers who abruptly discontinue services may not request re-enrollment for a period of three (3) years from the date services were discontinued.
- L) Failure to be accessible to members 24-hours a day or failure to be accessible to Alliant Health, case managers, or other providers, as appropriate.

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

NOTE:

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

603.2 Types of Adverse Actions

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

- A) No Member Referrals – No new ICWP/TBI referrals will be made to the provider for a minimum of six (6) months for the first offense and a minimum of six (6) months for any subsequent offenses.
- B) Sixty Day Delay of Processing or Denial of Approval of Additional Provider Enrollment Applications
- C) Termination of Provider Enrollment
- D) Selection of Another Provider – The DCH shall instruct Alliant Health or case managers to assist members in selecting another case manager/service provider when there is endangerment of the health, safety and welfare of the members.
- E) DCH has the right to assign another provider when there is endangerment of the health, safety and welfare of the members.

NOTE:

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

603.3 Duration of Adverse Action

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

NOTE:

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

603.4 Provider Notification of Adverse Action and Appeal Rights

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

- A) Reason for imposing the adverse action.
- B) The effective date and duration of the proposed adverse action(s). Generally, the adverse action will be effective thirty (30) calendar days after receipt of the notice. **If the DCH determines that the health, safety or welfare of members may be at risk, or if the provider has a history of non-compliance with policies and procedures of the ICWP/TBI, the 30-day notice of adverse action may be reduced. .**

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

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

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

- C) The actions required of the provider as a condition of removal of the adverse action.
- D) The address to which requested information is to be sent and the name of a DCH contact person to call for clarification regarding the notice.
- E) The actions and time frame necessary to oppose/appeal the adverse action. **If the provider fails to request an Administrative Review or fails to submit the requested information within the time frame specified in the Notice of Adverse Action, the adverse action becomes final and no further administrative or judicial review will be available. If the provider fails to respond to the notice to correct the deficiencies, the DCH may impose actions beyond those proposed in the letter, including termination of the provider's enrollment in the ICWP/TBI.**

NOTE:

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

NOTE:

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

604. Member Assurances

604.1 ICWP Member Rights and Responsibilities

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

Member rights include:

- 1) The right of access to accurate and easy-to-understand information.
- 2) The right to be treated with respect and to maintain one's dignity and individuality.
- 3) The right to voice grievances and complaints regarding treatment or care that is furnished, without fear of retaliation, discrimination, coercion, or reprisal.
- 4) The right of choice of an approved provider.
- 5) The right to accept or refuse services as agreed or as mutually established, recognizing that non-compliance with the memorandum of understanding will be cause for the termination of a member's participation in this program.
- 6) The right to be informed of and participate in preparing the care plan and any changes in the plan.

- 7) The right to be advised in advance of the provider(s) who will furnish care and the frequency and duration of visits ordered.
- 8) The right to confidential treatment of all information, including information in the member record.
- 9) The right to receive services in accordance with the current plan of care.
- 10) The right to be informed of the name, business telephone number and business address of the person/agency supervising the services and how to contact that person/agency.
- 11) The right to have property and place of residence treated with respect.
- 12) The right to review his/her records on request.
- 13) The right to receive care and services without discrimination.
- 14) The right to be informed on recognizing and reporting abuse, neglect, and exploitation.

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B) Member responsibilities include:

- 1) The responsibility to notify case manager/service provider(s) of any changes in care needs.
- 2) The responsibility to treat provider staff in a courteous and respectful manner, as well as cooperate with and respect the rights of the caregivers providing care.
- 3) The responsibility to be as accurate as possible when providing information on health history and personal care needs.
- 4) The responsibility to participate actively in decisions regarding individual health care and service/care plan development.
- 5) The responsibility to comply with agreed upon care plans.
- 6) The responsibility to notify the member's physician, providers, and/or caregiver of any change in the member's condition.
- 7) The responsibility to maintain a safe home environment and to inform providers of the presence of any safety hazard in the home.
- 8) The responsibility to be available to provider staff at agreed upon times services are scheduled to be rendered and to case management staff both in person and using audio visual equipment when allowed by policy.

- 9) to be available to provider staff at agreed upon times services are scheduled to be rendered.
- 10) The responsibility to avail the member to the utilization review team to make visits as needed.
- 7/11 11) The responsibility to maintain a safe environment for self and staff, including the responsibility to maintain a drug free environment at all times. If present in the home, alcohol must be concealed and must not interfere with the service delivery process.
- 7/11 12) The responsibility to not willfully have utilities (gas, water, electricity) disconnected for non-payment, or other reasons within the members control.
- 13) The responsibility of the ICWP member or member's representative to notify the case manager of any changes in his or her Medicaid status.

NOTE:
e required to sign a Memorandum of Understanding when placed into services. (Refer to Appendix C and C-1 for the Memorandum of Understanding.)

604.2 Reporting and Investigating Incidents

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

One form may be used to record multiple incident types if they relate to the same overall incident.

When an incident involves more than one waiver member, an incident report must be completed for each waiver member.

See Appendix X for definitions of reportable incident types.

Reporting of Incidents

Note: The responsibility for submission of an incident report falls on the first person to witness or discover the incident regardless of location or whether during the point of service. If the reporting provider is the direct service provider, the case manager will be notified of the incident by the confirmation email of the submission of the incident. The case manager is responsible for completing the follow-up and interventions report.

1. Providers must immediately take steps necessary to protect the waiver member's health, safety and welfare upon witnessing or discovering an incident.
2. The provider will immediately notify:
 - a. The individual's guardian and/or next of kin, as legally appropriate:
 - i. Notification of incident with a severity ranking of 3 and above shall occur within two (2) hours.
 - ii. Notification of all other incidents shall occur within twenty-four (24) hours.
 - b. If the event occurred in an unlicensed facility/agency, Law enforcement and Adult Protective Services in instances of suspected abuse, neglect and/or exploitation of the member.
 - c. If the event occurred in a licensed facility/agency, Law enforcement, Healthcare Facilities Regulation Division, and the Long-term Care Ombudsman in instances of suspected abuse, neglect and/or exploitation of the member.
 - d. If instances of suspected abuse, neglect and/or exploitation of a member who is a minor, Law enforcement and the Child Protective Services.
3. The provider will submit the Incident Report electronically via the webform located at <https://medicaid.georgia.gov/> under Provider links within twenty-four (24) hours of the incident, or the discovery of the incident, but no later than one (1) business day if the incident occurred after business hours or on a weekend or holiday.
4. A confirmation email with a summary of the incident will be sent to the reporting provider, the contact person identified, and the member's case manager if they are not the reporting provider.
5. In all cases of suspected abuse, neglect or exploitation follow-up on referrals to law enforcement and regulatory authorities until resolution.

Follow-Up and Intervention Reporting

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

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

- a. Investigate the cause of the incident

- i. Ensure that no other incidents or abuse takes place while the investigation is ongoing.
 - ii. Determine if risk factors existed prior to the incident, which may have identified potential for incident occurrence.
 - iii. Identify interventions to reduce or prevent a similar incident in the future.
 - iv. Identify the individual responsible for implementation of the interventions and the process for evaluating the effectiveness of the plan.
- b. DCH will confirm within seven (7) business days if the interventions identified are acceptable and provide on-going monitoring until completion of the identified activities.
 - i. If the interventions and/or corrective action are deemed to require modification, the provider will have three business days to resubmit the agency's plan to address the deficiencies cited in the follow-up and interventions report.
- c. Interventions Types include, but not limited to:
 - i. Staff related – staff training, review, changes to staffing patterns, or supervision
 - ii. Individual related – review of protocols, new/additional assessments (behavioral or medical), coordination of care, review of service plan, increased observation
 - iii. Equipment/Supplies related – purchase or repair equipment or supplies, obtain new devices
 - iv. Environment related – evaluate the area, make physical modifications for mobility or safety, temporary or permanent relocation
 - v. Policy and Procedure related – review or update written provider policies, procedures, and/or guidelines
 - vi. Provider Quality Improvement related – internal investigation, internal corrective action plan, systematic assessment or change
 - vii. Referral to other agencies or community services
 - viii. Other – any action not identified above
- d. Participate in regulatory agency investigations, if applicable
- e. In all cases of suspected abuse, neglect or exploitation follow-up on referrals to law enforcement and regulatory authorities until resolution.
- f. Maintain documentation of all reports and associated documentation in the client record.

PART II - CHAPTER 700

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ELIGIBILITY CONDITIONS

701. General

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

- A) have been determined disabled according to the Social Security Administration or the Department of Human Services, Division of Family and Children's Services, and are financially and resource eligible to participate in the ICWP.
- B) are age 21 through 64 years of age when services begin. Any member admitted to the program prior to the 65th birthday may remain in the program until death or termination from the program
- C) have a severe physical impairment and/or traumatic brain injury that substantially limit one or more activities of daily living and require the assistance of another individual.
- D) do not have a primary diagnosis of a mental disorder (i.e., mental retardation/mental illness).
- E) are medically stable as well as have or the ability to have a stable living environment but are at risk of hospital or nursing facility placement due to inadequate community based support services. **Rev. 7/1/17**
- F) are certified for a level of care appropriate for placement in a hospital or nursing facility.
- G) have a Plan of Care within the cost limit of the waiver .
- H) are able to be safely placed in a home and community setting. "Safely placed" means placed in a setting with sufficient human and technological support if the latter is required to prevent deterioration of the health condition; injury or harm. **Rev. 7/1/2017**
- I) currently in an institution or at risk of being placed in an institutional setting.

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

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If possible and with the approval of the member, the natural supporter is encouraged to be present at assessment and during development of the plan of care. The natural support system may include family members; significant others; community assistance; or members of social networks. The plan of care is developed in consideration of natural support, paid support by the applicant or family, and technology or environmental support. **Revs. 7/1/2017; 1/1/19**

The natural support system, when needed and available, is considered in development of a holistic plan of care that assures the safety of the applicant. Examples of extensive daily care include the need for 24-hour assistance; extensive transfer assistance without which the applicant will be unsafe and/or uncared for; and the need for continuous care of any kind. **Revs. 04/11; 1/1/19**

When the member is more independent, the presence of a natural support may be less crucial or may be needed to a lesser degree. When possible, however, periodic monitoring and oversight by a natural support, whether family member, friend or other designee helps to support the independence of the member in the community. **Rev.1/1/19**

NOTE: Applicants in a nursing home will be assessed under the nursing home level of care and if eligible for ICWP will be approved at the nursing home level of care cost. An individual in a nursing home may not be transitioned into the community at the hospital level of care unless being transitioned from a ventilator unit in a nursing facility.

NOTE:

An individual whose functional impairment is due solely to a mental health disorder (excluding TBI applicants), intellectual disability, or a developmental disability will not be approved for the ICWP waiver. The Alliant Health will refer these individuals to behavioral health or I/DD programs and services.

Transition of Children from the GAPP into ICWP

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

- Alliant Health GAPP nurse will forward the child's medical record to the Alliant Health ICWP team nurse.
- The child's medical record will be reviewed by Alliant Health ICWP review nurse to determine if the child meets the general eligibility criteria for the ICWP.
- If the child meets the general eligibility criteria, Alliant Health ICWP review nurse will send the family and/or applicant an introductory letter with an ICWP packet one year prior to the applicant's birthday. The application will be mailed to the parent or legal guardian by Alliant Health by the **sixth(6th) month** prior to the applicant's 21st birthday. The application must be returned by the applicant within 30 days of the date of the letter. Mailing the application will be followed by a telephone call to the applicant/family within ten (10) days to verify receipt. Failure to return the application may result in forfeiture of a slot by the applicant.
- A nurse from Alliant Health will contact the applicant or applicant's representative to schedule an assessment date within 30 days of receipt of the returned application. .
- At the time of the assessment, the Alliant Health nurse will inform the applicant or applicant's representative of the services offered under the ICWP. If the application was not returned by the applicant or applicant's representative, a final letter will be sent notifying the applicant of ineligibility for the ICWP.
- Once the assessment is completed an approval or denial letter is sent to the applicant or applicant's representative **within 30 days** of the completed assessment.
- If the applicant is approved for ICWP services, the approval letter will inform the applicant or applicant's representative to select a case manager from the case manager list provided in the letter. The applicant or representative must notify Alliant Health **within two weeks** of the selected case manager.

- Once the case manager has been selected by the applicant or applicant's representative, Alliant Health will send the selected case manager all the required documents to ensure the member will begin services the day he or she turns **21**.
- The ICWP member services **cannot** begin before the applicant's 21st birthday.
- If the applicant is denied ICWP services a denial letter will be sent to member within **30 days** of the assessment, and rights to appeal will be attached to the letter. The Alliant Health nurse may also refer the applicant to apply to another Medicaid program.

NOTE:

A member may NOT participate in more than one Medicaid waiver program at the same time. An applicant must apply to the ICWP and be assessed by the contracting agency. A slot maybe granted contingent upon eligibility and available funds. If a member is enrolled from another waiver program, ICWP services must begin on the first day of the month following discharge from the other waiver. Waiver services case managers and/or care coordinators along with providers involved in service delivery must clearly communicate with each other to verify service end dates to ensure that ICWP services begin on the first day of the month. Services rendered prior to the first day of the month may not be reimbursed.

Medicaid Waiver Programs include:

- Independent Care Waiver Program (ICWP)
- Community Care Services Program (CCSP)
- New Options Waiver (NOW)
- Comprehensive Supports Waiver (COMP)
- Georgia Pediatric Program (GAPP)
- SOURCE

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

702. The Selection Process

702.1 Selection Criteria

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

Rev. 04/14 Application date on a first come first served basis

702.2 Applying for Services

Individuals interested in receiving services through the ICWP/TBI must telephone or write Alliant Health at:

**Alliant Health Solutions
P.O Box 105406
Atlanta, Georgia 30348**

Telephone numbers: (678) 527-3632, (678) 527-3619 or 1-800-982-0411,

Local Fax Line 678-527-3001

Toll Free Fax Line 1-800-716-5358

Alliant Health Solutions is responsible for assessing individuals for appropriateness of services and initiating service delivery to members utilizing the policies and procedures and budgetary limitations established by the Department of Community Health.

702.3 Selection Procedures

A) Intake Process

1) Within two (2) workdays of receipt of an inquiry, Alliant Health Solutions (AHS) will contact the individual to complete an initial telephone screening. If appropriate, AHS will mail an application to the individual within one (1) workday. Once the application is returned to AHS it will be assigned to a review nurse to complete a Level of Care screening. If the individual is not appropriate, AHS will provide alternative resource information and mail a follow up letter to the individual.

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

3) Within thirty (30) days of receiving the completed application, which includes completion of the LOC screening, and slot availability, AHS will schedule the assessment, perform the assessment, and make a LOC determination. AHS may request medical records to determine level of care. If the applicant meets LOC, AHS will outline the initial Plan of Care and issue an approval letter. If the applicant does not meet LOC, AHS will issue a denial letter. The approval or denial letter will be mailed to the applicant or applicant's representative within two (2) business days.

5) If AHS is unable to schedule the assessment due to a lack of response from the applicant, a letter will be issued advising the applicant that they have 10 additional days to contact AHS to schedule the assessment. If AHS has been unsuccessful in their attempts to contact the applicant for 45 days after receiving the completed application, the application will be withdrawn.

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

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

B) Assessment Process, Alliant Health will:

- 1) Complete the ICWP Participant Assessment Form (PAF). (Refer to Appendix D for a copy of the PAF.) In addition to completing the PAF form, Alliant Health will also complete the Personal Care Attendant Hour Allotment work sheet. The Worksheet will assist in determining the number of personal care hours a member may require. (Please refer to Appendix D-1)
- 2) The Alliant Health nurse will inform the applicant that once he/she is approved for the waiver, it becomes their responsibility along with the case manager to obtain a signed DMA-6 from their physician. The physician will make Recommendation Concerning Nursing Facility Care or Intermediate Care Facility for the Mentally Retarded (**DMA-6**) form. All Medicaid eligible ICWP members must have a pre-admission screening to determine the level of care. The DMA-6 is the standard form used to document that the individual meets the level of care (LOC) for nursing facility placement. (Refer to Appendix E for a copy of the DMA-6.)
- 3) Have the applicant sign a **Release of Information** form. (Refer to Appendix F for a copy of the Release of Information form.)
- 4) Develop the **Initial Plan of Care**. Alliant Health will develop the Initial Plan of Care to:
 - (a) document the amount and type of services needed; and
 - (b) ensure that the applicant has a Plan of Care that is appropriate to his or her needs and can be implemented within the allocated budgeted amount. (An applicant in a nursing facility receiving care under the nursing home level of care will be assessed and approved if appropriate for the nursing home level of care).

C) Within ten (10) working days of the completion of the initial assessment, Alliant Health will notify the applicant of the status of his/her application through regular mail. The priority to be assigned to an application will be based upon the date of application unless there is a waiting list. If there is a waiting list, priority will be assigned to each application based on the score of the LOC screening tool which takes into account the acuity needs of the applicant.

NOTE:

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

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

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

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

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

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

NOTE:

ICWP providers may render ICWP services only to members with a current level of care. A DMA-6 is approved for no more than 12 months and expires on the last day of the expiration month of the POC...The validity of the DMA-6 expires 365 days from the date it is approved by Alliant Health and must be renewed on an annual basis. At the time of renewal, the case manager must submit a completed DMA-6 signed by the member and the member's physician to Alliant Health no more than sixty (60) days prior to the termination of the current level of care. Rev. 10/1/18

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

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

E) If there is no opening for services to start immediately and the individual is appropriate for services, Alliant Health will notify the applicant that he or she will be maintained on the waiting list to be admitted for services only as member discharges occur or additional funding becomes available for the program. Slots will be assigned according to the LOC screening tool score. The notice will advise the individual to contact Alliant Health if his or her condition or circumstances change.

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

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

702.4 Waiting List

Depending upon availability of ICWP benefit funds, applicants who have been telephone screened and determined eligible for ICWP may have to be placed on a waiting list for full assessment.

Cost factors and the number of individuals participating in the ICWP affect the availability of funds. If no waiting list exists, clients are admitted to the ICWP in the order they are referred to Alliant Health Solutions (AHS) for full assessments.

Before completing the full assessment, AHS will contact waiting list clients to determine if their living arrangements and need for services have changed.

A) Waiting List Procedures

IF	THEN AFTER COMPLETING TELEPHONE SCREENING
There are not budget constraints/no waiting list	Complete applicant assessments on a first- come, first- served basis.
Budget constraints prevent new admissions	Place names of applicants who appear eligible based on the DON-R scores for level of impairment and unmet need for care on a waiting list for assessment.
Budget constraints limit the number of admissions	Complete assessments on the applicants with the highest DON-R scores and the most days on the waiting list for initial assessments.
Budget allows new admissions	Complete assessments on the applicants with the highest DON-R scores and the most days on the waiting list for initial assessments.

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

703. Role of Case Manager in Starting Services

The case manager will:

- A) Conduct a **face-to-face visit** with the member within five (5) working days of selection by the member.
- B) Assist the member in establishing Medicaid eligibility through contact with the Division of Family and Children Services (DFCS). (Refer to Appendix G.)
- C) Case managers must assist the member with getting the DMA-6 signed by the physician. The physician signature date should be within sixty (60) days of the start date of service. New Admissions the date of service starts when Alliant Health receives the completed DMA-6. **Rev. 1/1/17**
- D) Provide the member with a **listing of available service providers, also utilizing the resources supplied by Alliant Health Solutions which is made available to the case manager upon admission of the member into the ICWP**. Assist the member in selecting providers.
- E) Applicants transitioning out of the Nursing Home through Money Follows the Person (MFP) will be assisted by the Transition Coordinators in coordinating all services needed for transition. The Transition Coordinator and the ICWP case manager will work closely to ensure the applicant can be served under the nursing home cost limit of the waiver.
- F) Within thirty (30) days, develop an **Individual Plan of Care** with the member that includes the selected providers, specific schedule for service delivery of the services approved on the initial plan of care, including those referred by Alliant Health Solutions, other goals and objectives identified, and discharge plans. The Individual Plan of Care must be completed, signed, and returned to Alliant Health electronically. **Rev. 1/1/17**

When an individual is placed into services, the Individual Plan of Care must be reviewed and signed by the case manager and the member's Plan of Care and must be reviewed and updated quarterly and every twelve months or more frequently, if warranted. (Refer to Appendix H for a copy of the Care Path form.)

- G) Complete the **DMA-80** form and submit it to Alliant Health. This information will be submitted electronically. **Rev. 1/1/17**. However, providers that are not able to submit via web due to natural disasters resulting in power outage should fax the information to the Alliant Health Review Nurse for that region.

using the fax number provided. Refer to Chapter 800 for additional information regarding approval of service. **Rev. 1/1/17**

- H) Have the member sign a **Freedom of Choice** form and send it to Alliant Health. The member and a member representative, chosen by the member, will be informed of alternatives available under the program and given the choice of either institutional or home and community based services following the level of care determination. The Freedom of Choice form is used to assure that the member and member's representative have been informed of the choices. The form must be signed and dated by the member, the case manager and an authorized member representative, when applicable. (Refer to Appendix I for a copy of the Freedom of Choice form.)
- I) Review with the member and have the member sign the **Member Rights and Responsibilities**. The original should be sent to Alliant Health. The case manager should maintain a copy in the member's file and distribute copies to the member and service providers. (Refer to Appendix B for the Member Rights and Responsibilities.)
- J) Review with the member and have the member to sign the Memorandum of Understanding. The **Memorandum of Understanding** contains responsibilities of the member and guidelines of the ICWP. Failure to comply with the terms of the agreement will result in discharge from the program. The original should be sent to Alliant Health. The case manager should maintain a copy in the member's file and distribute copies to the member and providers. (Refer to Appendix C and C-1 for the Memorandum of Understanding.)
- K) Have the member to sign an additional **Release of Information Form**, if necessary.

NOTE:

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

704. Verification of Medicaid Eligibility

Rev 10/01/08 Medicaid Eligible Members

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

704 .1 Cost Share Liability

ICWP Potential Medical Assistance Only (PMAO) Members

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

- A. Brokering PMAO Members - PMAO members, who do not yet possess current Medicaid member numbers, are determined eligible for Medicaid services by the county Department of Family and Children Services (DFCS). The case manager will broker services for Potentially Medical Assistance Only (PMAO) members with providers. If the member is PMAO:
1. During the initial assessment, the Alliant Health nurse must inform the member of the possible requirement to pay a portion of the cost of services (cost share), and must discuss the Medicaid eligibility process with the member/representative.
 2. The Alliant Health nurse, the ICWP case manager and the service provider must reinforce the member's cost share responsibility by clearly informing the member that if cost share is not paid, the member is at risk of losing ICWP services.
 3. The Alliant Health nurse must provide a copy of the PMAO Financial Worksheet (Appendix D-2) indicating the estimated cost share to the selected case manager.
 4. Once the case manager receives the information packet from Alliant Health indicating that the member has been approved to receive services through ICWP, the case manager must assist the member with submitting the Independent Care Waiver Communicator (ICWPC) form (Appendix G) to the local DFCS. Once DFCS verifies that the PMAO member is eligible for Medicaid, the case manager will assist the member with locating an ICWP personal support provider and other provider(s) as needed.
 5. The case manager must make a good faith effort to ensure that the member is proceeding with the Medicaid eligibility process. If the case manager determines that the member is having difficulty with the process, a case conference is scheduled with the member and DFCS to define areas where assistance is needed.
 6. Within 45 days of the Medicaid application date, the case manager must contact DFCS to ascertain the member's eligibility status. If DFCS has not yet determined the member's Medicaid eligibility, the case manager will contact DFCS at least every two weeks until eligibility is established.
- A. Accepting a PMAO member - When the provider accepts a referral for a PMAO member, the case manager must give the member a **written** estimate of the cost share amount **prior** to the delivery of services.

The provider must inform the member in writing that the member is responsible for the total cost of all services rendered if DFCS later

determines that the member is ineligible for Medicaid, or if the member fails to proceed with the Medicaid application.

- B. Cost Share Collection -The provider must have written policies clearly describing cost share billing/collection and refund policies and procedures. For PMAO members, the provider may either:
1. Collect only the estimated cost share from the member. If this method is chosen, services to the member must be delivered before collecting cost share. The provider must bill the member for cost share at least monthly. The provider is not required to wait until the end of the month before collecting cost share, but may collect cost share as service is provided until the provider has collected the entire cost share.
- EXCEPTION:** The Fiscal Intermediary (FI) providers may collect cost share at the beginning of the service month.
- or**
2. collect the entire cost of service from the member until DFCS establishes Medicaid eligibility
- Prior to delivering service, the provider must furnish the member written notice as to which of the above collection methods will be used.
- C. Reconciliation of the Member's Account - Once DFCS notifies the case manager of actual cost share amount, the case manager will submit the ICWPC form to Alliant Health within three days of receiving information from DFCS. This information will include the amount of the cost share to be billed to the member.
- Within 30 calendar days of receipt of the Prior Approval (PAs) showing the actual cost share, the provider must return any excess cost share collected, or bill the member for any remaining cost share due the provider. A member determined ineligible for Medicaid is responsible for the entire cost of services delivered.
- D. Reimbursement from Medicaid - The provider may not submit claims for Medicaid reimbursement until DFCS approves the member for Medicaid benefits. The nurse at Alliant Health must generate a PA Form showing the member's Medicaid member number and actual cost share.
- E. Member MAO Eligibility - Once eligibility is established and the actual cost share is determined, the PMAO member becomes MAO eligible.

NOTE:

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

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704.2 Medical Assistance Only (MAO) Members

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

A. Cost Share Collection

- Rev. 10/01/07
1. The ICWP provider must furnish the member a written statement of the amount of cost share, if any, each month cost share is due.

The monthly statement will include:

- The date of the statement
- The amount due
- The date payment is due
- The statement that, "If the bill is not paid within 30 calendar days, discharge from the agency will be effective the 46th calendar day from the date of this statement".

2. Providers will bill for cost share at least monthly

B. Members Failing to Pay Cost Shares

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

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

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

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

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

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

Rev. 10/08 705. Denial of Services

705.1 Reasons for Denial or Termination

- A) The member fails to meet eligibility criteria specified in Section 701.
- B) The member and/or member representative has not supplied necessary information to complete the determination of eligibility.
- C) The member and/or member representative has not signed the Initial Plan of Care and other forms specified in Section 703.
- D) The Initial Plan of Care cannot be implemented within the allocated budgeted amount.
- E) If a member fails to show medical necessity or a change in medical condition which justifies an increase in services or an increase in personal support hours

705.2 Right to Appeal

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

- A) Refusal to accept an application.
- B) Reduction in services.
- C) Denial of eligibility.
- D) Failure to offer the choice between home and community-based waiver services and institutional services upon approval to receive services through the ICWP.
- E) Termination of services.

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

706. Discharge of Members

- A) ICWP/TBI providers must maintain a coordinated program of discharge planning to ensure that each member has a planned program of continuing care that meets the member's post-discharge needs.
- B) The case manager must coordinate discharge planning in consultation with the member, Alliant Health, other providers, the member's physician, other involved service agencies, and other local resources available to assist in the development and implementation of the discharge plan. The case manager must consider the following factors in discharge planning:
 - 1) problem identification;
 - 2) anticipated progress;
 - 3) evaluation of progress to date;
 - 4) target date for discharge; and
 - 5) identification of alternative resources for care after discharge.

706.1 Discharge of Members from Participation in the ICWP

Discharge occurs when:

- A) Alliant Health, in consultation with the case manager and service providers, determines that the member is no longer appropriate or eligible for services under the ICWP. Case managers and providers may submit written recommendations of termination from the ICWP/TBI to Alliant Health. The recommendation must include documentation supporting the recommendation to terminate services.
- B) DCH's Utilization Review (UR) staff recommends in writing that a member be discharged from service.
- C) The enrolled member has not received any ICWP Service for thirty (30) consecutive days. Once 30 calendar days is reached Alliant Health Solutions will send a discharge letter that will be effective on the sixtieth (60) calendar day if services have not resumed. Appeal Rights will be provided to the member at the time the letter is sent out. The case manager is required to keep Alliant Health updated on the member's condition at least every two weeks

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

- D) Member / member representative consistently refuses service(s), fails to cooperate with the agreed upon plan of care, or fails to adhere to other program requirements for participation in the ICWP.
- E) Member fails to adhere to the conditions of the Memorandum of Understanding.
- F) Member enters an institution (Nursing Facility, Hospital, etc.). The provider must send discharge notice immediately to the case manager and Alliant Health. The ICWP level of care is no longer valid upon the member's entry into a nursing facility.

If the member is expected to be discharged from the nursing facility or institution within sixty (60) days of admission, the case manager must notify the providers and Alliant Health.

The case manager must coordinate the member's reassessment to ensure the member is appropriate to receive services in the ICWP. The Division of Medicaid will not reimburse for services unless the member has a current level of care approved and signed by the Alliant Health and the member's physician.

- G) Member engages in and/or allows illegal activities in the home; or member or others living in the home have inflicted or threatened bodily harm to another person within the past thirty (30) calendar days.
- H) Member/representative requests to be discharged.
- I) Member consistently refuses to comply with treatment(s).
- J) The cost to serve the member exceeds the budget allocation for the individual's slot.
- K) Member expires.

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

- 1) Member enters a nursing facility.
- 2) Member exhibits and/or allows illegal behavior in the home.
- 3) Member/representative requests to be discharged.
- 4) Member expires.

(Refer to Appendix K-1 for a copy of the Discharge Notice.)

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

706.2 Termination of Case Management/Provider Services.

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

- A) Member requests a change in providers or requests termination of services.
- B) Member/member representative consistently refuses service(s), fails to cooperate with the agreed upon plan of care, or fails to adhere to other program requirements for participation in the ICWP.
- C) Member fails to adhere to the conditions of the Memorandum of Understanding.
- D) Member enters an institutional setting; the provider must send discharge notice immediately to the case manager and Alliant Health. Upon the member's placement in an institution the member's stay may not exceed sixty (60) days.

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

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

Process:

1. A nurse from Alliant Health will schedule a time to reassess the member for the program.
 - a. If the member is deemed eligible for ICWP thru the reassessment within 30 consecutive days of the original stipulated 60th day of discharge, the applicant name will be placed at the top of the waiting list.

If the timeframe stipulated in 1a of this process is not followed, the applicant's name will be placed on the waiting list according to the application date.

The ICWP level of care is no longer valid upon the member's entry into a nursing facility. If the member is expected to be discharged from a nursing facility or institution within sixty (60) days of admission, the case manager must notify the providers and Alliant Health. The case manager

must coordinate the member's re-evaluation of appropriateness for services for the ICWP with Alliant Health. The Division of Medicaid will not reimburse for services unless the member has a current level of care approved and signed by Alliant Health and the member's physician.

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

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

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

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

EXCEPTIONS:

When UR recommends discharge or the member expires.

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

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

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

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

- A) information of current diagnoses;
- B) an evaluation of rehabilitation potential;
- C) description of prior treatment;
- D) target date for discharge;
- E) Identification of alternative resources for care after discharge.

PART II - CHAPTER 800

PRIOR APPROVAL

801. General

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

- 801.1 All requests for prior approval must be submitted via web portal electronically. Detailed instruction for completing the Prior Authorization Request Form (DMA-80) can be found in MMIS under Provider Education. If needed, to supplement the online provider education training, providers also may attend the quarterly New Provider Training conducted by Alliant Health. The duration of the DMA-80 must not exceed the expiration date of the DMA-6. Detailed instructions for completing the DMA-80 are provided in Appendix L. **Rev. 7/15**
- 801.2 Reimbursement will be authorized for Case Management services rendered no more than thirty (30) days prior to the initiation of additional ICWP services, except for the transition of a nursing home recipient. The nursing home recipients must be discharged from the nursing facility and receive services in ICWP before reimbursement can be made to the case manager.
- 801.3 Reimbursement is not authorized for delivery of Personal Support Services while the member is hospitalized, or the caregiver is on vacation.
- 801.4 The DMA-80 and all forms required in Chapter 700 must be submitted by the case manager electronically via the web portal in order for Alliant Health to complete the review. Do not upload handwritten copies care plan documents except for the signature page. **Rev. 7/15; 4/19**

All information must be submitted at least one week prior to the intended date of initiation of services. Do not upload handwritten copies of care plan documents or quarterly reviews. **Rev. 2/2020**

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

- 801.5 Alliant Health will review the DMA-80 to determine that services are consistent with the Initial Plan of Care. The DMA-80 will be approved in the web portal by the Alliant Health ICWP nurse. Data Direct sends out a notification to the provider with the member demographics, the approved date of services, number of units and the total cost of services approved by the Alliant Health ICWP review nurse. The Notification is sent to the ICWP member and the case manager. Notification also will be sent regarding disapproval of services by the Alliant Health ICWP review

nurse. When the Alliant Health review nurse changes the DMA-80, the nurse will communicate the change via the web portal through “Contact us” messaging to the case manager. **Rev. 7/15**

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

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801.7 If a change in approved services is indicated, the case manager must submit a modified plan of care, the completed last page of the PAF and a DMA 80 to Alliant Health for approval before services are rendered. The need for a change in approved services will be evaluated based on the condition and the needs of the member. Data Direct will generate notification to the providers with Alliant Health ICWP review nurse approval. Notification will also be forwarded regarding disapproval of services.

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801.8 A re-determination of eligibility (level of care) must be done, at minimum, annually by Alliant Health for the Division to continue reimbursement of service beyond the initial level of care determination before program participation is continued. Once the initial level of care is determined, the case manager is responsible for initiating subsequent approvals. The case manager must submit a completed DMA-6 signed by the member and the member’s physician to Alliant Health no more than sixty (60) days prior to the termination of the current level of care. **Rev. 10/1/18; Rev 1/1/19** The DMA-6 letter is sent to the case manager by GainWell Technologies once the care plan is approved in MMIS. A DMA-6 “In-lieu” letter can be provided upon request by Alliant Health prior to admission instead of a “stamped approved” DMA-6. The Alliant Health generated DMA-6 “In-lieu” letter may be utilized by the case manager along with the completed DMA-6 and ICWP Communicator form for new admissions and renewal care plans. The DMA-6 “In-lieu” letter, signed and completed DMA-6 and ICWP Communicator form is sent to DFCS for new and renewal Medicaid applications. **Rev. 1/1/19.** The case manager is required to keep the DMA-6 on file for DCH Program Integrity review. Additionally, the case manager must complete the PAF in its entirety for each member served. **Rev. 7/15**

PART II - CHAPTER 900

SCOPE OF SERVICES

901. General

The DMA reimburses providers only for ICWP and TBI services:

- A) rendered by enrolled providers who comply with the policies and procedures contained in the:
 - 1. Part I, Policies and Procedures Manual Applicable to All Medicaid Providers.
 - 2. Part II, Policies and Procedures for the Independent Care Waiver Program Services Manual.
- B) provided and supervised by staff as required for the specific ICWP service.
- C) ordered and authorized by the Initial and Individual Plan of Care.
- D) provided to persons who are Medicaid eligible at the time the services were rendered.
- E) provided to persons who are certified for a level of care appropriate for placement in a hospital or nursing facility.

902. Covered Services

902.1 Case Management

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

- i. A case manager may be employed by a private or public agency or may be an individual practitioner.
- ii. An enrolled case manager may hire an individual to assist with his or her caseload. The individual must meet the same qualifications as outlined below under #5. The enrolled case manager must submit a detailed resume of the applicant to the DCH Program Specialist for review and approval. The approval letter from DCH

must be maintained in the enrolled provider's file. The enrolled case manager must sign off with the case manager on all monthly visits. The enrolled case manager is responsible for all deficiencies related to a member's Plan of Care.

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

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

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

- i. Separation of case management from direct services: Structurally or operationally, case managers must not be employees of any organization that provides direct services to the individuals. Ideally, conflict-free case management agencies are stand-alone. A case manager may not enroll as a provider in any other service.
- ii. Separation of eligibility determination from direct services: Eligibility for services is established separately from the provision of services so assessors do not feel pressure to make individuals eligible to increase business for their organization. Eligibility is determined by the Department of Family and Children Services, an organization that has no fiscal relationship to the individual.
- iii. Case managers cannot establish funding levels for the individual: In the Georgia model, the case manager's responsibility is to develop a recommended plan of supports and services based on the individual's assessed needs.
- iv. Individuals performing evaluations, assessments and plans of care cannot be related by blood or marriage to the individual or any of the individual's paid caregivers, or financially responsible for the individual.

C. Types of Case Management

1. Traditional Case Management definition:

Traditional case managers provide an assessment of the ICWP member, including diagnosis and personal history, case management issues and dynamics and a plan to address the members needs and any unresolved issues. In addition to having knowledge and understanding of human interaction dynamics and interpersonal skills, the case manager must

have a comprehensive knowledge of community resources and services needed to maintain ICWP members in the community; access points to link members to services and resources; and maintaining ongoing relationships with agencies and resources which are instrumental to the member's care and service provision. Examples of such agencies include but are not limited to: Department of Family and Children's Services (DFACS); the Social Security Administration (SSA); Vocational Rehabilitation agencies; County Boards of Health or other counseling resources; Medicaid, Medicare and similar resources and agencies.

Traditional case managers assist members with: addressing issues that present as barriers to their care; accessing needed resources and services; fostering and maintaining family/significant other relationships and support and support needed to maintain the member in the community; and acts as an advocate in identifying the member's needs and taking active measures to address the member's needs. These activities provide a description of case management but are not intended to be all inclusive. Case management includes engaging in and performing a range of activities and interventions to meet the member's needs and advocating on behalf of the member to ensure that those needs are met.

2. Enhanced Case Management definition:

In addition to the basic case management activities and functions described above, enhanced case management includes advanced training, knowledge and skills required to address the severity of the disability and complexities that present in the provision of care and management of the member's physical and emotional health as well as interventions and activities that foster prevention and gross deterioration of the member's health.

Examples of conditions which may require enhanced case management include: ventilator dependency and/or tracheostomy care; severe maladaptive behavior as determined by diagnosis and/or Alliant Health assessment. Documentation must support or provide evidence of the presence of the condition. In addition, the condition must require frequent and an enhanced level of monitoring, intervention and follow-up which must be fully described and clearly documented in the member's case management file. These examples are not intended to be all inclusive. The need for enhanced case management is determined by Alliant Health at the initial assessment and annual review.

3. Enhanced Case Management Agency Model definition:

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

supervision model. In this model agency enrollment is based on the following requirements:

A. Agency model requirements:

1. A minimum of five (5) years of experience in the health care, behavioral health or case management field which includes:
 - a. providing home and community-based case management services for individuals with disabilities or similar HCBS populations, and demonstrate success in supporting individuals in community inclusion and person-centered planning;
 - b. serving individuals at risk due to medical, functional, and/or behaviorally complex conditions.
2. Have established or will establish working relationships with local community and advocacy groups, experience advocating for individuals in the community, and preparing individuals for self-advocacy;
3. Have experience and demonstrated success with outcome-based planning, and developing service plans based on the individual's goals, choices and direction;
4. Have experience with measuring quality of services and satisfaction with services, ensuring that the services that are provided are consistent with quality measures and expectations of the individual;
5. Demonstrated experience in serving diverse cultural and socioeconomic populations.
6. The applicant agency must assure compliance with conflict free case management as outlined in 42 CFR §441.301(b) (1).
7. If licensed, the agency will maintain the license as applicable in home health, private homecare, neurobehavioral center, or other. If out-of-state, must provide a letter of recommendation from current oversight agency along with the last audit/review.
8. The provider must assure a sufficient number of clinically licensed or certified supervisors to assure a ratio of no more than 1 supervisor to 5 case managers.
9. Proof of licensure is required for Enhanced Case Management Clinical Supervisors in the designated specialty area.

B. Agency Model Staff Qualifications and Responsibilities

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

1. Enhanced Case Management Clinical Supervision:

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

A. ECM – Medical/Clinical Supervisor Requirements:

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

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

B. ECM-Behavioral Clinical Supervisor Requirements:

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

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

C. Role of the Clinical Supervisor:

1. Assume a consultative relationship and participate in case conferences on behalf of medically or behaviorally at risk ICWP members.
2. Hold case conferences to discuss members in any of the following situations:
 - a. Transition following hospitalization or other acute setting
 - b. Members experiencing health or behavioral decline, particularly in the case of sudden onset
 - c. Members who may require additional referrals, coordination of healthcare or behavioral healthcare services, or communication with the larger healthcare system.
3. Perform joint visits with enhanced case managers quarterly to evaluate any additional or unmet needs
4. Meet with enhanced case managers monthly either individually or as a team to discuss difficult situations, community resources, policy changes or other timely issues.
5. Co-attend and/or coordinate specialized trainings or workshops on topical areas pertinent to needs of high-risk members.
6. Act as a clinical consultant for each of the enhanced case managers and each of the participants served within the ECM team's caseload.
7. Responsible for conducting a minimum of one quarterly joint visit with each ECM participant on their supervisory caseload.
8. Provide ongoing consultation to determine risks and unmet needs and collaborate in identifying and securing resources.
9. Follow up, either telephonically or on site, during and following acute changes in a participant's medical, behavioral or functional status. Provide continuous consultation to the ECM following such acute changes in condition. Collaborate with Alliant in the case of ongoing or acute changes that require immediate changes to the Service Plan.
10. Actively participate in hospital transition and discharge planning.
11. Maintain familiarity with nursing or behavioral health care plans developed by provider agencies to ensure that ECMs understand the purpose and evaluate the efficacy of the plans.
12. Maintain availability between supervisory sessions to help ECMs solve problems around key participant issues, resolve service problems, and visit participants as part of their interdisciplinary team for clinical consultation and planning.

13. Act as a resource for ECMs in navigating Medicaid State Plan/Medicare and coordinating services within the healthcare and/or behavioral services system
14. Establish working relationships with local advocacy groups. Advocate for community inclusion of individuals with disabilities and preparing individuals for self-advocacy.
15. Offer guidance to ECMs on outcome-based person-centered planning and developing plans based on the individual's assessed needs, goals, choices and direction.

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

1. Licensed as a registered nurse or have a BA or BS degree in a health care or human services related discipline from an accredited college or university
2. Three years of experience in healthcare service delivery or human services case management pertinent to the disabilities and conditions of the populations served by the ICWP; severely disabled adults and adults with traumatic brain injuries

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

1. Bachelor of Science degree in nursing or Master's or Doctoral level degree in other related discipline such as social work, psychology, or counseling from an accredited college or university and be certified in rehabilitation or case management. RN license can substitute for the degree.
2. Five years of experience in healthcare service delivery or human services case management pertinent to the disabilities and conditions of the populations served by the ICWP; severely disabled adults and adults with traumatic brain injuries
3. Individual Enhanced Case Management Providers must hold the following: Nurse Practice Act OCGA.43-26-1 for all registered nurse case managers or, Licensure under the Georgia Composite Board for counselors, social workers and marriage and family therapists or, Licensure in psychology

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

1. Detailed resume following standard resume format and must include:
 - A) The name and address of the employer
 - B) Dates of employment for each employer using the month/year beginning and end dates format
 - C) The supervisor's name and contact information, i.e., telephone number and/or e-mail address
 - D) If the employment was less than full time, the type of employment must be specified, e.g., part-time or contract work, etc.
2. A copy of the degree and documentation that the degree was obtained from an accredited college or university. Copy is any additional certification of licensure used to meet qualifications.
3. Enhanced Case Management Agency Model must submit evidence of meeting all agency requirements as outlined in the Enhanced Case Management Agency Model requirements section.
4. The applicant must submit proof that the provider agency has at least \$1,000,000 in general liability insurance coverage.
5. A complete list of documents required at application submission is located in Appendix A-1

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

1. Attend New Provider Training (NPT). The location, date, and time of training will be sent by the company contracted to perform ICWP training. Subcontracted or Case Manager employees who are not providers must be trained by the Case Manager employer before providing services and attend the next available New Provider Training.
2. New Case Managers must complete the DCH case manager modules within sixty days of approval. Contact HCBS.CaseManagement@dch.ga.gov to register for the modules.
3. Complete Certification to perform Consumer Directed Options (CDO) within six months of approval. Information on the CDO training will be provided at NPT.
4. Review Incident report training located on the DCH HCBS web site. Report contact information to the HCBS incident report administrator at HCBS.IncidentReports@dch.ga.gov

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

I. Specific Responsibilities – The case manager's roles include:

- a. Conduct a face-to-face interview with the member within five (5) working days of selection by the member.
- b. Inform the member of duration of service and assist the member in coordinating hours of services with providers. This includes reviewing the PSS hours the contracting agency approved for the member's Plan of Care. The case manager will assist the member in working with the approved PSS hours to meet the member's needs.
- c. Review the Member Rights and Responsibilities and the Memorandum of Understanding with the members and obtain signatures.
- d. Provide the member with a list of enrolled service providers and assist the member in utilizing the Alliant Health Solution's resource list, to select an appropriate community support provider.
- e. Assist the member in making informed decisions and ensure that the member's choices are respected throughout service delivery.
- f. Investigate and/or assist the member in accessing community resources that may assist the member in remaining in the home and community. Provide on-going case management as needed and as approved in the Initial Plan of Care.
- g. Coordinate case conference(s) with the member/member representative and providers, as appropriate to coordinate service delivery or resolve issues related to service delivery.
- h. Send all required documents (Refer to Chapter 700 and 800) to Alliant Health, the member and providers as appropriate. All Plans of Care, DMA 80, PAF's, DMA-6s required signed forms and variances reports must be submitted to Alliant Health in a timely manner.
- i. Monitor hospitalizations and report members who have not received services for 30 days to Alliant Health in order to send an initial 30 day discharge notice. If after 60 days the member still remains hospitalized, submit the Appendix K-1 Discharge Notice to Alliant Health to initiate a final discharge notice to the member via certified mail.

- j. Communicate to and request approval of changes in the member's services from Alliant Health. All changes in the amount and type of services must be approved by Alliant Health prior to implementation.
- k. Review the Individual Plan of Care at least every ninety (90) days with the member/member representative to determine and document compliance, progress, and continued appropriateness of the plan.

This must be a face-to-face visit in the member's place of residence. The Individual Plan of Care must be updated every twelve (12) months or more frequently, if warranted. During the quarterly review, the case manager should discuss member satisfaction with the provision of services and assist the member in addressing issues regarding services with the applicable service providers. The case manager will provide a copy of the reviewed and revised Plan of Care to the Personal Support Provider and Alliant Health. The case manager and the Personal Support Provider will keep a copy of the current Plan of Care on file.

- l. Communicate with the personal support provider after each quarterly review to address issues or Plan of Care changes..
- m. Provide detailed documentation that identifies dates of service, duties performed and actual hours rendered providing service to a member in order to be reimbursed for services rendered.
- n. Communicate with the member and agencies providing direct services to the member and resolve problems relating to coordination of services.
- o. Monitor the delivery of services to assure that services are rendered according to the Individual Care Plan and the member's satisfaction.
- p. Maintain a cooperative relationship with the member, other service providers, and the utilization review team.
- q. Coordinate the discharge of a member. This includes making arrangements when the member requires other services (discharge or transfer to a hospital, nursing facility, or other community-based care) as well as linking the member to other community resources. When a member is transferring from one waiver to another waiver the original case manager must complete and submit the Waiver Transfer Form (Appendix V) to Alliant Health Solutions. The original case manager must also provide a copy of Appendix V and one year of copied records to the receiving case manager. The original case manager will bill for the month the transfer occurred if the performance assessment has taken place for that month. The receiving case manager will bill the following month. It is recommended that transfers occur on the first day of the month with communication between case managers occurring in the month prior to transfer.
- r. Assist the member with submitting requests for hearings to appeal adverse actions affecting the member's services.

- s. Make referrals to Adult Protective Services and other non-ICWP services as appropriate.
- t. Conduct a visit once per month. Visits made to members receiving traditional case management must be in person visits at the initial visit and then at a minimum of quarterly ongoing. Monthly visits that are not conducted in person must be conducted with audio visual methods that allow the case manager to view the member. Visits made to members receiving Enhanced case management must be conducted in person at the initial visit and all subsequent monthly visits. Review and obtain members signature on the Informed Consent form at each in person visit.
- u. Notification of a reportable incident: Submit an incident report, as outlined in Section 604.2, within 24 hours or one (1) business day of the incident or discovery of the incident to the Department. Notify all appropriate parties in accordance with state law. Investigate the incident with involvement of appropriate parties while taking immediate steps to protect the waiver participant's health, safety and welfare. Submit the Follow-Up and Interventions Report to the Department within seven (7) business days of submitting the incident report. Participate in regulatory agency investigations, when applicable and take appropriate a corrective action if alleged violation is verified.
- v. Make sure that any time a member requests a change of PSS providers, the current PSS provider is notified of this request within 3 days of the request for change.. The reason for the change must be documented and a copy forwarded to Alliant Health to be placed in the member's file.
- w. Evaluate the member's Plan of Care. The case manager must make sure that an ICWP member is receiving only the medical supplies and equipment necessary for the current month. The case manager is responsible for taking inventory of the equipment and supplies the member receives each month. This will ensure that the department is being billed for only the equipment and supplies required to meet the member's needs.
- x. Ensure that Alliant Health receives all required documents within 30 days for new members.
- y. Keep Alliant Health informed of any member's change in status.
- z. Obtain signed Member receipt of forms (Appendix Z). Retain in member's file.

J. Member Funds

A case manager may not become involved in the handling or management of an ICWP member's personal funds including government

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

K. Case Management Adverse Action.

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

1. first occurrence: two (2) failures to meet set deadlines will result in a Verbal Reprimand with documentation of conversation documented at Alliant Health and DCH.
2. Second occurrence: three (3) failures to meet deadlines will result in a Formal Written Reprimand.
3. Third occurrence: four (4) failures to meet set deadlines will result in being placed in a probationary status or suspended status according to the severity of the infraction, ultimately placing a moratorium on new admissions to the case manager.
4. Fourth occurrence: five (5) failures to meet set deadlines will result in termination as a case management provider.

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

902.2 Personal Support Services

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

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

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

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C) Electronic Visit Verification (EVV)

1. EVV Requirement.

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

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

Georgia DCH selected Tellus, www.4tellus.com, as the State selected EVV system, The state selected system is available at no

cost to the Personal Support Provider/Consumer Direct member. DCH allows the provider to either select their own EVV system or use the DCH system. However, the provider is responsible for any costs associated with using the alternate EVV system.

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

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

2. EVV Non-compliance.

Consequences for repeated failure to use Electronic Visit Verification (EVV). As a result of identified deficiencies with using EVV and submitting claims via an improper method of billing, providers may be subject to various sanctions, including but not limited to: (1) Pre-payment Review; (2) Corrective Action Plan; (3) Termination.

There is no specific format for the Corrective Action Plan. However, the Corrective Action Plan must be specific and must actually correct the deficiencies identified. It must also: (1) be responsive to the cited deficiencies; (2) state and describe the end result; (3) indicate reasonable completion dates; and (4) fully describe the methodology used to accomplish complete and permanent corrective action. You will receive a letter by certified mail informing you whether your proposed Corrective Action Plan is acceptable or not acceptable.

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

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

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

For a provider to obtain Administrative Review, a written request must be received at the address of the office that proposed the adverse action or denial of payment within thirty (30) days of the date the notification of the proposed adverse action, the denial of payment, remittance advice or initial review determination was mailed to the provider. The request must include all grounds for Administrative Review and must be accompanied by all supporting documentation and explanation that the provider wishes the Division to consider. Letters requesting Administrative Review that are not accompanied by supporting documentation will not be accepted or considered... In cases involving an audit of a provider any documentation submitted for Administrative Review may, at the Department's discretion, subject the case, in whole or in part, to re-audit.

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

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

Georgia Department of Community Health
MAPs Division
Attn: Brian Dowd, c/o Valerie Harrell
19th Floor
2 MLK Jr Drive SE
Atlanta, Georgia 30334

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

- 1) Copy of a Current Private Home Care License

NOTE: A Provisional License will not be accepted.
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- 2) The applicant must submit proof that the provider agency has at least \$1,000,000 in general liability insurance coverage. In addition, private home care providers must submit proof of their agency's worker's compensation insurance coverage. **Rev. 4/1/19**

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

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

(A) CPR and Basic First Aid

(B) Emergency procedures

(C) Assistance with medications

(D) Specialized procedures.

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

(A) Infection Control

(B) How to give personal care

(C) Transfer techniques

(D) The need for confidentiality regarding the services being provided

(E) Agency policies and procedures

(F) Observation skills

(G) Safety and accident prevention

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

(A) Human needs and behavior

(B) Family relationships

(C) Stress management

(D) Meal planning

(E) Community resources

(F) Fire safety

(G) Conflict resolution

(H) Documentation

(I) Time management

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- 4) A resume and copy of the license of the Registered Nurse (RN) on staff. If the providers employs more than one nurse, whether R.N. or L.P.N., a copy of the current licenses must be submitted along with the application. The provider RN is responsible for preparing and selecting the training curriculum for the Aide to ensure adequate care is provided to all ICWP members. The RN and LPN must have a valid Georgia License with no restrictions.
- 5) A detailed resume of the Provider Agency Director or Administrator. **Rev. 4/1/19**

E) Staffing Qualifications and Responsibilities

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

Screen each potential employee for criminal background history (Georgia Criminal History Check System/GCHEXS). Evidence of a satisfactory criminal history background check determination must be maintained in the employee's personnel file.

Individuals who have been convicted of specific crimes and providers received an 'unsatisfactory determination' from the background/fingerprint check are ineligible for employment by an ICWP client/employer. A list of disqualifying crimes can be located online.

<https://dch.georgia.gov/georgia-criminal-background-check-system-gchexs/georgia-criminal-background-check-system-gchexs>

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

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

Depending on the charges and facts, the judgment may be deferred for a maximum of three years or five years.

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

F) Personal Support Service Supervision

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

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

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

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

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

H) Travel - Members receiving traditional Personal Support Services or Consumer Direct PSS can travel throughout the country/US and its territories. Prior notification to DCH and Case Management are required

for time out of the home (member and aide together) for vacation/family circumstance purposes. Traditional PSS and CD PSS must establish a schedule in the EVV system to be eligible for reimbursement. Providers are not responsible for travel costs. Out of Country travel with Medicaid is prohibited.

Note: The Elderly and Disabled Waiver 1915c does not include transportation in the rate for personal support or extended personal support services. NEMT is available to all Medicaid participants under the state plan to provide transportation to medical appointments and for waiver services such as adult day health. A provider who allows an aide to make use of a member's or aide's car for transport needs to be sure the member's or aide's auto insurance assumes liability in case of an accident. Consider having the member or their family sign an agreement that discusses the assumption of liability in case of an accident. The provider should also carry adequate liability and worker's comp insurance to cover any accidents. Any such transportation activities are at the risk of those who engage in them. Providers should consult their legal teams to determine the extent of liability to which their agency may be exposed through such transportation activities, particularly if an aide assumes that this is part of their normal duties.

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

J) Hospice Benefits and ICWP Services:

NOTE:

ICWP

If an individual is enrolled in the Independent Care Waiver Program and is later diagnosed with a terminal illness, he/she may elect to enroll in the Hospice program. He/she may continue to receive waiver services that are not duplicative of the hospice services. Waiver services that the Department has determined not duplicative of hospice services are:

- **Adult Day Care**
- **Behavior Management**
- **Respite Care (In home only)**
- **Personal Support Services** **Rev. 10/1/2015**

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

When an individual enrolled in the waiver elects hospice services the hospice agency assumes full responsibility for the professional management of the individual's **hospice** care in accordance with the hospice Conditions of Participation. The hospice agency and the waiver provider **must** communicate, establish, and agree upon a coordinated plan of

care for both providers which reflects the hospice philosophy and is based on an assessment of the individual's needs and unique living situation.

Covered Hospice Services include:

- Routine Home Care
 - Continuous Home Care
 - General Inpatient Care
 - Nursing Care
 - Medical Social Services
 - Physician Services
 - Counseling Services (For the purpose of helping the individual and those caring for him/her to adjust to the individual's approaching death.)
 - Medications
 - Physical Therapy, Occupational Therapy, Speech-Language (For purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills).
 - Hospice home health aide services are not covered in combination with ICWP services. Such services are considered duplicative of personal support services.
- Rev. 10/1/2015**

Waiver Residential Services:

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

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

Evidence of the coordinated plan of care must be in the clinical records of both providers. The facility and the hospice must communicate with each other when any changes are

indicated to the plan of care and each provider must be aware of the other's responsibilities in implementing the plan of care.

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

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

902.3 Skilled Nursing Services **Rev. 4/1/19**

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

Licensure Requirement

Agencies enrolling to provide nursing services, hourly or per visit, must hold and maintain in good standing licensure in one of the following categories:

- Home Health Agency under the Official Code of Georgia (O.C.G.A.) § 31-7-150 and Licensure Rules under Chapter 111-8-31 of Healthcare Facility Regulation, or
- Private Home Care agency under O.C.G.A. § 31-7-300 et seq. and Licensure Rules under Chapter 111-8-65 of Healthcare Facility Regulation.

Definition and Scope of Services

Skilled nursing services are rendered in accordance with the provisions of the Georgia Registered Professional Nurse Practice Act, O.C.G.A. 43-26-1 and Georgia Practical Nurses Practice Act, O.C.G.A. 43-26-30, when ordered by a physician in a plan of care. All services rendered to the member require certification by a physician. *Physician orders/certifications are specific for procedures performed and are time limited.*

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

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

Nursing Services

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

The Clinical Record:

The private home care provider must establish and maintain a current clinical record on all members admitted to the agency for ICWP reimbursed services.

These records must include at a minimum:

1. Appropriate member identifying information;
2. Name and telephone number of member's attending physician;
3. Pertinent past and current findings, including the admission assessment done by the provider RN;
4. A plan of care signed and dated by the attending physician at least every ninety (90) days or every three (3) months that includes drug, dietary, treatment and activity orders;
5. Member care plan, reviewed, updated, signed, and dated at least every 62 days by the provider RN.
6. Signed and dated clinical notes written by the close of the business day immediately following the day the service was rendered by the providing member of the health team and incorporated in the record no less often than weekly;
7. Copies of summary reports sent to the physician at least every sixty-two (62) days or every two (2) months; and

8. A discharge summary when applicable.

Registered Nurse Qualifications

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

Registered Nurse Responsibilities

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

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

1. Initial plan of treatment;
2. Preparation of clinical progress notes;
3. Coordination of services;
4. Informing the physician and other personnel of changes in the member's condition or needs;
5. Member and family teaching;
6. Development of teaching plan and caregiver(s) Competency Checklist
7. Administration of medications and treatments as prescribed by a physician in accordance with currently accepted standards of medical practice;
8. Total member care;
9. Supervising and teaching other nursing personnel;
10. Reviewing and revising the member care plan at least every 62 days and communicating revisions to appropriate staff.

Licensed Practical Nurse (LPN) Qualifications

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

Services Which May be Provided by a Licensed Practical Nurse Include:

1. Any service in accordance with and outlined in the Official Code of Georgia Annotated (O.C.G.A.), Section 43-26-30 through 39, Georgia Practical Nurses Practice Act;
2. Documenting clinical and progress notes
3. Assisting the registered nurse
4. Assisting the member in learning appropriate self-care techniques
5. Teaching the member and family
6. Performing and/or assisting with range-of-motion exercises and ambulation

7. Administering and setting up medications ordinarily self-administered and which have been ordered by a physician and supervised by the RN
8. Reporting of changes in the member's condition and needs to the RN
9. Taking and recording vital signs

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

1. The initial evaluation visit;
2. Initial development of the Treatment Plan
3. Initiation of the plan of care; and
4. Re-evaluation of member.

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

902.4 Specialized Medical Equipment and Supplies

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

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NOTE:

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

- B) Standards – Providers of specialized medical equipment and supplies must meet Underwriter's Laboratory or Federal Communications Commission standards where applicable.

Modification and equipment must meet acceptable industry standards.

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

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

- E) Services - Specialized medical equipment and supplies includes the following services:

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

Exclusions and Special Requirements:

- A) The need for specific modification is documented in the Individual Plan of Care.
- B) Repair or replacement costs for vehicle adaptations for member-owned vehicles are allowed as necessary when specified in the Individual Plan of Care.
- C) The costs of acquiring a vehicle is not covered.
- D) Reimbursement to cover replacement of equipment within three (3) years of purchase is not covered unless specific written prior approval is obtained from the Division of Medicaid.

NOTE:

The maximum amount allowable for this service is \$247.50 per year.

- 2) Specialized Medical Equipment

- A) Only medical equipment that cannot be obtained under Georgia's approved Medicaid Plan, or that is needed in excess of State Plan limitations, is covered under this program.
- B) Reimbursement is limited to the maximum allowable monthly cost of \$1,026.00 for specialized medical equipment and supplies. Equipment costs may not exceed the maximum annual allowable amount of \$12,312 or the member's annual budget allocation. Reimbursement for both medical supplies and equipment is based on medical necessity as determined and approved by Alliant Health. **4/1/17**

Only the most cost effective equipment which will meet the member's needs will be considered and approved for reimbursement after all other resources or DME have been exhausted. Alliant Health may require the provider to obtain cost estimates from up to three equipment suppliers, including online suppliers to ensure the most cost effective equipment is reimbursed. **4/1/17**

- 2) Specialized Supplies – Specialized supplies are critical to the health and wellbeing of the member and necessary to prevent institutionalization. Examples include:
 - A) Special food supplements
 - B) Special clothing
 - C) Diapers
 - D) Bed wetting protective chux
 - E) Other items as specified in the Individual Plan of Care.

Exclusions and Special Requirements:

- B) The need for specialized supplies and equipment must be documented in the Individual Plan of Care and be prior approved by the Division.
- C) Only supplies and equipment that cannot be obtained under the Medicaid State Plan maybe covered under this program.
- D) Reimbursement is limited to actual costs or the maximum allowable monthly cost of \$1,026.00 for medical supplies and equipment. Equipment cost may not exceed an annual amount of \$12, 312. **4/1/17**

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902.5 Environmental Modification

- A. Description – Providers of environmental modifications services provide physical adaptations to the private home specified in the Individual Plan of Care, which are necessary to ensure the health, welfare, and safety of the member, or which enable the member to function with greater independence in the home and without which, the waiver participant would be at risk of institutionalization. Those modifications include items or equipment not otherwise available through the Medicaid State Plan and not available through other fund sources, whether public or private foundations or grants. Such improvements or adaptations do not increase the square footage of the private home.
- B. Requirements – All providers of environmental modification services must meet state or local requirements for licensure or certification, if applicable, including building contractors, plumbers, engineers and electricians. The provider must be in good standing with the local Better Business Bureau.
- C. Submission Requirements – A provider seeking enrollment to provide environmental modification services must submit a copy of its current **Business License** with the Provider Enrollment Application. A provider must submit all building licenses that are applicable to environmental modification. The applicant must submit proof that the provider agency has at least \$1,000,000 in general liability insurance coverage.
- D. Training - The provider of environmental modification must attend a new provider training session provided by Alliant Health prior to delivery of ICWP services and any subsequent training, as warranted.
- E. Services – Environmental modifications may include the following:
 - 1) Installation of ramps and grab-bars
 - 2) Widening of doors
 - 3) Modification of bathrooms facilities
 - 4) Installation of specialized plumbing and electrical systems necessary to accommodate medical equipment.
 - 5) ICWP will provide the basic modifications and installations to assist a member in their ADLs.
- E. Procedures - Case Managers are expected to assist the member with obtaining three bids to complete environmental modifications to ensure that members have a selection of qualified and experienced contractors from which to choose. The member is required to accept the lowest bid of the three qualified contractors. Further, the case manager shall assist the member with obtaining in writing from the contractor the specific agreed upon work to be performed by the contractor and all costs associated with the

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environmental modification. Any changes to the original bid must be in writing as well. Efforts must be made to identify three contractors for bid. However, if three contractors are not available, e.g., as may be the case in certain rural areas of the state, the case manager must document their efforts to comply with this policy and submit the documentation to the review nurse along with the submission requirements stated below.

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

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

- A written narrative of the work that the member is requesting to be completed along with an explanation of why the home modification is needed. (Submit as an Appendix U addendum)
- Pictures of the area that is to be modified.
- An itemized contract indicating the work that will be completed. This is to be provided to the case manager from the home modification provider
- The case manager, member, and contractor must sign the itemized contract agreeing with the work that will be completed.
- Proof of home ownership or agreement with owner required. If the member does not own the home, the property owner must agree to the planned modification and give their approval in writing before the service is approved. Maintain the property owner's approval in the member's file.
- Home modifications services for provider owned housing is not allowable.
- The DMA-80 which is provided by the home modification provider. (This form is called the Appendix L and is found in the policy manual) The date the home modification provider intends to start the job must be included on the DMA-80.

The case manager is responsible for gathering all of the required documentation to submit to the review nurse. The complete packet of information must be submitted at one time in order for the review nurse to make a determination

of the necessity of the home modification.

If the Alliant Health Review Nurse approves the request for the home modification, one half of the total amount will be approved to start the home modification.

After the work is in progress, the case manager must go in person to see the work or contact the member by telephone to receive a progress report from the member on the work being performed. Any issues or concerns regarding the work should be discussed at the time of case manager contact or agreement between the member and case manager that the work is progressing well.

Submission of the Final Packet to Alliant Health by the Case Manager

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

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

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

NOTE: All modifications, improvements or repairs must be in accordance with local and state housing building codes and Special Requirements:

- 1) Adaptation or improvements to the home which are not of direct medical or remedial benefit to the member are not covered (e.g., carpeting, roof repair, air conditioning controls, etc.).
- 2) Adaptations and improvements must be specified in the Individual Plan of Care and must receive prior approval from Alliant Health. Estimates from various contractors must be submitted for review by Alliant Health to assure efficient use of funds. Three bids or estimates is required if there are three available providers, but the number of bids is limited to the number of approved ICWP providers available to perform the service.
- 3) Home modification funds cannot include the basic construction costs of room additions or new buildings.
- 4) The total amount allowable for home and environmental modifications is limited to the actual costs of the modification or a maximum expenditure of **\$8,800** per member per lifetime.
- 5) Resources such as the Georgia Residential Finance Authority, local homebuilders' associations, and other volunteer sources should be used before drawing upon ICWP funds. Written documentation must be maintained indicating the provider has exhausted these resources before billing Medicaid.

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

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

- B) Qualifications - Individual providing counseling services shall have at least a Master's degree in one of the behavioral sciences and one year of related counseling experience.
- C) Submission Requirements - A provider seeking enrollment to provide counseling services must submit proof of licensure/certification with the Provider Enrollment Application. The applicant must submit proof that the provider agency has at least \$1,000,000 in general liability insurance coverage.

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- D) Training - The provider of counseling services must attend a new provider training session provided by Alliant Health prior to working with members and any subsequent training, as warranted, and must understand and subscribe to the independent living philosophy and goals of the ICWP.
- E) Services - Counseling services are available to members needing treatment for personal, social or behavioral disorders to maintain and improve effective functioning. The counselor shall keep a written record of services provided. The record shall contain summaries of each scheduled session and any other significant contact. The record shall include, but is not limited to, the following data:

- 1) Date of contact
- 2) Names, addresses and phone numbers of the people involved in contact
- 3) Duration of contact
- 4) Progress toward objectives of the counseling case plan
- 5) Recommendation for changes in counseling or the Individual Plan of Care.

The counselor shall send a written report to the case manager at least every six (6) months. The report shall contain a statement on the progress toward the goals of

the Individual Plan of Care and recommendations for changes in the plan.

902.7 Personal Emergency Response System (PERS)

- A) Description – PERS is an electronic device that enables high-risk members secure help in the event of an emergency. PERS providers provide two-way verbal and electronic communication systems with a central monitoring station seven (7) days a week, 24 hours a day to geographically and socially isolated members. The member may wear a portable “help” button to allow for mobility. The system is connected to a member’s phone and programmed to signal a response center once a “help” button is activated.

NOTE:

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

- B) Qualifications – PERS providers must utilize devices that meet Underwriter’s Laboratory or Federal Communications Commission standards and must be in good standing with the local Better Business Bureau. The response center must be staffed by trained professionals.
- C) Submission Requirements - A PERS provider seeking enrollment in the ICWP must submit a copy of its current **Business License** with the Provider Enrollment Application. A PERS provider must provide an estimated number of active employees for their company. The applicant must submit proof that the provider agency has at least \$1,000,000 in general liability insurance coverage. **Rev. 4/1/19**
- D) Training - The PERS provider must attend a new provider training session provided by the Alliant Health prior to working with members and any subsequent training as required.
- E) Responsibilities – The PERS provider is responsible for the following:
- 1) Designating or operating an emergency response center (monitoring station) where signals are received and response is made according to specified operating protocol.
 - 2) Calling the member at least once a month to test system operation.

- 3) Providing operational and technical manuals and training to appropriate PERS staff.
 - 4) Any replacement or repair needs that may occur. The provider shall present the member with instructions on how to request replacement or repair of the equipment. Such replacement and repair must occur within three (3) working days of notification of malfunction.
 - 5) Assessing the member's ability to use the system correctly and documentation of such.
 - 6) The cost of all long distance charges associated with the use and monitoring of the PERS.
- F) Equipment Specifications – The provider must be trained and knowledgeable of the detailed manuals received from PERS equipment vendor relating to operational aspects of the system, including technical specifications, installation and testing.

Home Unit Specifications

- 1) The voice button or other simple device that can be worn or attached to the member shall activate the home equipment.
 - 2) The system shall be usable by persons who are visually and/or hearing impaired, or physically disabled.
 - 3) The communicator shall provide for two-way communication and shall have a receiver to receive wireless signals.
 - 4) The communicator shall be attached to existing telephone lines and shall not interfere with normal use of the telephone.
 - 5) The communicator shall have a battery to provide minimum of eight to twelve hours of operation in the event of a power failure. It shall utilize a self-charging system and report its condition to the monitoring station after two hours of power loss.
 - 6) The communicator shall be equipped with a self-diagnostic program that it performs in each twenty-four periods.
- G) Twenty-four Hour Monitoring Equipment Specifications
- 1) Maintain detailed technical and operations manuals that describe program elements, including equipment

functioning, response protocol, record keeping and reporting procedures, equipment testing and installation in the member's home.

- 2) The emergency response center's equipment shall consist of a primary receiver, a back-up receiver, a clock printer, a back-up power supply and a telephone line monitor.
- 3) The primary receiver and back-up receiver shall be independent and interchangeable.
- 4) The printer shall print out the time and date of the emergency signal, the member's identification code, and emergency codes indicating active or passive alarm or responder reset.
- 5) The emergency response center shall have the backup supply power capacity to operate in excess of eight hours.
- 6) The telephone line monitor shall give visual and audible signals in the event an incoming telephone line is disconnected for more than ten seconds.
- 7) The receiving and printing stations at the monitoring center shall have a minimum of two incoming telephone lines that are automatically interchanged in the event of telephone or equipment malfunction or unusual load demands.

H) Other Requirements

- 1) PERS providers are not required to replace a system unless there is a malfunction/defect in the current unit, unit upgrade by the provider agency or act of nature issue with the existing unit. If the unit is damaged or lost by the member/caregiver, neither the provider nor Medicaid will be responsible for the cost of a new unit/install. A member remaining active in the waiver program but requesting ERS service termination and then return of the ERS service within a 12 month period (excluding a temporary nursing home stay) will be subject to the cost of the second installation fee.
- 2) The need for Personal Emergency Response System is identified in the Individual Plan of Care and prior approved by the Division.
- 3) The provider shall maintain a written monthly log of all emergency signals received and appropriate actions taken, i.e., incident reports.

- 4) The maximum allowable cost for installation is \$75.00 per residence.
- 5) The maximum allowable cost for monthly monitoring is \$25.00 per month.

902.8 Behavioral Management

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

B) Staff Requirements - Providers of behavioral management services must have direct clinical oversight and supervision by:
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- 1) A psychiatrist who has one year providing neurobehavioral services, or
- 2) A licensed psychologist, certified rehabilitation counselor, or licensed professional counselor who has one year of experience in providing neurobehavioral services or traumatic brain injury services. (The psychologist, psychiatrist or counselor must be licensed in Georgia and readily available to the member unless the member has been approved to receive services out of state.) **Rev. 1/1/2018**

The member receiving behavior support services must also receive services from a professional meeting the qualifications in 1) and 2) above. That professional must oversee the member's behavior supports plan and assist all service providers, family members and caregivers in implementing and adjusting the plan as the member's behavioral needs change.
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Behavior specialists will have at least one-year experience working with individuals with traumatic brain injuries, other disabilities, and/or behavioral difficulties. These individuals must successfully complete 40 hours of training in TBI, behavior analysis, and crisis intervention techniques provided by a Behavior Management program. The Georgia Division of Medical Assistance's Waiver management staff may request to review the training manual. The Behavior Specialist must work under a professional who meets the director qualifications listed above. **Rev. 1/1/2018.**

- C) Submission Requirements - Individuals seeking enrollment to provide behavior management services must submit with the Provider Enrollment Application, a detailed plan that demonstrates the ability to provide behavioral training to the member with a TBI as well as individuals who have significant contact with TBI members. The applicant must submit proof that the provider agency has at least \$1,000,00 in general liability insurance coverage. **Rev. 4/1/19**
- D) Training - Providers of behavior management services must attend a new provider training session provided by the Alliant Health prior to working with members and any subsequent training as required.
- E) Services – Behavior Management should consist of the following services:
- 1) A comprehensive assessment of maladaptive behavior(s).
 - 2) Development of a structured behavioral intervention plan, which has as its primary focus, teaching socially appropriate behaviors and eliminating maladaptive behaviors and eliminating maladaptive behaviors.
 - 3) Implementing plan of care.
 - 4) Ongoing training and supervision of the TBI member, family members, caregivers, and all other service providers.
 - 5) Periodic reassessment of the plan.

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

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

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

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

902.9 Adult Day Services

- A) Description – Providers of Adult Day services provide services specializing in treatment techniques for members with traumatic brain injuries and or a major neurological deficit. Providers of Adult Day Services develop and provide staff training, which focuses on the needs of individuals with a traumatic brain injury or neurological deficit identified in the Plan of care, and the specific manner in which this service will meet the member’s individual needs. The program focuses on adaptive skills and is distinct from work production objectives. These services are provided during the day through day care programs that are offered at facilities within the community. At the end of each day, the member returns to his/her home.
- B) Requirements – Adult Day Services must be provided by an enrolled not for profit or proprietary health and human services agency, such as a licensed or certified home health care agency, hospital, nursing facility, or diagnostic and treatment center specializing in treatment techniques for persons with a major neurological deficit. These providers must have, at a minimum, one year experience providing services to individuals with a traumatic brain injury. They must directly supervise all direct care staff and must meet the following criteria: **Rev. 1/1/2018**
- 1) Psychologist with a specialty in Cognitive Remediation,
 - 2) Certified Rehabilitation Counselor,
 - 3) Certified Rehabilitation Registered Nurse (CRRN), or
 - 4) Licensed Professional Counselor (LPC), or
 - 5) An individual with a master’s degree and two years of experience providing services to individuals with a major neurological deficit. Rev. 1/1/2018**
- C) Submission Requirements - Individuals seeking enrollment to provide Adult Day services must submit proof that staff meets the qualifications in B above with the Provider Enrollment Application. If state or local law requires licensure of the agency, organization or health facility, the provider must also

submit proof of licensure at the time of application and annually thereafter. The applicant must submit proof that the provider agency has at least \$1,000,000 in general liability insurance coverage. **Rev. 4/1/19**

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

E) Specific Tasks - Providers of Adult Day services will:

- 1) Develop individual service plans for each ICWP member with input from the member to the extent possible. **Rev. 1/1/2018**
- 2) Develop and provide staff training that focuses on the needs of individuals with a TBI and/or a major Neurological deficit and must specify the manner in which this service will meet the member's individual needs.
- 3) Develop a detailed plan that reflects the specific habilitation needs of the member and the activities and/or other approaches for meeting those needs. (The Plan of Care must be reviewed by the case managers and Alliant Health before approving services).
- 4) Provide sufficient space to meet the needs of the member and staff. The program must provide adequate protection for the member's safety, accessibility and fire safety, and must be located in a building that meets all provisions of the Georgia Fire Prevention and Building Code.

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

- 1) a habilitation program in the areas of social, emotional, physical and intellectual development,
- 2) training in the areas of daily living skills (including leisure/recreation skills), mobility, programming to reduce inappropriate and/or maladaptive behaviors and training in the independent use of common community resources,
- 3) lunch meal.

G) Location - Adult Day Health facilities/Mobile ADH cannot be located on the grounds/roofline* of or adjacent to any ALS Home. Members must have freedom of choice when selecting services and providers. Members cannot be coerced or encouraged to

select services from a provider that has the same ownership or other relationship to the ADH provider. (Rev. 4/2022)

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

NOTE: A member receiving Adult Day Services may not receive PSS simultaneously during the same hours under the ICWP; however, they may receive both services at different times of the day unless a lack of continual one on one assistance presents a significant safety risk to the member or other persons being served. A Personal Support Provider may not bill for PSS hours during the time a member is receiving Adult Day Services unless the absence of a personal support attendant disqualifies the member from participation due to significant physical limitations or behavioral dysfunction. Justification which requires the one on one assistance during adult day services must be documented in the member's medical record. **Rev. 1/1/2018**

NOTE: Ongoing services will be supervised by a Behavior Specialist. The program director will provide ongoing supervision to the Behavior Specialist.

902.10 Respite Care

Rev.10/09

2. Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of the people normally providing care.
3. Licensure – In-Home Respite Care providers must be licensed by the Healthcare Facility Regulation Divisions (HFRD) within DCH as a Private Home Care Provider to provide personal support services or a licensed personal care home. Out of Home Respite Care Providers must be a Medicaid certified nursing facility, a certified hospital, a licensed respite care facility, or other facility approved by the contracted review team. Licensure must be posted in a conspicuous location open to public view.
4. Submission Requirements – Providers seeking enrollment to provide respite care services must submit the following with the Provider Enrollment Application:

- a. In Home Respite providers must submit their current Healthcare Facility Regulation Divisions license.
- b. Out of Home Respite providers must submit a description of facilities including the number of available beds and a staff coverage plan to accommodate overnight services in addition to documents to verify that the agency is a Medicaid certified nursing facility, a certified hospital, a licensed respite care facility, or other facility approved by the contracted review team.
- c. Training Package or Proposal – Training programs must be developed by all respite care providers and must include all areas of training specified in the policies and procedures manual. The service provider must certify that individuals have met and completed all training requirements. Staff must indicate by signature and date completion of each area of training. All training must be maintained in the personnel file.
- d. The applicant must submit proof that the provider agency has at least \$1,000,000 in general liability insurance coverage. **Rev. 4/1/19**

5. Training

- a. New Provider Training – Providers of respite care services must attend a New Provider Training session provided by Alliant Health prior to working with members and any subsequent training, as warranted, and must understand and subscribe to the Independent Living Philosophy and goals of the ICWP.
- b. Specific Training Requirements – Individuals providing respite care services must have completed training in the following areas prior to delivery of services:

(A) CPR and Basic First Aid

(B) Emergency procedures

(C) Assistance with medications

(D) Specialized procedures.

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

(H) Infection Control

(I) How to give personal care

- (J) Transfer techniques
- (K) The need for confidentiality regarding the services being provided
- (L) Agency policies and procedures
- (M) Observation skills
- (N) Safety and accident prevention

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

- (J) Human needs and behavior
- (K) Family relationships
- (L) Stress management
- (M) Meal planning
- (N) Community resources
- (O) Fire safety
- (P) Conflict resolution
- (Q) Documentation
- (R) Time management

Rev.10/09

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

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

6. Levels of Service - Respite services are provided and reimbursed on the following levels: **Rev. 1/1/2023**

LEVELS OF CARE	DESCRIPTION
-------------------	-------------

<u>Level I</u>	Cognitive and/or behavioral issues that require general safety oversight
	Requires Medication Reminders
	Moderate to total assistance with ADLs such as feeding, bathing, bowl care, grooming; and general housekeeping
	Moderate to total transfer assistance to maintain continence and hygiene
	Needs assistance with feeding and meal prep
	Needs assistance with elimination such as catheter/colostomy/urostomy care
	Care of stage I or II decubitus ulcer
	Tube feeding oversight and/or administration of tube-feeding
<u>Level II</u>	Requires a minimum of four hours a day of behavior management due to TBI
	Unstable medical condition requiring three or more hospitalizations per year
	Complex skilled needs such as trach care, ventilator care, or suctioning
	Care of stage III, or IV decubitus ulcer
	Receiving parenteral nutritional supplementation

NOTE:

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

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

903. Non-Covered Services

The following services are not reimbursable:

- A) Services for which prior authorization was not obtained,
- B) Services provided prior to the effective date of enrollment,
- C) Services not contained in the Individual Plan of Care,
- D) Services for which another payer is liable,
- E) Services provided while a member is incarcerated,

- F) Case finding, legislative advocacy, training, medical treatment,
- G) Payment for services which are an integral and inseparable part of another Medicaid covered service, and
- H) Services provided in a manner, which is in violation of the provisions contained in this manual.
- I) Services provided by family members (spouses, children, etc.).

904. Durable Medical Equipment (DME)

- A) Procedures relating to purchase, rental, repair maintenance, and delivery of equipment and appliances, refer to the DMA Policies and Procedure Manual for Durable Medical Equipment.
- B) The DME service manual may be located on the www.AlliantHealth.georgia.gov Web site.
- C) Equipment and supplies covered through DME must be submitted for approval through the DME Program prior to accessing items through the ICWP.

The case manager must assure provision of DME as follows:

- If the DME item is directly related to the service being provided under the ICWP, and is reimbursable under the Medicaid program, the case manager must assist the member in obtaining the item through a DME vendor enrolled with the Division of Medical Assistance. If requested by the DME vendor, the case manager must assist the member in obtaining a prescription or Certificate of Medical Necessity from the physician.
- The case manager must also send a copy of the PAF and the initial Plan of Care to the DME vendor. The DME vendor should submit this information and all other required forms and documentation necessary for approval through the DME Program. The DME vendor must send copies of the approval/disapproval through the DME Program to Alliant Health and the case manager within five (5) working days of receipt.
- If needed equipment and/or supplies are not directly related to the service being provided, the case manager will assist the member in obtaining the item(s) through a Medicare or Medicaid approved vendor.

905. Non-Emergency Transportation Services (NET)

For more detailed information, contact the NET broker serving the member's location. (Refer to Appendix M for NET Brokers.)

906. Documentation

906.1 General Record Keeping Standards

All provider records for the member must contain a copy of the submitted DMA-6 and DMA-80. The Mailer Data form that Alliant Health Solutions sends out to providers must be attached and kept with the submitted copies of the DMA 6, and DMA 80 in the member record. This will verify approval from Alliant Health. If a DMA 80 is amended this must also be kept on file with the new Mailer Data form and the correspondence from Alliant Health stating that the DMA was amended. All providers, excluding Environmental Modification providers, must establish and maintain a current record for each individual evaluated and admitted for services.

- A) The record may be duplicated and maintained in various provider locations responsible for providing services.
- B) There must be sufficient documentation in the record to demonstrate the quality of care being provided and to allow the appropriateness of care to be maintained and evaluated.
- C) Documentation for personal support services must include the following: type of service identified, arrival time/departure time, and total hours for services rendered; plus, the member's initial and personal support provider signature.
- D) Documentation for case management must include time spent for telephone calls related to the member's care. The face to face monthly visit must be dated and signed with the ICWP member.
- E) For providers of Case Management, Personal Support, Respite, Skilled Nursing, Counseling, Behavior Modification and Adult Day Services, all member records must contain the following basic information:
 - 1) Appropriate member identifying information, including the name of the member's attending physician, pertinent past and current findings;
 - 2) A copy of the Participant Assessment Form (PAF);
 - 3) A copy of the original DMA-6 submitted to Alliant Health and the approved Mailer Data form must be attached and on file to verify approval
 - 4) copy of the Member's Rights and Responsibilities and the Memorandum of Understanding;
 - 5) A copy of the original DMA-80 submitted to Alliant Health and the approved Mailer Data form must be attached to verify approval.
 - 6) Individual Plan of Care authorized by Alliant Health Solutions, signed and dated by the case manager, the member and the planning team at least every twelve (12) months;
 - 7) A copy of the Freedom-of-Choice form;

- 8) A copy of the Release of Information form;
- 9) Documentation of services provided by each health team discipline, signed and dated the day the service is rendered.
- 10) Member information regarding critical medical issues, such as allergies, life-threatening diseases, special precautions and next of kin or person to notify in case of emergency;
- 11) Documentation of the member's involvement in the provision of services;
- 12) Monitoring of services documentation;
- 13) Discharge plan when applicable;
- 14) Advance Directives (The Georgia Living Will. See Appendix N.)
- 15) Directions to the member's home. Directions must contain specific instructions on how to reach the member's home from the provider agency/office. Adult Day Service providers are excluded from this requirement.
- 16) Providers must keep a copy of the GChex file for each employee.
- 17) A copy of the employees CPR and first Aid card must be maintained on file for PI review

907. Utilization Review

- A) The DMA performs periodic utilization reviews of ICWP member services to assure the medical necessity for continued care and the effectiveness of the care being rendered. Each provider is reviewed as frequently as deemed appropriate or necessary, with on-site reviews or audits sometimes conducted with no prior notice.
- B) During each review visit, the DMA examines member records and conducts in-home or on-site individual member assessments.
 - 1) The DMA examines member records to assure that they contain the following:
 - an approved Level of Care;
 - physician's orders, if applicable;
 - provider care plans;

- documentation of services provided, their frequency, and appropriateness of service revisions; and
- documentation of supervisory visits.

C) ICWP providers are required to submit prior authorization requests and certain other documentation electronically to Alliant Health for review and approval. These documents along with other documents required as a part of the assessment, reassessment and service delivery process are to be maintained in members records as well. A complete list of documents which must be in the record include: **Rev. 1/2016**

Review Period: From _____ To _____

1. DMA-6 (Appendix E) and any mailer data forms
2. DMA-80 (Appendix L) and any mailer data forms
3. Individual Plan of Care/ICWP Community Care path (Appendix H, H1, H2, H3)
4. Participant Assessment Form/PAF (Appendix D)
5. Memorandum of Understanding (Appendix C)
6. Personal Care Attendant Hour Allotment (Appendix D1) **
7. Rights and Responsibilities Form (Appendix B)
8. Advanced Directives Form (Appendix N)
9. Release of Information Form (Appendix F)
10. Freedom of Choice Form (Appendix I)
11. Service Record Forms (record of billable time, activity notes)
12. Supervisory Visits
13. Progress Notes
14. Directions to the home (if applicable)
15. Physician Orders (if applicable)
16. MARs (if applicable)
17. Licenses/Permits for provider facilities
18. Discharged Records (if applicable) (Appendix K1)
19. Power of Attorney (if applicable)

OTHER: Providers may be asked to coordinate member assessments, home visits or facility tours that are needed during the review.

** Personal Care Attendant Hour Allotment form (Appendix D1) – This form is completed during initial assessments **only** by the ICWP Assessment Nurse.

NOTE:

The following items are determined to be recoupable: Deficiencies related to the DMA-6 and DMA-80, required quarterly review, documentation of services, Supervision of personal support services and qualities issues.

2) The DMA conducts on-site assessments of members to determine if the member's condition warrants continuation of the current level of services rendered by all ICWP providers. The assessments determine whether:

- additional needs exist;
- care provided is adequate;
- services have been effective; and/or
- alternative methods of care should be considered.

C) Upon completion of the on-site visit, the DMA forwards to the provider a written report of the Utilization Review findings. The provider must submit a corrective plan of action to the Division of Medical Assistance within fifteen (15) calendar days of the date of the utilization review report. The Division will review the corrective plan and notify provider of the plans acceptability.

The provider's failure to comply with the request for a corrective plan of action may result in adverse action, including suspension of referrals or termination from the program.

D) When Utilization Review reports include recommendations for changes in member services, the DMA will mail the report to the provider five (5) business days prior to mailing the member letter(s). The member has the right to appeal any adverse action recommendations made by the DMA. Adverse actions imposed by DMA include:

- 1) reducing service(s);
 - 2) terminating service(s); and
 - 3) determining service is inappropriate.
- If the member appeals by filing for a hearing within ten (10) calendar days of the date of the member letter, the member may continue to receive services until the Administrative Law Judge (ALJ) makes a decision. Providers must consult with the case manager to confirm that the member has requested a hearing within ten (10) calendar days and wishes to continue service. The DMA will reimburse the provider for services rendered during the DHR hearing process if the member's request for a hearing was filed timely.
 - If the member does not file for a hearing within the ten (10) calendar days of the adverse action letter, the DMA's

recommendation becomes effective at the end of the ten (10) calendar days as stated in the utilization review report and the DMA notice to the member. However, the member has the right to request a hearing within thirty (30) calendar days from the date of the member's letter.

PART II - CHAPTER 1000
BASIS FOR REIMBURSEMENT

1001. Conditions of Reimbursement:

Reimbursement is made to ICWP providers who have:

- A) completed the ICWP enrollment process;
- B) been assigned an ICWP provider number;
- C) delivered services ordered on the Individual Plan of Care;
- D) provide services to a member enrolled in ICWP;
- E) provided services approved prior to delivery;
- F) exhausted all other sources of health care reimbursement; and
- G) provided services covered by the provisions of this manual.

1002. Reimbursement

1002.1 Reimbursement and Claim Form

The DMA reimburses for services rendered at rates established by the DMA in accordance with the policies and procedures of this manual. See Appendix O for current procedure codes and reimbursement rates.

Effective May 1, 2015, the department will only accept electronic claims. Any paper claims submitted to the fiscal agent for payment after this date will be returned to the provider. Please refer to the Medicaid and Peachcare for Kids Part I Policies and Procedures manual, Section 112 for more information. **Rev. 7/15**

A DCH approved EVV vendor must be used to submit all Personal Support Services claims to be eligible for reimbursement. **Rev. 10/21**

1002.2 Service limits apply to the following services: (See Appendix O.)

- A) completed the ICWP enrollment process;
- B) Environmental Modification;
- C) Vehicle Adaptation;
- D) Specialized Medical Equipment and Supplies;
- E) Personal Emergency Response Services.
- F) Skilled Nursing

- G) Personal Support Services
- H) Case Management
- I) Respite Care
- J) Behavior Management
- K) Counseling

1002.3 Reimbursement is not authorized for the following:

- A) any date of service in which the member was/is inpatient in a nursing facility, hospital, or other institution
 - B) Room and board; and
 - C) Georgia Medicaid will not reimburse for personal care services or any waiver services when provided to recipients by legally responsible relatives, i.e., spouses, parents of minor children, legal guardians, or anyone with any power of attorney, when the services are those that these persons are already legally obligated to provide.
1. Services provided by relatives, except as noted above, may be covered when the following criteria are met:
 - The relative must meet all required training and qualifications before he/she assumes the role of paid caregiver for the member
 - the relative is hired, trained, supervised, and reimbursed by an approved ICWP Private Home Care Agency
 - payment is limited to the relative in return for specific services rendered
 2. In the case of self-directed care, all of the following criteria must be met:
 - The family member or friend must meet the provider qualifications and training standards specified in the waiver for that service;
 - The family member must meet the training qualifications prior to rendering services to an ICWP member;
 - An agreement must be in place between the member, employee and or the provider before services is rendered;
 - The member must pay the caregiver at a rate that does not exceed that which would otherwise be paid to a provider of a similar services;

- If approved, an individual caregiver (family member) may not provide more than 40 hours of paid personal support services in a seven day period. For members that have hired a family member as a caregiver, 40 hours is the total amount that can be paid to the caregiver; and
- The caregiver must review and approve the time worked by the caregiver in the FI EVV system.

1003. General Claims Submission Policy for Ordering, Prescribing , or Referring (OPR) Providers Rev. 2014

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid.**

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

For the NEW CMS-1500 claim form:

Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

For claims entered via the web:

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

1004. Rounding Rules

To provide the most accurate and fair methodology for billing for services rendered. The state utilizes the following Rounding Rules as it relates to those services provided in 60 minute increments. For those Personal Support Services (PSS) billed hourly, less than 30 minutes rounds down to the next whole unit. Thirty (30) minutes will round up to the next whole unit.

Documentation with actual time spent rendering services will be reflected in the member's service notes. All other services not billed in 60 - minute increments are to be billed as indicated within the Reimbursement Rate Table Appendix O.

APPENDIX A
INDEPENDENT CARE WAIVER SERVICES PROGRAM
PROVIDER APPLICATION ADDENDUM FORM

Review and complete sections I – IX.

I. Agency Name: _____

Contact Person name, phone number, email address:

(Name)	(Phone Number)	(Email Address)

II. Indicate the specialty selection(s) for which application is being made. Examples of specialty services include PSS, skilled nursing, case management, environmental modification, etc.

Specialty/Specialties selected:

III. Indicate the type and number of staff, by service category (specialty), that will be personally and directly providing the service (s).

IV. Attach a copy of the current professional license for all nursing staff, including RNs and LPNs who will deliver ICWP services. For case managers, a copy of a detailed resume along with the R.N. license and/or BA/ BS and graduate degree if applicable along with documentation of accreditation of the school attended must be submitted (See Section 902.1) Attach additional sheets as needed.

V. Attach a copy of documents showing that you have the current and appropriate license, certification or permit to participate in the selected service categories.

VI. If you are applying to become a provider of Personal Support or Companion services, attach policy, curriculum and schedule which lists appropriate training. Training should include not only the physiological aspects of providing care, but should address the psycho-social and psychological aspects of members care as well.

- VII. Personal support service providers must meet the pre-requisite requirement of providing either personal support services or community living support services as a CCSP, SOURCE, NOW, COMP, or GAP program provider for at least one year prior to enrollment in ICWP.
List your provider # that meets this requirement _____.
- VIII. Review Appendix A-1 for the list of documents and/or information requirement for each specialty. Email the pending ATN and documents to ICWP.documents@dch.ga.gov.
- IX. Policies and procedures must include the topics listed in the General Conditions Policy section 602 as well as the service specific requirements listed in Section 902.1 – 902.10 or Section 1254.2 of the ALS manual if providing ALS services. Review these sections and compile documents to show compliance with each requirement.
- X. I hereby certify that my application to provide Independent Care services is complete and contains all required materials in accordance with the submission requirements established by the Division of Medical Assistance. I understand that my application will be returned to me if it is not complete and that this could delay Approval as a provider.

Signature of person legally authorized to act
as the provider of services

Date

Complete electronic application online and submit application and upload required documents and materials to:

DX/MMIS
www.mmis.georgia.gov

Note: All services will be available to all members based on their need according to the individualized Plan of Care.

Independent Care Waiver Services

ICWP (Category 660) Provider Application Checklist
Appendix A-1

ICWP Specialty Codes

197 – PSS, Personal Support Services

243- RSP-IH, Respite, In-Home

244-RSP-OH, Respite, Out-of-Home

010- ALS, Alternative Living Services

- Group Homes (7-24 beds) not allowed.
- ALS MA- ALS Management agencies must apply to become a provider. See column 010-MA.
- ALS PCH- Management agencies (MA) must submit packets to apply for a Medicaid # for each 2-6 bed PCH they manage. See column 010-PCH.

005- ADS, Adult Day Services

030-CM, Case Management- (Contact ICWP Specialist for requirements and approval)

- CM-T- Traditional Case Management (will not have enhanced rates on file)
- CM-E- Traditional and Enhanced Case Management
- CM-A-Enhanced agency model

058-DME, Specialized Medical Equipment and Supplies

064-ERS, Emergency Response Services

249-SN, Skilled Nursing Services

- PD- Per Diem only nursing (will not have hourly rates on file)
- H- Per Diem plus hourly nursing.

216-FI, Fiscal Intermediaries (contact ICWP specialist for requirements and approval)

289-BM, Behavior Management

041-CSL, Counseling

067-EMOD, Environmental Modifications

275-Vehicle Adaptations

[illegible]

[illegible]

in caring for severely disabled patients and/or TBI patients with special health care needs. Nurses should also have experience in home health services, public health, geriatrics, long-term care or a related field												
Your back-up plan or your agency's plan to provide coverage in the event the nurse that is scheduled to provide services is unable to work his/her schedule.	N	N	N	N	N	N	N	N	N	N	N	N
Staff Training Plan with topics and timelines	Y	Y	Y	Y	Y	N	N	N	N	N	N	N
Licensed as a Medicaid certified nursing facility, a certified hospital, a licensed respite care facility, or Personal Care Home	N	N	Y	N	N	N	N	N	N	N	N	N
Description of facilities including the number of available beds and a staff coverage plan to accommodate overnight services	N	N	Y	N	N	N	N	N	N	N	N	N
Owners Resume must include one year of ALS Management experience under another waiver	N	N	N	Y	N	N	N	N	N	N	N	N
Pre-placement screening form (Appendix A from the ICWP-ALS manual)	N	N	N	N	Y	N	N	N	N	N	N	N
Subcontract with PCH	N	N	N	N	Y	N	N	N	N	N	N	N
Fire Safety Inspection	N	N	N	N	Y	Y	N	N	N	N	N	N
PCH permit that lists only 2 – 6 beds	N	N	N	N	Y	N	N	N	N	N	N	N
Diagram of PCH Floor Plan	N	N	N	N	Y	N	N	N	N	N	N	N
License and resume for one of the following: 1) Psychologist with a specialty in Cognitive Remediation 2) Certified Rehabilitation Counselor 3) Certified Rehabilitation Registered Nurse (CRRN) 4) Licensed Professional Counselor (LPC) 5) An individual with a master's degree and two years of experience providing services to individuals with a major neurological deficit.	N	N	N	N	N	Y	N	N	N	N	N	N

[illegible]

[illegible]

Building license or Contractor license	N	N	N	N	N	N	N	N	N	N	N	N
Resume of owner that details relevant experience providing home modifications such as installation of ramps and grab-bars, widening of doors, modification of bathrooms facilities, and installation of specialized plumbing and electrical systems necessary to accommodate medical equipment	N	N	N	N	N	N	N	N	N	N	N	N
If licensed, the agency will maintain the license as applicable in home health, private homecare, neurobehavioral center, or other. If out-of-state, must provide a letter of recommendation from current oversight agency along with the last audit/review	N	N	N	N	N	N	N	N	Y	N	N	N
Must employ or contract with at least one Medical/Clinical Supervisor who has the following qualifications and experience: Registered Nurse, physical or occupational therapist, physician assistant or other mid-level healthcare provider. Minimum of 2 years' experience in acute care, long term care, or medical rehabilitation. Must have at minimum three (3) years' experience providing home and community- based case management services for individuals with disabilities. Must have a minimum of 2 years professional experience with individuals with complex medical issues in a setting related to individuals with, specialty clinics, or other rehabilitation/habilitation settings.	N	N	N	N	N	N	N	N	Y	N	N	N
Must employ or contract with at least one Behavioral Clinical Supervisor who	N	N	N	N	N	N	N	N	Y	N	N	N

[illegible]

STANDARD ASSURANCE

Appendix A-2 (3 pages)

The _____
(Legal Name of Provider Agency)

assures and certifies with respect to this agreement that as a Provider of Home and Community Based Services, this agency must:

1. Comply with all Independent Care Waiver Services policies and procedures and service standards.
2. Employ appropriate staff as required for the specific service types for which the agency has requested enrollment.
3. Comply with Title VI of the Civil Rights Act of 1964. (See Attachment C)
4. Be familiar with Section 504 of the Rehabilitation Act of 1973 and comply with the provisions set forth in it.
5. Understand that my agency staff is a mandated reporter of abuse, neglect, mistreatment, and/or exploitation.

Signature of person legally authorized to act for the organization or person to whom responsibility
for these assurances is delegated

Typed name of above person

Title

Date

**ASSURANCE OF COMPLIANCE WITH TITLE VI
OF THE CIVIL RIGHTS ACT OF 1964**

_____(Hereinafter called the "Agency")
(Legal Name of provider agency)

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 80) issued pursuant to that Title, to the end that, in accordance with Title VI and that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity financed in whole or in part by Federal funds, which the Agency provides or participates directly through a contractual or other arrangement.

The Agency agrees to make no distinction on the ground of race, color, or national origin with respect to admission policy or procedure or in the provision of any aid, care, service, or other benefits to individuals admitted or seeking admission to the Agency.

This assurance is given in consideration of and for the purpose of receiving any and all payments from State agencies receiving Federal grants. The Agency recognizes and agrees that State agency financial payments will be extended in reliance on the representation and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Agency, its successors, transferees, and assignees. The person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Agency.

Name of Provider Agency

Signature of Director or Administrator

Typed name of Director or Administrator

Signature of Owner or Chairman of Board

Typed name of Owner or Chairman of Board

Date

LETTER OF UNDERSTANDING

The _____
(Legal Name of Provider Agency)

understands and certifies with respect to this agreement that the following terms and conditions shall be met in order to receive recommendation for enrollment in the Independent Care Waiver Services Program:

1. Provider has consistently received a satisfactory rating for any other services it provides which is regulated by the Department of Human Services or the Department of Community Health.
2. Provider must participate in Independent Care Waiver Services Program New Provider training provided by the Alliant Health Solutions.
3. Provider understands that Medicaid enrollment does not guarantee client referrals.

Signature of person legally authorized to act for the organization or person to whom legal authority is delegated

Typed name of above person

Title

Date

APPENDIX B

MEMBER RIGHTS AND RESPONSIBILITIES

Member's rights include:

1. The right of access to accurate and easy-to-understand information.
2. The right to be treated with respect and to maintain one's dignity and individuality.
3. The right to voice grievances and complaints regarding treatment or care that is furnished, without fear of retaliation, discrimination, coercion, or reprisal.
4. The right of choice of an approved provider.
5. The right to accept or refuse services.
6. The right to be informed of and participate in preparing the care plan and any changes in the plan.
7. The right to be advised in advance of the provider(s) who will furnish care and the frequency and duration of visits ordered.
8. The right to confidential treatment of all information, including information in the member record.
9. The right to receive services in accordance with the current plan of care.
10. The right to be informed of the name, business telephone number and business address of the person/agency supervising the services and how to contact that person/agency.
11. The right to have property and place of residence treated with respect.
12. The right to review member's records on request.
13. The rights to receive care and services without discrimination.
14. The right to be informed on recognizing and reporting abuse, neglect, and exploitation.

Member's Responsibilities include:

1. The responsibilities to notify case manager/service provider(s) of any changes in care needs.
2. The responsibility to treat provider staff in a courteous and respectful manner, as well as cooperate with and respect the rights of the caregivers providing care.
3. The responsibility to be as accurate as possible when providing information on health history and personal care needs.
4. The responsibility to participate actively in decisions regarding individual health care and service/care plan development.
5. The responsibility to comply with agreed upon care plans.
6. The responsibility to notify the member's physician, providers, and/or caregiver of any change in one's condition.
7. The responsibility to maintain a safe home environment and to inform providers of the presence of any safety hazard in the home.
8. The responsibility to be available to provider staff at agreed upon times services are scheduled to be rendered and to case management staff both in person and using audio visual equipment when allowed by policy.

By signing this form, member has read and understands member rights and responsibilities.

This _____ day of _____ 20____

Print Name of Member/Legal Guardian

Signature of Member
Legal Representative

Print Name of Case Manager Date

Signature of Case Manager Date

APPENDIX C

MEMORANDUM OF UNDERSTANDING

Rev. 04/03

Member _____ Medicaid Number _____

Purpose:

It is the intent of this agreement to provide an assurance that members understand the expectations and guidelines of the Independent Care Waiver Program (ICWP). The members must follow specific guidelines in order to ensure compliance with the Plan of Care. Failure to follow these guidelines may result in termination from the program. Signing this agreement indicates that you understand and will abide by the terms and conditions for participation in the ICWP as implemented by the Georgia Division of Medical Assistance. The following does not intend to address all of the conditions of participation, therefore please discuss with your case manager if you have any questions or concerns.

Special Participation Eligibility Criteria:

1. Medicaid eligible or potentially Medicaid eligible;
2. Between twenty-one (21) and sixty-four (64) years of age when services are started;
3. Have a severe physical disability and/or traumatic brain injury that substantially limits one or more activities of daily living and requires help from another person;
- 7/1/14 4. Mentally capable to direct own care (does not apply to those with a traumatic brain injury); Mentally capable means must be cognitively alert and capable of directing their own services. Cognitively alert means the member displays or exhibits reasoning and perception abilities in their thought processes at the time of assessment and thereafter. Directing their own services means the member must be able to make independent decisions and judgements regarding their care, care choices and overall wellbeing. In addition, members must be able to communicate their decisions and care choices through commonly accepted forms of communication including verbal communication, sign language, or through acceptable communication assistive devices such as communication boards mediums. Access to and the use of such devices is the sole responsibility of the member;
5. Medically stable but in or at risk of hospital or nursing home placement;

- 7/1/14
6. Does not have a primary diagnosis of a mental disorder including mental retardation or mental illness;
 7. Certified for a level of care appropriate for placement in a hospital or nursing home;
 8. Have a Plan of Care within the cost limit of the waiver;
 9. Are able to be safely placed in a home and community setting; and
 10. Currently in an institution or being placed in an institutional setting.

General Understanding:

1. Alliant Health develops the Initial Plan of Care.
2. Approval is needed in writing from Alliant Health for all services rendered under this program.
3. All services must be rendered according to the Individual Plan of Care signed by the member, case manager and the planning team.
4. Cost of care must be provided within the allocated budgeted amount.
5. A member may not participate in more than one Medicaid Waiver Programs at the same time.
6. The Utilization Review team will make in-home visits as needed and required.

Discharge of Members:

Discharge may take place when any of the following occurs:

1. Alliant Health in consultation with the case manager and other providers, determines that the member is no longer appropriate or eligible for ICWP
2. The Utilization Review (UR) staff recommends discharge (10 day notice is required).
3. The member has not received ICWP services for sixty (60) consecutive days.
4. The member has behavior that is disruptive, illegal, threatening, and /or dangerous to self or others.
5. The member refuses to comply with treatment/agreed upon plan of care.
6. The member chooses to be discharged or enters long-term facility.
7. The cost to serve member exceeds the allocated budgeted amount.

The member will receive the discharge notice thirty (30) days prior to the effective date of discharge, stating the reason for the discharge, with the exception of #2 (Utilization Review).

Additional terms_____

As an ICWP consumer, it is your responsibility to be actively involved in achieving goals related to good health and community living. Goals identified for all participants in ICWP are:

1. Maintain maximum control over daily schedules and decisions.
2. Participate socially and be connected and involved in community activities of your choice.
3. Assume responsibility of cost effective medical services and supplies.
4. Be responsible for behavior so that it will not place you at risk of social isolation, neglect or physical injury to yourself or others.
5. Maintain a diet that is balanced and appropriate for decreasing risk of further disability.
6. Participate in interventions that maintain skin in a healthy condition, avoiding breakdowns
7. Understand and observe medication regimen.
8. Participate in interventions of daily living without interruptions due to cognitive or physical impairments (self or informal caregiver report, observation by case manager, provider reports, etc.).
9. Maintain bowel and bladder program that promotes skin integrity, cleanliness and positive health status.
10. Perform transfers and mobility safely and when needed.

It is the responsibility as ICWP case managers to:

1. Respond to phone calls and requests in a timely manner.
2. Respect your choices throughout the development and maintenance of your individual community plan.
3. Provide you with options and information in order for you to make informed decisions.
4. Meet with you and your significant other and notify you of any changes in your service.

5. Consider ceasing ICWP services after a 30 day notice is given if any of the following activities are taking place; use of drugs or other harmful substances, consumer or household involvement in any type of illegal activity, lack of effort or concern in maintaining you physical health or emotional health, lack of effort or concern in actively participation in your life, or abuse of any services provided by ICWP.

Mutual Responsibilities:

The term of this agreement is for one year from the year of approval date, and must be renewed annually or as warranted by mutual written consent of the member and the case manager.

As a recipient of the ICWP, you may be assessed intermittently, but at least annually to determine if your care can be managed under the policy and fiscal limitations of the ICWP.

This _____ day of _____ 20_____

Print Name of Member/Legal Guardian

Signature of Member Date
Legal Representative

Print Name of Case Manager

Signature of Case Manager Date

APPENDIX C-1

CONSUMER DIRECTED CARE

MEMORANDUM OF UNDERSTANDING

Member_____ Medicaid Number_____

Purpose:

It is the intent of this agreement to provide an assurance that members understand the expectations and guidelines of the Consumer Directed Care option under the Independent Care Waiver Program (ICWP). The members must follow specific guidelines in order to ensure compliance with the Plan of Care. Failure to follow these guidelines may result in a member returning to the traditional option or termination from the program. A member's signature on this agreement indicates that the member understands and will abide by the terms and conditions for participation in the Consumer Directed Care option as implemented by the Georgia Division of Medical Assistance. The following is not intended to address all of the conditions of participation. Members should discuss any concerns or questions with their case manager..

In order to be eligible for Consumer Directed Care under ICWP the member must meet the following criteria:

1. Meet all ICWP eligibility criteria
2. Be motivated to self-direct care
3. Be willing to assume responsibility for cost effective use of Personal Support Services
4. Does not have a history of behavior that places self or others at risk
5. Must fulfill the training requirements of Consumer Directed Care by successful review and demonstration of understanding of the training sessions
6. Is able to maintain maximum control over daily schedule and decisions
7. Must stay within the established budget to remain eligible for Consumer Directed Care.
8. Is able to make an informed choice to accept Medicaid Waiver services in a Plan of Care.
9. Must be willing to sign this Memorandum of Understanding (MOU) which outlines the roles and responsibilities of Consumer Directed Care.

General Understanding:

1. Alliant Health Solutions (AHS) develops the Initial Plan of Care.
2. Prior approval is needed from AHS for all services rendered.
3. All services must be rendered according to the Individual Plan of Care signed by the member, case manager, and approved by AHS.
4. Cost of care must be provided within the allocated budget. The funding for employee salaries, taxes and the FI agency fee cannot exceed the approved care plan budget.
5. A member may not participate in more than one Medicaid Waiver Programs at the same time.
6. The Utilization Review team will make in-home visits as needed or as required.
7. The member or his/her representative, to be referred to as the employer, is responsible for hiring, training, supervising, disciplining, terminating and paying their attendant through the FI.
8. The Employer will have the freedom to choose an enrolled Medicaid Fiscal Intermediary (FI).
8. The Employer will be responsible for staffing/scheduling employees as well as developing a backup plan in the event the employee is unavailable.
9. CDC services will not be paid during the time the member is admitted to a hospital.
10. If the FI has provided the employer with any equipment to be used in submitting employee time, the employer will be responsible for maintenance, proper use and replacement of the equipment.
11. The **employer will be responsible** for any cost associated with backgrounds checks that **exceed 5** per Plan of Care year.
12. If the background check has not been confirmed by the FI, the **employer will be responsible** for paying any employee.

Discharge of Members:

Discharge may take place when any of the following occurs:

1. AHS, in consultation with the case manager, determines that the member is no longer appropriate or eligible for ICWP
2. The Utilization Review (UR) staff recommends discharge (10 day notice is required).
3. The member has not received ICWP services for sixty (60) consecutive days.

4. The member has behavior that is disruptive, illegal, threatening, and /or dangerous to self or others.
5. The member refuses to comply with agreed upon plan of care.
6. The member chooses to be discharged or enters long-term facility.
7. The cost to serve member exceeds the allocated budgeted amount.
8. The member knowingly and freely commits fraudulent activities.
9. If the Case Manager notifies the AHS Review Nurse that the member has failed to meet the following care path goals for two consecutive quarters:
 - Failure to maintain maximum control over daily schedule and decisions
Preventable decline in health outcomes
 - Failure to assume responsibility for cost effective use of medical services and supplies
Unable to stay within budget for two consecutive months
 - Exhibition of problem or symptomatic behavior which places the ICWP participant at risk of social isolation, neglect, or physical injury to themselves or others

After reviewing the documentation submitted to AHS, the review nurse will determine if the member should remain in Consumer Directed Care or be returned to Traditional Services.

NOTE: If a member has been moved into the traditional option, the member must remain in CDC for one year before requesting to return to CDC.

ICWP Member Goals:

As an ICWP member, it is your responsibility to be actively involved in achieving goals related to good health and community living. Goals identified for all participants in ICWP are:

1. Maintain maximum control over daily schedules and decisions.
2. Participate socially and be connected and involved in community activities of your choice to avoid social isolation.
3. Assume responsibility for the cost effective use of medical services and supplies.
4. Avoid behaviors that may place you or others at risk for neglect or physical injury.
5. Maintain a diet that is appropriate for decreasing risk of further disability.
6. Participate in interventions to avoid skin breakdown.

7. Understand and follow medication regimen.
8. Activities of daily living are not interrupted due to cognitive or physical impairments.
9. Maintain a bowel and bladder program that promotes skin integrity, and cleanliness.
10. Transfers and mobility will occur safely and as needed.

It is the responsibility of ICWP case managers to:

1. Respond to phone calls and requests in a timely manner
2. Respect members' choices throughout the development and maintenance of individual care plan.
3. Provide members with options and information to allow for informed decisions.
4. Meet with members and their support system to discuss changes in their service.
5. The case manager must notify AHS if any of the following activities are taking place:
 - use of drugs or other harmful substances,
 - consumer or household involvement in any type of illegal activity,
 - lack of effort or concern in maintaining you physical health or emotional health,
 - lack of effort or concern in actively participation in your life,
 - or abuse of any services provided by ICWP.

ICWP will review the provided information and determine if probationary status is needed or if termination of services should be initiated.

Mutual Responsibilities:

The term of this agreement is for one year from the year of approval date, and must be renewed annually or as warranted by mutual written consent of the member and the case manager.

As a recipient of the ICWP, you may be assessed intermittently, but at least annually to determine if your care can be managed under the policy and fiscal limitations of the ICWP.

As a member of the Consumer Directed option, I understand that I, or my documented representative, assume the responsibility of Employer and all the related duties required of my attendants. This process has been explained to me and all of my questions have been answered.

This_____day of _____20_____

Print Name of Member/Legal Guardian

Signature of Member Date
Legal Representative

Print Name of Case Manager

Signature of Case Manager Date

Rev. 4/1/19

Approved NH LOC

Approved HLOC

Denied

Initial Assessment

Reassessment

Re-Application

Appendix D
Participant Assessment Form
(PAF) (Independent Care Waiver/ Traumatic
Brain Injury Program)

Identify Assessment site:		Facility	
Assessment Mode:			
Assessing RN:		Date	

Identifying Information

Client Name: _____ Social Security # _____

Street Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

County: _____

Date of Birth: _____ Age: _____ Sex: _____

Phone #: _____ Email: _____

Marital Status _____ Primary Language: _____ Interpreter needed? _____

Note: _____

Highest Level of Education Completed:

Area of study OR Primary Career/Job: _____

Medicaid # _____ Medicare? _____

Note: _____ Private insurance? _____

Do you have a legal guardian? _____ Guardian's Name: _____

Note: _____

Do you have a Power of Attorney? _____ POA Name: _____

Note: _____

Person(s) assisting with this assessment:

Name	Relation to applicant	Phone#	Miscellaneous

Current Diagnoses:

<i>Diagnoses</i>	<i>Date of Onset</i>	<i>Diagnoses</i>	<i>Date of Onset</i>

Neurological*Level of consciousness (LOC):*

<i>Oriented to:</i>		Person			Place			Time
<i>Responds to:</i>		Verbal stimulation			Touch stimulation			None
		Follows commands Appropriately			Does not follow commands			
<i>Face:</i>		WNL/ symmetrical			Asymmetrical			
					Rt/ side droop			Lt/ side droop

Section Note:

Hearing, Speech, and Vision

Ability to hear:	
Hearing aid or other hearing appliance used?	
Speech Clarity: -	
Making Self-understood:	

Vison:		WNL		Wears/needs glasses		Glaucoma		Cataracts
	Other:							
Dental:		WNL		Other:				
Section Note:								

Respiratory:	WNL- breathing spontaneous and unlabored							
	Short of breath on exertion			Short of breath at Rest			COPD	Asthma
	Nonproductive Cough			Productive Cough			Uses CPT Vest	
	Tracheostomy:		Requires supplemental oxygen/ ventilation assist:					
	Nasal Cannula				Face mask		CPAP	BiPap
	Ventilator:				Trilogy			

Section Notes:

Cardiovascular:	WNL							
	High BP			Heart attack			CHF	Anemia
	High Cholesterol			Stents			CAD	AFib or other dysrhythmias
	Edema			Bypass			PVD/ PAD	

Section Notes:

Gastrointestinal:	HT:		WT:		WNL- Weight stable with no issue			
	Obese			Difficulty swallowing food or pills				Reflux
	Underweight/Malnourished			Decreased appetite				Heartburn
	Cirrhosis/ Ascites			Increased appetite				Ulcers

Section notes:

Nutritional Needs: Please describe any special dietary needs, including allergies, need for modified food, and preferences. For tube feeding include rate/ amount, bolus or cyclic.

Diet:			
Food Allergies?			
Feeding Tube:			
Tube Feeding Name:		Amount:	Rate:
Feeding tube Flushes:			
Section Notes:			

Physical Status: For at least 60% of assessment, client was:

In bed	Resting in chair	Up ambulating	Other:	
--------	------------------	---------------	--------	--

Musculoskeletal: ☐ WNL: Full ROM to all 4 extremities without difficulty

☐ SCI at level: _____

☐ Paralysis ☐ Waist down ☐ Mid-chest down ☐ Neck down ☐ Left side ☐ Right side

Dominant side: ☐ Right ☐ Left _____

Affected side: ☐ Right ☐ Left _____

Physical Status: ☐ WNL/ No impairment. Skip to section devices/aides used by client

<i>Physical Status</i> Upper extremities									
LUE		WNL/ No impairment				RUE		WNL/ No impairment	
		No Independent movement						No Independent movement	
Paralysis		Weakness		Spasticity		Paralysis		Weakness Spasticity	
Amputation:						Amputation:			
Prosthesis:						Prosthesis:			
Contracted:						Contracted:			
Edema:						Edema:			
Not able to move fingers						Not able to move fingers			
Not able to bend at elbow						Not able to bend at elbow			
Not able to shoulder shrug						Not able to shoulder shrug			
Not able to do Passive ROM to the affected side by using the stronger side					Not able to do Passive ROM to the affected side by using the stronger side				
<i>Comment:</i>					<i>Comment:</i>				

<i>Physical Status</i> Lower extremities									
LLE		WNL/ No impairment				RLE		WNL/ No impairment	
		No independent movement						No independent movement	
Paralysis		Weakness		Spasticity		Paralysis		Weakness Spasticity	
Amputation:						Amputation:			
Prosthesis:						Prosthesis:			
Contracted:						Contracted:			

Edema:	Edema:
NotAble to toe tap	NotAble to toe tap
NotAble to bend at knee	NotAble to bend at knee
NotAble to bend at hip	NotAble to bend at hip
NotAble to do Passive ROM to the affected side by using the stronger side?	NotAble to do Passive ROM to the affected side by using the stronger side?
Comment:	Comment:

Indicate devices and aids used by the Client. Check all that apply

☐	Manual wheelchair	☐	Walker
☐	Motorized wheelchair and/or scooter	☐	Orthotics/ Prosthetics
☐	Mechanical lift	☐	None / Other
Comments:			

Ambulation/Locomotion

Indicate Primary mode of locomotion:

☐	1. Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
☐	2. With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
☐	3. Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces
☐	4. Able to walk only with the supervision or assistance of another person at all times.
☐	5. Chairfast, unable to ambulate but is able to wheel self independently.
☐	6. Chairfast, unable to ambulate and is unable to wheel self.
☐	7. Bedfast, unable to ambulate or be up in a chair.

If 1, 5,6, or 7 is selected then skip to section: _____

Coding for Mobility. Activities may be completed with or without assistive devices.

1. **Independent** – Patient completes the activity by themselves with no assistance from a helper.
2. **Supervision or touching assistance** – Helper provides verbal cues, touching, steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
3. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
4. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
5. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.
6. **Not asked, N/A.** Provide explanation in comments.

Bed Mobility

Roll left and right: The ability to roll from lying on back to left/right side, and return to lying on back on the bed.

Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with no back support.

Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.

Section comments:

Transferring:

Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.

Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).

Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

Section Comments:

Ambulating:

Walk 10 feet: Once standing, the ability to walk across a room.

Walk 50 feet with two turns: Once standing, the ability to cross 2 rooms and/or hallway- making at least two turns.

1 step (curb): The ability to go up and down a curb or up and down one step.

4 steps: The ability to go up and down four steps with or without a rail
12 steps: The ability to go up and down 12 steps with or without a rail.
Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
Section comments:

Notes:

Functional Abilities

Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
Meal prep: planning meals, assembling ingredients, cooking, setting out food and utensils

Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front- opening shirts and blouses, managing zippers, buttons, and snaps.
Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes.

Grooming: Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth/ denture care, or fingernail care).

Section Notes:

Check all that client uses:

Bed bath tub Walk in shower tub/shower Grab bars

Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).

	Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
	With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
	Able to bathe in shower/ tub with the intermittent assistance of another person:
	intermittent supervision, encouragement or reminders
	to get in and out of the shower or tub
	for washing difficult to reach areas.
	Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
	Unable to use the shower or tub, but able to bathe self independently at the sink, in chair, or on commode.
	Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
	Dependent- Unable to participate effectively in bathing and is bathed totally by another person.

Section notes:

Bladder and Bowel

<i>Toilet Transferring:</i>	Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

<i>Toileting Hygiene:</i>	Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

<i>Urinary Continence</i>	

Catheter: External/condom Indwelling Intermittent suprapubic

Dialysis:

Days:

Shunt:

Bowel Incontinence Frequency

Bowel Program

Diaper/pull-up/brief

☐

disposable chux

☐

reusable pad

Section notes:

Pain

WNL/ No issue

Chronic- Location: _____

Takes scheduled narcotic pain medication Pain is managed by pain clinic

Takes PRN prescription pain medications Pain is managed by Primary doctor/ facility

Take OTC medications as needed Other: _____

Ask: "Over the past 5 days, have you limited your day to day activities because of pain?"

Notes:

Skin:

WNL/ none = skin intact- Skip to section:

Is client at risk for developing pressure ulcers?

Does the client currently have 1 or more unhealed pressure ulcer? Yes

No

comment

Hx of healed pressure ulcer:

Other Ulcers, wounds and skin problems:

Cellulitis Diabetic foot ulcer(s) Open lesion(s) on the

foot Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)

Surgical wound(s) Burn(s) (second or third degree) Skin tear(s)

Moisture Associated Skin Damage (e.g., incontinence-associated dermatitis, perspiration, drainage).

Skin and Ulcer treatments :

N/A

Turning/repositioning program: How often?

Pressure reducing device for bed.

Pressure reducing device for chair

Other:

Pressure ulcer care provided by: _____

Notes:

TBI Screening Tool:

Have you ever had a head injury (i.e. due to an accident, physical assault, sports injury, or fall)?	Yes	No
If the answer to the previous question is “yes,” did you lose consciousness as the injury?	Yes	No
Were you ever hospitalized or treated in an emergency room following an injury to the head?	Yes	No
If so, did you undergo a CAT scan, MRI, EEG or were you seen/treated by a neurologist?	Yes	No
Did a physician ever confirm a traumatic brain injury?	Yes	No
If so, who, when, where and through what diagnostic test? _____		

Mental Health screening

Behavioral: WNL TBI None noted/ unable to determine other: _____

Is there a history of Intellectual or developmental delay? _____

Is there any indication of suicidal ideation? _____

Is there a history of mental illness? _____

Is there any evidence of psychosis (i.e. delusions, hallucinations, paranoid ideation)? _____

Are you currently under psychiatric care? _____

Notes: If yes, provide the doctor/ clinic: _____

Drug and Alcohol Use

Do you use tobacco? Cigarettes Vape Chewing tobacco Other:

For how long? Amount? Quit?

Do you use alcohol? How Often? Do you currently use any any illegal substances?

Notes:

**M
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n**

Are you allergic to any type of medication? If yes, what medications and type of reaction:

For Diabetics: Is BG controlled? How is it controlled?

Explain any assistance that is needed, and why, with administering and taking your medication:

--

[illegible]

Does the applicant understand the purpose and time for this medication? Knowledge of medication or the ability to learn if knowledge deficit is present?

Comments:

List personal physicians and specialists:

Name	Specialty:	Date last seen:

Have you had any hospitalizations in the past year?

Diagnosis	How long were you there	Approximate Dates

Hospital of Choice: _____

Current Therapies

Are you receiving any therapies?

Therapy	Frequency	
Physical		
Speech		
Occucational		

Section Notes:

Self- reported:

Ask: "In general, how would you rate your health?"

How many hours are you out of bed on a typical day?

How many times are you able to leave your home and go into the community during a typical week?

Please describe obstacles preventing you from participating in the community as you wish.

What access do you have to transportation? Consider dependability, ease of access, and how frequently transportation is available.

GOALS: What is your personal goal/ what are you hoping to achieve/ or describe why you want to be in ICWP. (***)The individual needs to answer this section, not their advocate. If the advocate answers for the individual, the nurse needs to note it on the PAF).

Assessor: comment on the answer and whether it seems appropriate and realistic:

Describe your interests/ hobbies on any typical day: (Examples: watching TV, using the computer, recreation, socializing, leisure outside the home, work, volunteer activities, school, housework, yard work, going to movies, games, bingo, reading books, etc.)

In the event of an emergency, such as severe illness or fire, what would you do?

Assessor: comment on the answer and describe if the answer seems appropriate and realistic.

If you are alone and in need of general help, but it isn't medical or life threatening, who are you most likely to call?

Not Asked

No one

Unable to respond

Family/ significant other

Neighbor

Friend

Other: _____

Assessor: comment on the answer and describe if the answer seems appropriate and realistic.

Section Notes:

Cognitive Patterns:

Does the applicant/care giver indicate any problems with memory?

Should Brief Interview for Mental Status be Conducted?

Repetition:

Ask Client: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."

Number of words repeated after first attempt.

IF needed: repeat the words using cues ("sock, something to wear; blue, a color;

Section notes:

bed, a piece of furniture"). You may repeat the words up to two more times.

Temporal Orientation. Ask the client:

"Please tell me what year it is right now."

"Please tell me what month it is right now."

"What day of the week is today?"

Recall:

Ask resident: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock".

B. Able to recall "blue".

C. Able to recall "bed".

Memory:

Seems or appears to recall after 5 minutes?	Yes	No	N/a	Unable to determine
---	-----	----	-----	---------------------

Seems or appears to recall long past?	Yes	No	N/a	Unable to determine
---------------------------------------	-----	----	-----	---------------------

1. Inattention - Did the resident have difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said?

2. Disorganized thinking - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

3. Altered level of consciousness - Did the resident have altered level of consciousness as indicated by any of the following criteria?

Environmental Assessment:

CURRENT RESIDENCE

Current place of residence (ie. house, apartment, etc.)? If

the client is in a facility, when was the Admit Date?

If in a facility, where did the client live before admission? What were the reasons the client entered the facility?

Is the client in an appropriate and safe living environment?

If applicable: is the client aware of ALS homes and would they be willing to transfer to one in order to receive ICWP?

Does client feel safe in current home?

Are there stairs inside of the home?

Are there stairs to get in/out of home? Does home h

Does the home have a ramp

Need a ramp

Is the client able to access the area in the home:

Living area

Bathroom area

Kitchen area

Any plans to move? What is the future plans for living residence?

Assessors, please comment on the response and indicate whether it seems reasonable and appropriate.

SOCIAL CONTACTS and SUPPORT:

Do you have someone you plan to live with or want to live with?

Do you have a strong and supportive relationship with family/ friends living in the area (less than 30 minutes away)?

Informal Helpers: None

1. _____ Age of individual: _____

Relationship to individual:

Employed:

Distance to individuals home:

Was person present during assessment?

Ph: _____

2. _____ Age of individual: _____

Relationship to individual:

Employed:

Distance to individuals home: _____

Was person present during assessment?

Ph: _____

How often will the individual receive assistance from the informal support?

How often is the individual alone (or will be alone) during the day?

Needs Identified: Health and safety Risks: Risk for Falls Risk for Wounds Risk
for hospitalizations Risk for aspiration

Recommended annual Preventative Healthcare:

Did the patient receive the influenza vaccine for this year's flu season? Yes No

Is the client's Pneumococcal vaccination up to date? Yes No N/a

If eligible, has the client received shingles vaccination? Yes No N/a

Last visit to PCP?

Waiver support

Is MFP following applicant? ☐ Yes ☐ No

Are you receiving supportive services (PSS) through another waiver program? ☐ Yes ☐ No

If yes, which waiver? ☐ CCSP ☐ Source ☐ NOW/COMP ☐ GAPP ☐ Home Health ☐ Hospice
☐ Other (Please specify) _____

Identify agency/ company: _____

Services Provided: _____

Hours received per day _____ Number of days per week _____

Are these hours sufficient to meet your needs? ☐ Yes ☐ No ☐ N/A

Comment:

Do you have a Case Worker/Manager/Coordinator? ☐ Yes ☐ No ☐ N/A

If yes, provide the following:

Name: _____ Phone # _____ ext. _____

Agency: _____

Have you had any problems getting the health or social services you need? ☐ Yes ☐ No ☐ N/A

If yes, please explain: _____

The following items have been discussed by the Alliant | GMCF nurse at the assessment:

Yes	No	
☐	☐	Applicant has been advised that this is a Medicaid waiver program.
☐	☐	Applicant has been advised to visit the Department Of Family & Children Services (DFACS) in the county in which they live to apply for Medicaid if they have not already done so and to inquire with DFACS for possible cost share.
☐	☐	Information has been given on the 'Traditional Care' option of managing personal support.
☐	☐	Information has been given on the 'Consumer Directed Care' option.
☐	☐	'Home and Community Based Services Information Booklet.' Has been given to the applicant
☐	☐	Applicant has been informed that they may be placed on a waiting list before services begin. ☐ N/A



INTERMEDIATE LEVEL OF CARE CRITERIA

The following status is assessed to determine if the applicant meets Intermediate Level of Care Criteria. This requires a “yes” in number 1 with a “yes” in any question from 2-8 from Criteria A, plus one item from Criteria B or C. If number 5 is chosen from Criteria C, another deficit in functional status is required to meet Intermediate Level of Care Criteria.

CRITERIA A (Medical Status):

Requires a “yes” in number 1 and a “yes” in any question from 2-8.

- | | |
|--|--|
| 1. This applicant has a medical condition(s) that requires monitoring and overall management of a licensed physician. | Yes ☐ No ☐ |
| 2. This applicant requires nutritional management which may include therapeutic diets or maintenance of hydration status. | Yes ☐ No ☐ |
| 3. The applicant requires assistance to maintain skin integrity and/or treatment of skin conditions such as cuts, abrasions, or healing decubiti. | Yes ☐ No ☐ |
| 4. The applicant requires catheter care such as catheter change and irrigation. | Yes ☐ No ☐ |
| 5. The applicant requires therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy (less than five (5) times weekly). | Yes ☐ No ☐ |
| 6. The applicant requires restorative nursing services such as range of motion exercise and bowel/bladder training. | Yes ☐ No ☐ |
| 7. The applicant requires vital signs and laboratory studies or weights monitored. | Yes ☐ No ☐ |
| 8. The applicant requires monitoring of medication regime. | Yes ☐ No ☐ |

CRITERIA B (Mental Status):

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

- | | |
|---|--|
| 1. This applicant has documented short or long-term memory deficits with etiologic diagnosis. | Yes ☐ No ☐ |
| 2. This applicant has moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making. (See MDS/Care Plan, if presently in nursing home.) | Yes ☐ No ☐ |
| 3. This applicant has problem behavior, i.e., wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention. | Yes ☐ No ☐ |
| 4. This applicant has undetermined cognitive patterns which cannot be assessed by a mental exam, for example, due to aphasia. | Yes ☐ No ☐ |

CRITERIA C (Functional Status):

- | | |
|---|--|
| 1. This applicant requires limited/extensive physical assist from another person to transfer and/or ambulate. | Yes ☐ No ☐ |
| 2. This applicant requires assistance with feeding. Specifically continuous stand-by supervision, constant encouragement or cueing and set up of meals. | Yes ☐ No ☐ |
| 3. This applicant requires direct assistance of another person to maintain continence. | Yes ☐ No ☐ |

4. This applicant has documented communication deficits in making self-understood or understanding others. (Deficits must be addressed in medical record with etiologic diagnosis on MDS/Care Plan if presently in nursing home.). Yes ☐ No ☒

. This applicant requires direct stand-by supervision or cueing with one person physical assistance to complete dressing and personal hygiene. Yes ☐ No ☒

****Applicant meets Intermediate Level of Care Criteria as outlined above: Yes ☐ No ☒

ICWP HOSPITAL LEVEL OF CARE CRITERIA

****To qualify an individual must meet the criteria set in #1 or #2 below.****

- 1.** This category is for those individuals who require the skilled services of Licensed medical professionals on a daily basis, but may not meet Interqual Criteria for acute care hospitalizations. These individuals must meet the criteria in A, B and C below.
 - A.** The individual must have a condition that requires a treatment regimen that must be monitored by licensed medical professionals to ensure adequate care; for example, on ventilator, receiving parenteral nutritional supplementation, care of stage III or IV decubitus ulcers, a minimum of 4 hours per day of behavior management (TBI) or if the person has been receiving services in an inpatient hospital setting for more than 60 consecutive days and for whom it is likely that the stay would continue without ICWP services.
 - B.** The family/circle of support must have been educated on the treatment regimen by medical professionals and is able to articulate signs/symptoms to report to medical professionals.
 - C.** The individual must have a condition that is expected to last at least six (6) months and normally requires services in an inpatient/skilled setting, but can safely receive those services in community under the ICWP.

☐ Criteria Met ☐ Criteria Not Met

OR

- 2.** The individual has a chronic condition that varies in intensity and severity of needs, such that the person frequently meets Interqual Criteria for acute care (general for regular ICWP member or psychiatric for TBI member) hospitalization (three (3) or more admissions per year), and the use of ICWP services has potential to reduce or eliminate the need for hospitalization.

☐ Criteria Met ☐ Criteria Not Met

☐ Case Approved for Hospital Level of Care Criteria
☐ Case Denied for Hospital Level of Care Criteria

ASSESSOR

***If in a nursing home, attach to this assessment 3 months of nursing home records, MDS (one year and quarterly report) and PASARR data. If in hospital, attach hospital record.

I have calculated the cost of care to be approximately \$ _____ per year.

Narrative Summary:

Appendix D-1

PERSONAL CARE ATTENDANT ALLOTTMENT WORKSHEET GUIDELINES

Member Name: _____ **Review Nurse:** _____

<i>LEVELS OF CARE</i>	<i>DESCRIPTION</i>	<i>Enter (✓)</i>
<u>Level I</u>	Cognition and/or behavioral issues that require general safety oversight	
	Requires Medication Reminders	
	Moderate to total assistance with ADLs such as feeding, bathing, bowel care, grooming; and general housekeeping	
	Moderate to total transfer assistance to maintain continence and hygiene	
	Needs assistance with feeding and meal prep	
	Needs assistance with elimination such as catheter/colostomy/urostomy care	
	Care of stage I or II decubitus ulcer	
	Tube feeding oversight and/ or administration of tube-feeding	
<u>Level II</u>	Requires a minimum of four hours a day of behavior management due to TBI	
	Unstable medical condition requiring three or more hospitalizations per year	
	Complex skilled needs such as trach care, ventilator care, or suctioning	
	Care of stage III, or IV decubitus ulcer	
	Receiving parenteral nutritional supplementation	

Scoring Grid:

Basic needs: 4 hours/day____: body/mouth hygiene; dressing/undressing; simple transfers; light housekeeping; Grocery shopping; light meal preparation; basic range of motion; basic skin care; medication reminders.

System needs: Dependent on specific need +1 to +4 hours depending on clinical assessment (i.e., decreased Cognitive, respiratory, or cardiac functioning or decreased ability to communicate)

Elimination needs:	Straight cath/Foley = 0	Bowel/Bladder training =1
	Bowel/Bladder Program =1 hour	Transfer to maintain continence =+1
	Intermittent catheterization qid =1 hour	Incontinence care= +1

Nutrition: Complete dependence/Tube feeding =1 hour

Living Situation: Lives alone; single parent or limited assistance primary caregiver=1 hour

Skilled Nursing Needs as outlined in Level II: 4-8 hours depending on clinical assessment

Miscellaneous needs _____ No. of hours _____ Hours

Allotted: _____ Level I _____ Level II

Total Hours Allotted: _____

Nurse's Additional Comments:

APPENDIX D-2

INDEPENDENT CARE PARTICIPANT APPLICATION

Note: Please read all information concerning the Independent Care Waiver Program (ICWP), prior to completing this application. It is important that you become familiar with the ICWP rules and regulations that pertain to your Plan of Care. If you have any questions, please call Alliant Health Solutions at 1-800-982-0411. Please return application to Alliant Health Solutions, P. O. Box 105406, Atlanta, Georgia 30348.

1. PERSONAL INFORMATION

Name: _____ Medicare# _____
 Address: _____ Medicaid# _____
 Private Insurance ____Y ____N
 Social Security# _____
 Male ____ Female ____
 County City State Zip
 Phone#: (____) _____ Date of Birth: _____ Age: _____
 Email: _____ @ _____ Income: \$ _____ (per. month)
 Contact Person: _____ Phone#: (____) _____

2. DISABILITY INFORMATION

(Check all that best describes the reason for your disability)

☐	Spinal Cord Injury: Paraplegic	☐	Amputation	☐	Cerebral Palsy
☐	Level of injury: _____	☐	Of what? _____	☐	Muscular Dystrophy
☐	Spinal Cord Injury: Quadriplegic	☐		☐	Multiple Sclerosis
☐	Level of injury: _____	☐	Parkinson's Disease	☐	
☐	Head Injury	☐	Spina Bifida	☐	
☐	Stroke	☐	CHF/ heart failure	☐	
☐	Aneurysm	☐	COPD/ Emphysema	☐	
☐	Tumor	☐	Diabetes	☐	
☐	Arthritis or Rheumatism	☐	Non- verbal	☐	

Additional Diagnosis _____

Date of onset of disability: _____

How would you describe your general health?

Poor	Fair	Good	Excellent
☐	☐	☐	☐

(Check One)

3. If you had a choice, where would you choose to live? Is there a specific person(s) you would like to live with, or would you choose to live alone? Please explain.

4. What is your present living arrangement? Check one of the following:

☐ House: is the home ☐ owned or ☐ rented?
☐ Apartment
☐ Nursing Home ☐ Hospital ☐ Group Home ☐ ALS/ PCH Other

The ICWP does not allow members to live in Personal Care Homes. Would you be willing to move into an Alternative Living Services (ALS) Home? (yes) (no)

Nursing Home/ALS/ PCH Name:

Address:

Phone number:

Social Worker: Phone: ()

Email: @

Date admitted: Date discharged:

If application is being submitted and the applicant is in a Nursing home:

Does the facility have internet capability?

Does the facility have access to a device with a web cam?

Is the applicant currently receiving: ☐ PT ☐ OT ☐ Speech ☐ Wound Care?

Please submit: ☐ history and physical ☐ current medications

5. TRANSFER METHOD (Please check one item that BEST describes how you transfer)

☐ Two people assist with adaptive equipment
Specify

☐ Two people assist without adaptive equipment

☐ One person assist with adaptive equipment
Specify

☐ One person assist without adaptive equipment

☐ Can transfer without human assistance but with adaptive equipment
Specify

☐ Can transfer without assistance

___ Other: _____

6. ACTIVITIES OF DAILY LIVING NEEDS

Please indicate, in each row, how much assistance you need:

	TOTAL	PARTIAL	MINIMAL	NONE
Bathing				
Dressing				
Eating				
Bowel/ Bladder Care				
Reposition to Prevent sores				
Other:				

7. EQUIPMENT YOU USE DAILY

	Use	Needed/Requested
Ventilator or Respirator		
Modified Power Wheelchair		
Regular Power Wheelchair		
Modified Manual Wheelchair		
Regular Manual Wheelchair		
Hoyer Lift		
Transfer Board		
Mouth stick		
Walker		
Brace(s)		
Prosthesis		
Crutches		
Cane		
Hospital Bed		
Hospital Bed w. Special Mattress		
Reacher		
Shower/Commode Chair		
Splints		

8. Do you require any of the following interventions?

Tracheostomy requiring suctioning		BG checks/ insulin injections	
Ventilator		Wound Care	
Tube Feeding		Colostomy	
Urinary Catheter		Medication administration assistance	

9. RELATIONSHIPS

Who visits? (Check ALL that apply)

(Frequency)

Do you have regular visitors?

____ Yes ____ No

____ Spouse	_____
____ Parents	_____
____ Other relatives	_____
____ Friends	_____
____ Pastor or Rabbi	_____

Do you live with someone or plan to live with someone? _____

If "YES", with whom? _____

Does that person provide any care? _____

10. Help needed at the following times (Check all that apply)

☐	Night	10:00 p.m. to 6:00 a.m.
☐	Morning	9:00 a.m. to Noon
☐	Afternoon	Noon to 4:00 p.m.
☐	Early Evening	4:00 p.m. to 7:00 p.m.
☐	Evening	7:00 p.m. to 10 p.m.

Total hours requested _____

11. Please identify caregivers who will commit to providing care on a daily basis.

_____	_____ (____)	_____
Name	Relationship	Phone #

_____	_____ (____)	_____
Name	Relationship	Phone #

_____	_____ (____)	_____
Name	Relationship	Phone #

12. List all the medications you are currently taking:

Name of Medication	Dose strength	How is it given? Oral/ inhaler/ injection	How often is it given?

13. List your current doctors you routinely see:

Doctors name:	Specialty:	City/ Location:	When did you last see the doctor?

14. How many times have you needed hospital care in the past year _____?

Diagnosis for your hospital admission?	How long were you there?	Approximate dates?

15. Are you currently receiving services from another wavier program? ____Yes ____No

- a. If so, from which program do you receive services? _____ b. How many hours per day or per week do you receive? _____
- c. Do these services sufficiently meet your needs? ____Yes ____No
- Why or Why not? _____

Please provide any additional information that would be helpful in identifying your needs.

ATTESTATION STATEMENT

The information I have provided in this ICWP application is true and complete to the best of my knowledge.

 Client / Client Representative Signature

 Date

Appendix D-3 Independent Care Waiver Program

POTENTIAL ICWP MEDICAD FINANCIAL APPLICATION WORKSHEET

Client's Name _____ Date of Birth _____

Section I	<u>INCOME</u>	<u>AMOUNT</u>
	Social Security	\$ _____
	VA Benefits	\$ _____
	Retirement / Pension	\$ _____
	Interest / Dividends	\$ _____
	Other (specify)	\$ _____
	<u>TOTAL INCOME</u>	\$ _____

Note: If monthly income exceeds the limit, stop here.

Section II	<u>RESOURCES</u>	<u>ESTIMATED VALUE</u>
	Cash	\$ _____
	Checking	\$ _____
	Savings Account	\$ _____
	Credit Union Account	\$ _____
	Certificate of Deposit or IRA	\$ _____
	Stocks or Bonds	\$ _____
	Patient Fund Account (held by nursing home)	\$ _____
	House or Property other than home	\$ _____
	Place that is not producing income	\$ _____
	Other (specify)	\$ _____
	<u>TOTAL RESOURCES</u>	\$ _____
	Subtract Individual or Spousal Impoverishment Resource Limit	\$ _____

Appendix D-4
RENEWAL PARTICIPANT ASSESSMENT FORM

Care plan due date:	
---------------------	--

Identifying Information

Member Name _____
Last First Middle Initial Suffix

Address: _____
Apartment# _____
City State Zip County

Phone #: _____ Cell# _____

Date of Birth _____ Age: _____ Male Female

Have you moved in the past year? Yes No

If yes; when did you notify DFCS? _____

Living Arrangements at the time of the Renewal Assessment:

___Lives Alone ___With Other Family Member ___With Paid Help (not ICWP PSS)
___With Spouse/Significant other ___With a Friend ___ALS (Alternative Living Services)

As compared to 1 year ago, Member now lives with other persons (e.g. moved in with another or other person moved in with member). Yes No

Comments:

Member Name: _____

Medical Information

Current Diagnosis:

Medication List:

Skilled care duties required:

	Tracheostomy Care		Suctioning		Medication administration		Catheter Care
	Vent		Wound Care		Tube feeding set up/ administration		Accucheck/ injections
	Other:						

EVALUATION

What is the Member's condition compared to the last annual plan care year?

___Stable ___Improved ___Declining

Functional Potential:

- ___ Member believes he/she is capable of increased functional independence
- ___ Caregivers believe Member is capable increased functional independence
- ___ Good prospects of recovery for current disease of conditions, improved health status expected
- ___ None of the above

Independent Care Waiver Services
April 1, 2023

Member Name: _____

Significant Changes in Last Year as reported by the ICWP member:

____ Hospitalizations _____ Functional Decline

____ Caregiver Status change

____ New Diagnosis _____ Loss of Loved One _____ Any critical incident

Comments:

Member Name: _____

STATUS:

1. What was the date of the last physician visit? _____
2. Were any new physician's orders received this annual period? _____ yes _____ no
If yes, please describe: _____

3. Were there any emergency room visits or hospitalizations during this annual period? _____ yes _____ no
If yes, please provide the dates and diagnosis: _____

- a. Did you, the Case manager, submit a variance? _____ yes _____ no
4. Is the individual in jeopardy of moving from their home to a facility to get the care they need? _____ yes _____ no

Risk factors:

1.	Does member have a history of nursing facility placement in the past year?	Yes	no
If yes, what were the reasons?			
2.	Does the member have a progressive disease?	Yes	no
If so, state the disease:			
3.	Has the member fell 2 or more times in the past year?	Yes	no
If so, has a fall safety program been implemented?			
If the member has fallen, what were the contributing factors?			
4.	Does the member have urinary incontinence?	Yes	no
5.	Does the member have bowel incontinence?	Yes	no
6.	Ventilator Care Prescribed to Participant?	Yes	no
If yes, What is the back-up plan in the event the ventilator is not functioning?			

Member Name: _____

If Incontinent, what devices does member use?

☐	Diaper/ pull-up/ brief	☐	In-dwelling cath	☐	Bowel program
☐	Chux	☐	Supra pubic cath	☐	Ostomy
☐	Urinal	☐	Self-cath	☐	Dialysis
☐	Condom cath	☐	Ileostomy/ ileoconduit	☐	Other: _____

Comments:

SKIN:

Does member have a wound? yes no

If yes, where is it located and what stage is it? _____

If yes, where is the wound being treated

☐	Home Health	☐	Wound Clinic
☐	Doctor's office	☐	Informal Caregiver
☐	Other: _____		

Please attach wound care notes. The notes should include location, stage of wound, current treatment plan, progress being made with treatment. If skilled PSS care for wounds has been approved, submit notes from the PSS provider detailing the additional care aides are providing.

Have you included these notes in a separate attachment? _____ Yes _____ No

Comments:

Independent Care Waiver Services

April 1, 2023

Member Name: _____

Primary Modes of Locomotion:

☐	No assistive device	☐	wheelchair
☐	Cane	☐	activity does not occur
☐	walker/crutch scooter	☐	Other:

Comments:

Memory Issues:

Based on your personal knowledge, does the member appear to have difficulties in remembering things?

☐

☐

No issues

No personal knowledge

☐

☐

Yes, there are issues

Member is non-verbal

If yes, would you classify memory difficulty as (choose one):

☐

☐

☐

☐

Short-term memory problems that, with occasional reminders, do not cause difficulty in the person performing self-care tasks.

Memory lapses that result in the person frequently not performing self-care tasks without

reminders? Memory lapses resulting in the inability to perform routine tasks on a daily basis?

Comments: _____

Independent Care Waiver Services

April 1, 2023

Member Name: _____

Behavior Issues:

Are there any behavior issues that may impact their ability to continue living in the community?		Yes	No
If yes, describe:			
Is the member:			
Smoking without supervision?	Yes	No	
If yes, interventions:			
Suspected alcohol abuse?	Yes	No	
If yes, interventions:			
Suspected drug abuse?	Yes	No	
If yes, interventions:			

Comments:

--

Personal Assistance Services Needed:

☐	Meal prep	☐	Bathing	☐	Routine hair care	☐	exercise
☐	Feeding/eating	☐	shaving	☐	Routine skin care	☐	laundry
☐	Oral care	☐	grooming	☐	shopping	☐	Community outings
☐	transfers	☐	dressing	☐	cleaning	☐	
☐	Assist with self-administered medication			☐	Other:		

Comments:

--

Member Name: _____

ENVIRONMENTAL:

<u>SAFETY Hazards:</u>		None			
☐	Inadequate floor/ roof/ windows	☐	Unsafe gas/electric appliance	☐	lack of safety devices
☐	inadequate heating	☐	inadequate cooling	☐	Unsafe floor coverings
☐	inadequate stair railings	☐	Other:		
Comments:					

<u>Sanitation Hazards:</u>		None			
☐	No running water	☐	inadequate sewage disposal	☐	no schedule trash pick-up
☐	Contaminated water	☐	inadequate/improper food storage	☐	cluttered/soiled living area
☐	No toileting facility	☐	no cooking facility	☐	insects/ rodents present
☐	Other:				
Comments:					

Social functioning:

In the past year has there been a decline in the member's level of participation in social, religious, occupational or other preferred activities?

☐	No	☐	Decline, but individual is not distressed	☐	Decline, and individual is distressed
☐	Other:				

Isolation:

How often is the member alone during the day?

☐ Never or Seldom ☐ About 1 hour ☐ Long periods of time ☐ All the time

Is the member involved in community activities (ex: church, shopping, social activities)?

☐ yes ☐ no

Comments:

Member Name: _____

Informal Caregiver:

Does the member have an informal support system?

☐

yes

☐

no

If yes, was the informal support person present for your renewal visit?

☐

yes

☐

no

no

☐

yes

☐

If you answered "no" to any of the above questions, please explain:

Informal Caregiver Status (check all that apply):

☐

Caregiver is unable to continue in caring activities (e.g. decline in health of care giver makes it difficult to continue).

☐

Primary caregiver is not satisfied with support received from family and friends (e.g. other children of individual).

☐

Primary caregiver expresses feelings of distress, anger or depression.

☐

Caregiver expresses feelings of frustration with current PSS staffing

☐

No issues

☐

Other: _____

How often does the Member receive assistance from the Primary Informal caregiver?

☐

Several time during the day and night

☐

once daily

☐

1-2 times per week

☐

Several times during the day

☐

3 or more times per week

☐

less often than weekly

LIST MEMBER'S INFORMAL SUPPORT:

1. _____

a. Lives with Member? ___Yes ___No

b. Relationship to Member: ___child ___spouse ___friend/neighbor ___parent

Other: _____

2. _____

c. Lives with Member? ___Yes ___No

d. Relationship to Member: ___child ___spouse ___friend/neighbor ___parent

Other: _____

Independent Care Waiver Services
April 1, 2023

Member Name: _____

By signing below, I agree that I will continue to follow the Independent Care Waiver program's policies and procedures. I agree that if I have concerns or questions about the program, I will seek clarification from my case manager. If I am utilizing the Consumer Directed Care Option (CDC), I agree to follow the CDC's policy and procedures as well as maintain my budget as approved.

Client/Representative Signature

Date

Member Name: _____

Case Manager Narrative

Case Manager Signature

Date

Appendix D-5

INDEPENDENT CARE WAIVER ADDRESS STATUS FORM COMPLETE WITH ANNUAL REVIEW AND/OR CHANGE OF ADDRESS

Member's Name:		Medicaid ID:	
Date Completed:			
Current Street Address:			
Apt. No:			
City:		State:	
		Zip:	
		County:	
Previous Street Address:			
Apt. No.			
City:		State:	
		Zip	
		County	

Member's Phone No.:

Date Member Moved:

Private Home: Assisted Living: Licensed PCH: Other:	☐ ☐ ☐ ☐	Living Setting: ALS: Group Home: ☐	☐ ☐
--	--	---	--

Member's support system, emergency contact or responsible party information:

Name:		Relationship to Member:	
Phone:		Alternate Phone:	
Street address:			
City:		Zip:	
County:			

Appendix E

PHYSICIAN'S RECOMMENDATION CONCERNING NURSING FACILITY CARE OR

INTERMEDIATE CARE FOR THE INTELLECTUALLY DISABLED

Section A – Identifying Information											
1. Applicant's Name/Address: County _____				2. Medicaid Number:		3. Social Security Number					
						4. Sex	Age	4A. Birthdate			
				7. Patient's Name (Last, first, middle initial)							
5. Type of Facility (Check One) 1. Nursing Facility 2. ICF/ID		6. Type of Recommendation 1. Nursing Facility 2. ICF/ID 3. Continued Placement		8. Date of Nursing Facility Admission / /		9. Patient Transferring From (Check One): Hospital _____ Home _____ Another Nursing home Private Pay Medicare					
Recipient's Home Address:			Date of Medicaid Application		9A. State Authority (MH & ID Screening)						
Recipient's Telephone Number:			/ /		Level I/II						
This is to certify that the facility of attending physician is hereby authorized to provide the Department of Community Health, Division of Medical Assistance and the Division of Family and Children Services, Department of Human Resources with necessary information including Medical Data. 10. Signature _____ 11. Date _____ (Patient, Spouse, Parent or other Relative or Legal Representative)					Restricted Auth Code _____ Date _____						
					9B. This is not a re-admission for OBRA purposes						
					Restricted Auth Code _____ Date _____						
Section B – Physician's Report and Recommendation											
12. Diagnosis on admission to the facility (hospital transfer report may be attached) 1. Primary _____ 2. Secondary _____ 3. Other _____					1. ICD-10		2. ICD-10		3. ICD-10		
12A. Diagnosis on admission to the facility (hospital transfer report may be attached) 1. Primary _____ 2. Secondary _____ 3. Other _____					1. ICD-10		2. ICD-10		3. ICD-10		
13. Treatment Plan (Attach copy of order sheet if more convenient)					Hospital Dates: _____ to _____						
Hospital Diagnosis 1. Primary _____ 2. Secondary _____ 3. Other _____											
Medications				16. Diagnostic and Treatment Procedures							
Name		Dosage	Route	Frequency	Type		Frequency				
14. Recommendation Regarding Level of Care Considered Necessary 1. Skilled 2. Intermediate 3. Intermediate Care for the Intellectually Disabled				15. Length of Time Care Needed _____ Months 1. Permanent 2. Temporary _____ estimated			16. Is Patient free of communicable diseases? 1. Yes 2. No				
17. This patient's condition could not be managed by provisions of community care or home health services. 18. I certify that the patient requires the level of care provide by a nursing facility or an Intermediate care facility for the intellectually disabled. _____ Physician's Signature				19. Physician's Name (Print)							
				Physician's Address (Print)							
				20. Date Signed by Physician / /		21. Physician's License Number		Physician's Phone Number ()			
Section C – Evaluation of Nursing Care Needed (check appropriate box only)											
22. Diet		23. Bowel		24. Overall Condition		25. Restorative Potential		26. Mental & Behavioral Status			
Regular Diabetic Formula Low Sodium Tube feeding Other		Continent Occas. Incontinent Colostomy		Improving Stable Fluctuating Deteriorating Critical Terminal		Good Fair Poor Questionable None		Agitated Noisy Dependent Confused Nonresponsive Anxious Depressed Violent Well Adjusted Forgetful Wanders Disoriented Alert Withdrawn Inappropriate Reaction			
27. Decubitus		28. Bladder		30. Indicate Frequency Per Week							
Yes _____ Surgery No _____ Date: Infected On Admission		Continent Occas. Incontinent Catheter			Physical Therapy	Occupational Therapy	Remotive Therapy	Reality Orientation	Speech Therapy	Bowel and Bladder Retrain	Activities Program
				Received							
29. Hours Out of Bed Per Day _____ Intake IV Output Bedrest		Catheter Care Colostomy Care Sterile Dressing Suctioning		Needed							
31. Record Appropriate Legend											
IMPAIRMENTS					ACTIVITIES OF DAILY LIVING						
1. Severe 2. Moderate 3. Mild 4. None Sight Hear Speech Ltd. Motion Paralysis					1. Dependent 2. Needs Asst. 3. Independent 4. Not App Eats Wheelchair Transfer Bath Ambulation Dressing						
32. Remarks											
33. Pre-Admission Certification Number				34. Signed				35. Date Signed / /			
DO NOT WRITE BELOW THIS LINE											
Continued Stay Review Date: _____ Payment Date _____ Approved for _____ Days _____											
36. Level of Care Recommended by GMCF			LOS		37. Signature (GMCF)			Date: / /		38. Attachments (GMCF) 1. Yes 2. No	

APPENDIX F

Georgia

Department of Human Resources



Name of Member/Patient/Applicant

Date of Birth

IF AVAILABLE:

ID Number Used by
Requesting AgencyID Number Used by
Requesting Agency**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby request and authorize:

(Name of Person or Agency Requesting Information)

(Address)

to obtain from:

(Name of Person or Agency Holding the Information)

(Address)

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

for the purpose of:

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

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

☐ *One (1) year.*

☐ *The period necessary to complete all transactions on accounts related to services provided to me.*

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent. I may withdraw this consent at any time.

(Date)

(Signature of Member/Parent/Applicant)

_____ (Signature of Witness)	_____ (Title or Relationship to Member)	_____ (Signature of Parent or Authorized Representative, where applicable)	_____ (Date)
------------------------------------	---	--	-----------------

USE THIS SPACE ONLY IF MEMBER WITHDRAWS CONSENT

_____ (Date this consent is withdrawn by member)	_____ (Signature of Member)
---	--------------------------------

Form 5450 (Rev. 2-80)

**Independent Care Waiver Program
AUTHORIZATION FOR RELEASE OF INFORMATION
& INFORMED CONSENT**

Client Name: _____ **ID:** _____

Initial all that apply:

- _____ 1. This is to certify that the ICWP is hereby authorized to release necessary information including medical data to the agencies which will provide services to me as outlined in the care plan. ***The level of care medical review team may request and/or retrieve additional medical information for the purpose of determining eligibility. Information may include hospitalization information, medical equipment needs, previous treatment, and medical history.**
- _____ 2. This is to certify that I choose to participate in the ICWP-Traditional/Enhanced Services and participation is based on annual renewal/approval of level of care.
- _____ 3. This is to certify that I received information about the Consumer-Direction Option for Personal Support Services
- _____ 4. This is to certify that I received educational/referral information about Abuse, Neglect and Exploitation.
- _____ 5. This is to certify that I choose placement in the community instead of nursing home placement.
- _____ 6. Discharge plan / Emergency Preparedness plan discussed with client/representative.
- _____ 7. This is to certify that I participated in the development of my Care Plan, including determining which services will be provided to me and which providers I choose through the Traditional/Enhanced Services.
- _____ 8. This is to certify that I have been advised to contact my Case Manager with any service issues/problems.
- _____ 9. I acknowledge the responsibility for the completion of the ICWP Medicaid application and submission of required documents to determine eligibility.
- _____ 10. ALL OF THE MEDICAL, SOCIAL AND FINANCIAL INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

11.

SIGNATURE OF CLIENT OR CLIENT'S REPRESENTATIVE

DATE

12.

SIGNATURE OF ICWP CASE MANAGER

DATE

APPENDIX G

INDEPENDENT CARE WAIVER COMMUNICATOR

The purpose of this form is to establish the Independent Care 30 day length of stay requirement for individuals whose Medicaid eligibility is based on Independent Care Waiver participation. Case Managers are to complete Section I of this form and forward to the appropriate DFCS caseworker.

_____	_____	_____
Member Name	County	Medicaid Number
_____	_____	_____
Member Name	County	Medicaid Number

SECTION I - COMPLETED BY CASE MANAGER

- I. The above member has elected to accept Independent Care Waiver Program services. Case Management began effective _____, and the member was placed in an ICWP slot effective _____.
- ☐ The member is currently receiving Medicaid. Please determine cost share.
- ☐ The member has been referred for Medicaid eligibility and cost share determination.

Signature _____ Date _____

SECTION II - COMPLETED BY DFCS CASEWORKER

- II. ☐ The member has been determined Medicaid eligible effective _____.
- ☐ The member is receiving Independent Care Waiver services and is responsible for contributing \$_____ monthly toward the cost effective _____.
- ☐ The member has a change in cost share.

\$ _____	Effective _____
\$ _____	Effective _____
\$ _____	Effective _____

- ☐ The above named member has been determined ineligible for Medicaid effective _____

Reason: _____

[] Other _____

Signature _____ Date _____

SECTION III - COMPLETED BY CASE MANAGER

III. [] The above named member is being released from the Independent Care Waiver Program effective _____.

Reason: _____

Signature _____ Date _____

APPENDIX H 1

Independent Care Waiver Program Community Carepath Signature Sheet

Member Name: _____ DOB: _____ Medicaid No.: _____

Case Manager Name: _____
Print Signature

DMA-6 Date: _____ Plan of Care Dates: _____

By signing and initialing the lines below I am acknowledging that my plan of care and goals have been discussed between the member/caregiver and case manager conducted during the quarterly visits per ICWP policy and we are in agreement.

First Quarter/Renewal: _____ Date: _____ CM Initials: _____

Second Quarter: _____ Date: _____ CM Initials: _____

Third Quarter: _____ Date: _____ CM Initials: _____

Fourth Quarter: _____ Date: _____ CM Initials: _____

Obtain signatures every quarter and forward to Alliant Health with Annual Renewal. Enter the Carepath and Quarterly information in the web portal.

The ICWP 'Community Care Path Signature Page' must have four signatures when it is uploaded with renewal care plan documents.

Rev. 8/1/2022

Participant Name: _____ Medicaid No. _____

GOAL	PLAN	REVIEWS
1. <i>ICWP participant will maintain maximum control over daily schedule and decisions.</i> PARTICIPANT INDICATORS: A. Participant contributes to successful design and implementation of community-based plan. Key participant responsibilities: - Accept and participate in services planned with case manager - Provide accurate information on health status and care received - Maintain scheduled contact with case manager B. ICWP participant anticipates needs and plans accordingly. Indicators of inadequate planning include: - Recurrent depletion of supplies - Failure to develop or use back-up PSS plan. - Failure to promptly report faulty equipment to vendor. C. ICWP participant communicates with PCA in a clear, positive and proactive manner. Indicators of desirable patterns of communication include: - Clear communication directly with PSS attendant. - Problem solving around PSS issues prior to crisis level. - Establishing balance between critical job functions and desirable personality traits.	CASE MANAGER: _____ EDUCATION by case manager on service plan and provider roles. LIVING ARRANGEMENTS: __alone __roommate: with her son. __spouse and/or family: _____ __paid companion _____ X REVIEW/EDUCATION by case manager in key areas (supply inventory, back up PSS plan, equipment repair, etc.), upon enrollment and as indicated. EDUCATION for ICWP participant on skills for clear, positive and proactive communication. __case manager counseling __role playing __peer counseling __assertiveness training NOTES: __ Case _____	Baseline/Annual Review: (__/ __/ __) A. __ met __not met B. __ met __not met C. __ met __not met Second Review (__/ __/ __): A. __ met __not met B. __ met __not met C. __ met __not met Third Review (__/ __/ __): A. __ met __not met B. __ met __not met C. __ met __not met Fourth Review (__/ __/ __): A. __ met __not met B. __ met __not met C. __ met __not met

Participant Name. _____ Medicaid No. _____

GOAL	PLAN	REVIEWS
Cont'd from Page 1 PROVIDER INDICATORS: A. ICWP support services are delivered in a manner satisfactory to the participant and case manager. Key provider performance areas: • Reliability of service • Responsiveness to participant concerns • Coordination with participant and case manager • Competence and compatibility of staffing B. PSS staffing will be consistent, without excessive turnover. C. Supplies will be provided in a timely manner, in the correct amount and of the specific type ordered. D. Primary medical care will be characterized by: • Availability of prompt appointments • Timely response to participant/case manager calls • PCP staff cooperation on issues related to meeting carepath goals • Appropriate specialist referrals	PSS Provider: _____ Primary Care Provider: _____ Supplies Provider: Other Providers: MONITOR PROVIDER PERFORMANCE: ICWP participant and case manager; routine conferencing and other communication as needed to meet carepath goals. NOTES _____ _____ _____ _____ _____ _____ _____ _____	Baseline/Annual Review (__/__/__) A. _ - met—not met B. _ met—not met C. _ met----not met D. _ met----not met Second Review (__/__/__) A. met-----not met B. met-----not met C. _met-----not met D. _met-----not met Third Review(__/__/__) A. Met---not met B. Met---not met C. Met----not met D. Met----not met Fourth Quarter (__/__/__) A. Met----not met B. Met----not met C. Met-----not met D. Met---not met

Participant Name. _____ Medicaid No. _____

GOAL	PLAN	REVIEWS
2. <i>ICWP participant will be socially connected and involved in community activities of their choosing.</i> INDICATORS: A. Transportation is adequate and available. B. Participant is out of bed on a regular basis. C. PSS is adequate and appropriate for social and community involvement. D. Physical and/or mental health do not interfere with community or social activities. E. Opportunities are offered for community and social activities.	Main Community Activities*: __ education _____ _____ __ work/training _____ _____ __ volunteering _____ _____ __ religious _____ _____ __ leisure _____ _____ __ other _____ __ Senior Center _____ _____ When _____ (*Indicate accompaniment by PSS aide) Social/Emotional Support: — _____ Transportation/Phone No. Provided by: _____ NOTES: _____ _____ _____ _____	Baseline/Annual Review (date): (__/ __/ __) A. __ met __ not met B. __ met __ not met C. __ met __ not met D. __ met __ not met E. __ met __ not met Second Review (__/ __/ __): A. __ met __ not met B. __ met __ not met C. __ met __ not met D. __ met __ not met E. __ met __ not met Third Review (__/ __/ __): A. __ met __ not met B. __ met __ not met C. __ met __ not met D. __ met __ not met E. __ met __ not met Fourth Quarter (__/ __/ __): A. __ met __ not met B. __ met __ not met C. __ met __ not met D. __ met __ not met E. __ met __ not met

Participant Name Medicaid

GOAL	PLAN	REVIEWS
3. <i>ICWP participant assumes responsibility for cost effective use of medical services and supplies.</i> INDICATORS: A. Participant seeks/accepts medical treatment as indicated for optimal health status. B. Participant utilizes emergency room appropriately. C. Participant identifies only essential personal care needs for performance by PSS attendant. D. Participant maintains inventory of medical supplies proportionate to need. E. Participant receives services according to the type, scope, amount, duration, and frequency as specified in the service plan.	EDUCATION by case manager on criteria for accessing specific medical services: ___ Review criteria for medical services; discuss individual medical issues with participant as indicated. ___ Review with participant adaptive equipment available that may reduce reliance on human assistance. IDENTIFICATION of local/regional resources preferred for specific medical services. _ ___ hospital inpatient or outpatient: _ _ primary care physician: ___ specialists: _ ___ other _____ _____ EDUCATION NOTES _____ _____ _____ _____ _____	Baseline/Annual Review (date): A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met D. ___ met ___ not met E.. ___met ___ not met Second Quarter (___/___/___): A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met D. ___ met ___ not met E.. ___met ___not met Third Quarter (___/___/___): A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met D. ___ met ___ not met E.. ___met ___not met Fourth Quarter (___/___/___): A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met D. ___ met ___ not met E.. ___met ___not met

Participant Name. _____ Medicaid No. _____

GOAL	PLAN	REVIEWS
4. <i>Problem or symptomatic behavior will not place the ICWP participant at risk of social isolation, neglect or physical injury to themselves or others.</i> INDICATORS: A. Living arrangements remain stable. B. Behavior will be managed by ICWP participant, informal caregiver and/or PSS attendant. Signs of inadequately managed behavior include: • Hospitalization for behavioral issues • Increased level of caregiver stress (informal or paid) • Potential physical danger to self or others posed by behavior • Discharge from a program or service due to behavior. • High level of complaints/refusals-to-serve from PCAs.	IDENTIFICATION - with the ICWP participant and other parties involved - of the precise behavior(s) potentially putting participant at risk. DEVELOPMENT OF A PLAN OF ACTION to specifically address problem or symptomatic behavior (see attached as applicable).* MEMORANDUM OF UNDERSTANDING detailing plan of action, roles/responsibilities, etc., signed by all parties. * NOTES_ (*attach to carepath as developed)	Baseline/Annual Review (date): A. __met __not met B. __met __not met Second Review (__/__/__): A. __met __not met B. __met __not met Third Review (__/__/__): A. __met __not met B. __met __not met Fourth Review (__/__/__): A. __met __not met B. __met __not met

Participant Name _____ Medicaid No. _____

GOAL	PLAN	REVIEWS
5. <i>ICWP participant's diet will be balanced and appropriate for</i> INDICATORS: Diet does not contribute to any of the following: • Related new diagnosis or exacerbation of existing diagnosis • Decreased function • Change in size of equipment • Skin problems	EDUCATION on dietary/weight issues related to disability and overall health status: __primary care physician: _____ __dietitian _____ __other_ _____ MEAL PREPARATION: __self care (no assistance required) __informal/PSS caregiver(s) _____ _____ __home delivered meals _____ __PSS attendant (include G-tube) _____ provider: _____ MEAL PREP. SCHEDULE - indicate SELF, INF, PSS or OTHER (optional): Mon_PSS/INFS _____ B_PSS/NFL _____ L_INF/PSS _____ S Thurs_PSS/INF _____ B_PSS _____ LINF/PSS- S Tues_PSS/INF _____ B_PSS/INF _____ L_PSS/INF _____ S Fri_PSS/INF _____ B_PSS/INF _____ L_PSS/INF _____ S Wed_PSS/INF _____ B_PSS/INF _____ L_PSS/INF _____ S Sat_PSS/INF _____ B_PSS/INF _____ L_PSS/INF _____ S Sunday_PSS/INF _____ B_PSS/INF _____ L_PSS/INF _____ S __gastrostomy tube informal caregivers: _____ skilled nurse/provider: _____ NOTES _____ _____ _____	Baseline/Annual Review (date): __met __not met Second Review (___/___/___): __met __not met Third Review (___/___/___): __met __not met Fourth Review (___/___/___): __met __not met

Participant Name: _____ Medicaid No. _____

GOAL	PLAN	REVIEW
6. <i>Participant's skin will be maintained in healthy condition, avoiding breakdowns and pressure sores.</i>	EDUCATION for participant or caregiver: __physician__ __other_____ MONITOR skin for integrity: __self care __physician __informal/PSS support_____ __specialist_____ __PSS attendant/nursing supervisory visit: provider_____ __ASSISTANCE REQUIRED: __turning/repositioning (see below) __incontinence (see below) __nutrition (see above) __wound care/skilled nursing provider: Amicus Home Care_____ schedule:_____ __specialized equipment: Hoyer lift_____ _____ Seating clinic:_____ _____ NOTES_____ _____ _____	Baseline/Annual Review (date): __met __not met Second Review (___/___/___): __met __not met Third Review (___/___/___): __met __not met Fourth Review (___/___/___): __met __not met

Participant Name. _____ Medicaid No. _____

GOAL	PLAN	REVIEWS
7. <i>ICWP participant understands and observes medication regimen.</i>	PHARMACY_ EDUCATION for participant or caregiver: __physician: other _____ _____ COORDINATION between participant and physician(s) for efficient and effective medication management: __participant __ICWP case manager ADMINISTRATION/MANAGEMENT: __self-care __informal caregiver(s): __PSS attendant (cueing or as directed by participant) provider: schedule: _____ OBTAINING MEDICATIONS: __self care __informal caregiver: __pharmacy __PSS attendant NOTES _____ _____ _____ _____	Baseline/Annual Review (date): __met __not met Second Review (___/___/___): __met __not met Third Review (___/___/___): __met __not met Fourth Review (___/___/___): __met __not met

Participant Name. I _____ Medicaid No. _____

GOAL	PLAN	REVIEWS
8. <i>Activities of daily living are not interrupted due to cognitive or physical impairments.</i> INDICATORS: Reports from participant, informal caregiver, case manager or provider of: • Problems with IADLs or ADLs (inadequate assistance, etc.) • Equipment repairs needed	Indicate SELF; INF=informal support; or PSS=PSS aide (may be combination): ___PSS/INF_____bathing ___PSS/INF_____dressing ___SELF/PSS/INF transferring SELF/PSS/INF:turning/repositioning PSS/INF_toileting ___SELF:bowel program ___PSS/INF_____errands ___PSS/INF_____chores ___SELF/INF_____financial mgt. ___PSS/INF_____meal preparation Informal caregiver(s)/role: assistance with adl's,errands,_____ _____ PSS provider: Amicus Home Care___ Total hours/week: _56 PSS Schedule (optional): ___ERS provider:___ Responder(s): _____ NOTES _____ _____ _____ _____ _____	Baseline/Annual Review (date): _met ___not met Second Review (___/___/___): _met ___not met Third Review (___/___/___): _met ___not met Fourth Review (___/___/___): _met ___not met

Participant Name _____ Medicaid No. _____

GOAL	PLAN	REVIEWS
9. <i>Bowel and bladder care will promote cleanliness and positive health status.</i> INDICATORS: A. Participant maintains acceptable personal hygiene (self or caregiver report, provider/PCP report, case management observation, etc.). B. Participant is free of excessive episodes of incontinence. C. Participant has no urinary tract infections or complications.	EDUCATION for ICWP participant (and caregiver as applicable): __physician's office __other _____ __catheter __intermittent catheter (IC) __indwelling __external __self care __assistance by informal caregiver: _____ __assistance by provider: Physician _____ schedule: _____ __ostomy __self-care __assistance by informal caregiver: _____ __assistance by provider: _____ schedule: _____ __bowel program __in bed __raised toilet seat __commode chair __Digital stimulation __suppository __assistance by informal caregiver: _ son _____ __assistance by provider: _____ schedule: _____ SEE ATTACHED SUPPLIES. NOTES _____ _____ _____ _____ _____ _____	Baseline/Annual Review (5/1/17): A. __met __not met B. __met __not met C. __met __not met Second Review (__/__/__): A. __met __not met B. __met __not met C. __met __not met Third Review (__/__/__): A. __met __not met B. __met __not met C. __met __not met Fourth Review (__/__/__): A. __met __not met B. __met __not met C. __met __not met

Participant Name. _____ Medicaid No. _____

GOAL	PLAN	REVIEW
10. <i>Transfers and mobility will occur safely and when needed.</i> INDICATORS: A. ICWP participant has no falls due to unsuccessful attempts to transfer. B. Participant is not restricted in activity due to inability to transfer or self-mobilize (self-report or caregiver report, etc.).	Physical Assistance: __PSS/Informal caregiver(s): _____ __PSS provider: _____ Home Modifications: RAMP: __has __needs (date obtained :) WIDER DOORWAYS: __needs (date obtained :) BATHROOM MODIFICATIONS: __has __needs (date obtained: _____) AUTOMATIC DOOR OPENER: __has __needs (date obtained: _____) Other: _____ _____ _____ NOTES: _____ _____ _____ _____	Baseline/Annual Review (date): A. __met __not met B. __met __not met Second Review (__/__/__): A. __met __not met B. __met __not met Third Review (__/__/__): A. __met __not met B. __met __not met Fourth Review (__/__/__): A. __met __not met B. __met __not met

11. Ventilator care will continue in the event of an electrical interruption or natural disaster or equipment malfunction. INDICATORS: A. ICWP Member has no interruption of Ventilator care. (1)	Ventilator Care Prescribed to Participant? ____ Yes ____ No Emergency back-up plan in the event of an electrical outage, natural disaster, or equipment malfunction: _____ _____	Baseline/Annual Review (_ / _ / _): A. __met not met B. __met not met Second Review (_ / _ / _): A. __met not met B. __met not met Third Review (_ / _ / _): A. __met not met B. __met not met Fourth Review (_ / _ / _): A. __met not met B. __met not met
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GOAL	PLAN	REVIEW
12. Physical and Wellness exam will occur annually and when needed. A. Annual physical exam completed B. ICWP participant will receive recommended seasonal and preventative vaccines as needed	Approximate date of annual exam _____ Seasonal vaccine received: A. Flu vaccine Preventive Vaccines received: B. Pneumococcal Vaccine – up to date C. COVID vaccine D. Shingles vaccine	Baseline/Annual Review (__/__/__): A. __met __not met B. __met __not met C. N/A Second Review (__/__/__): A. __met __not met B. __met __not met C. N/A Third Review (__/__/__): A. __met __not met B. __met __not met Fourth Review (__/__/__): A. __met __not met B. __met __not met

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NAME _____		Medicaid No. _____
GOAL	PLAN	REVIEW
		Baseline/Annual Review (__/__/__): Second Review (__/__/__): Third Review (__/__/__): Fourth Review (__/__/__):

EQUIPMENT SHEET

Equipment LIST FOR: _____ DATE: _____

Wheelchair Accessories		Respiratory Equipment		Assistive Devices for Increased Function:		Miscellaneous:	
Manual Wheelchair		ventilator		Specialty Phone		Electrical stimulation unit	
Power Wheelchair		Insufflator (cough assist)		Mouth stick		Portable Ramps	
Tilt in space wheelchair		Suction machine		Plate Guard		Augmented communication devices	
Wheelchair Cushion		Ambu- bag		Specialty Utensils		Reacher	
Wheelchair Lap Tray		other		Over the Stove Mirror		Shoe horn	
Lift Chair						sponge	
Mobility Assistance Devices		Bathroom Equipment		Beds/ mattresses		Dressing stick	
Quad cane		Tub grab bars		Hospital Bed		Sock aid	
standard Cane		Raised toilet seat		Specialty mattress			
Side Walker/ hemi walker		Bedside commode chair		Safety bed rails			
Lofstrand/ forearm crutches		Drop arm commode		Other:			
Regular Crutches		Upright shower chair		Over the bed table			
Rolling walker		Shower stool		Transfer Devices			
Walker without wheels		Reclining shower chair		Sliding board			
Walker platform attachment		Bath transfer bench		Hoyer lift			
scooter		Bath tub safety rail		Gait belt			

ICWP SUPPLY LIST FOR: _____ DATE: _____

SUPPLY ITEM	PER MONTH	PER YEAR	COST PER UNIT	TOTAL COST PER YEAR
<i>Bowel and Bladder</i>				
Gloves			\$	\$
Adult Briefs/ pullups			\$	\$
Bladder control pads cs			\$	\$
Chux			\$	\$
Wipes- disposable			\$	\$
Skin Cream:			\$	\$
Reusable under pads			\$	\$
Urinal			\$	\$
Bisacodyl box of 10			\$	\$
Glycerin box of 4			\$	\$
Magic bullets box 100			\$	\$
Fleet enema			\$	\$
Lubricant *M pays 4ea/mo.			\$	\$
Urinary leg bag			\$	\$
Other:			\$	\$
			\$	\$
			\$	\$
<i>Feeding</i>			\$	\$
TF formula case:			\$	\$
Glycerin swabs			\$	\$
Toothettes- bx 250			\$	\$
Sip and puff straws bx 100			\$	\$
Bibs- disposable cs500			\$	\$
Bibs- reusable			\$	\$
			\$	\$
			\$	\$
<i>Trach Supplies</i>			\$	\$
Inner cannula bx10			\$	\$
Trach care kit			\$	\$
Trach collar tie bx12			\$	\$
Drain sponge pk50			\$	\$
Multidose saline bx100			\$	\$
			\$	\$
Barrier spray			\$	\$
Peri wash			\$	\$
Heel protector			\$	\$
Elbow protectors			\$	\$
Skin barrier wipes bx50			\$	\$
Geomat			\$	\$
Reacher			\$	\$
			\$	\$
Grand Total:			\$	\$

ICWP Financial Summary

Name: _____ Date: _____

Service Description		Frequency Intensity	Responsible Provider	Per Unit Cost	Yearly Cost
	Grand Total:				

Reference Sheet

Name: _____ Plan of Care Date: _____

This reference sheet will assist you and your provider in addressing your needs.

Your ICWP case manager is: _____
Phone number: _____

Your Emergency Contact Name: _____
Phone Number: _____

Personal Support Provider: _____
Phone Number: _____

Your Primary Care Physician: _____
Phone number _____

Supplies and Equipment
Supplies Provider _____
Phone number _____
Equipment Provider: _____
Phone number _____

Hospital for Emergencies: _____
Phone number: _____
Address: _____

Behavior Management: Yes ____ No _____
(if yes, see specific plan)

Notes:

Quarterly Review Tool

Participant Name _____

QTR/Date _____

Answer Sheet (column A)	Notes (column B)
1.1 Control A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met	
1.2 Control A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met D. ___ met ___ not met	
2. Connect A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met D. ___ met ___ not met E. ___ met ___ not met	
3. Cost A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met D. ___ met ___ not met	
4. Behavior A. ___ met ___ not met B. ___ met ___ not met	
5. Diet A. ___ met ___ not met	
6. Skin A. ___ met ___ not met	
7. Meds A. ___ met ___ not met	
8. ADLs A. ___ met ___ not met	

9. B/B A. ___ met ___ not met B. ___ met ___ not met C. ___ met ___ not met	
10. Trans A. ___ met ___ not met B. ___ met ___ not met	

Participant Signature_____ Date_____ CM Signature

1. At the end of the quarter, complete column A and document compliance, progress, and continued appropriateness of the plan in column B.

Obtain signatures and forward to Alliant Health every quarter. Fax number 678.527.3004

Appendix H-4

Case Manager Packet Submission Checklist

- ☐ DMA – 6
 - Member's signature & date
 - Diagnosis
 - MD's signature & Dated (within 30 days of start/renewal of plan of care)
 - Case Manager's signature & date
- ☐ **RPAF (Renewal Participant Assessment form) – submitted by the case manager for the annual renewal and for new admissions if it has been more than 9 months since the initial assessment.**
- ☐ **Narrative Summary – a detailed narrative is very important for the new admission. This will provide pertinent information to review nurse if anything has changed since the initial assessment.**
- ☐ Reference Sheet (signed by member and case manager)
- ☐ Equipment / Supply List
- ☐ Release of Information Form (Appendix F)
- ☐ Care Path (10 pages for Initial & Renewal) – this may be entered electronically in the LTC system vs sending actual documents
- Signature page of Community Care path – review nurse must see this page uploaded for renewals. The member signatures must be wrote on this form for each quarterly visit when the renewal care plan is uploaded.**
- ☐ Financial Summary
- ☐ Address Status Form
- ☐ Memorandum of Understanding (MOU) (Appendix C)
- ☐ Freedom of Choice (Appendix I)
- ☐ Member Rights and Responsibilities (Appendix B)

CDC Option:

- ☐ CDC Member Skills Inventory Checklist
- ☐ CDC Memorandum of Understanding (MOU) (Appendix C-1)
- ☐ Appendix P-2

****It is the responsibility of the case manager to review the FI statements monthly with the member. Monthly, case managers should review the budget to assure that member is still within CDC budget and will remain so for the remaining care plan year.**

APPENDIX I

Independent Care Program FREEDOM OF CHOICE (Statement of Informed Consent)

It is the policy of the State of Georgia that participants have the option to receive appropriate services in the setting of choice. Further, it is the policy of the State to recognize the participant's individual dignity; providing safeguards to protect rights, health, and the welfare of recipients. **Rev. 10/2015**

Based on these beliefs the State of Georgia assures that potential participants and their authorized representative(s) will be afforded an opportunity to make an informed choice concerning services. Once an individual is determined to be likely to require the level of care provided in a nursing facility or hospital the individual or his/her authorized representative will be (1) informed of any feasible alternative available under the waiver, and (2) given the choice of either institutional or home and community-based services, and (3) that the substance of the information provided will make one reasonable familiar with service options, their alternatives, and possible benefits and hazards, and (4) the disclosure of said information is designed to be fully understood and appears to be fully understood.

Verification

I have verified that the participant or his/her authorized representative have been informed about their choices in the manner outlined above.

Case Manager

Date

Acceptance

I and/or my authorized representative have been informed of my choices and have chosen to participate in the Home and Community Based Services Program.

Participant

Date

Authorized Representative

Date

Witness

Date

Refusal

I and/or my authorized representative have been informed of my choices and have chosen to refuse waiver services.

Participant

Date

Authorized Representative

Date

Witness

Date

Independent Care Program FREEDOM OF CHOICE FORM INSTRUCTIONS

Purpose

The intent of this form is to assure that the participants and their representatives will be:

- (1) informed of this form is to assure that the participants and their representatives will be:
- (2) given the choice of either institutional or home and community-based services.

The process assures that participants and their representatives can make an informed choice concerning services option(s). the presumption of the law is that a person may consent for him/herself. This presumption should be abandoned only when it is evident that the individual is not capable of doing so. The Independent Care Program has chosen to involve and recognize the rights of all participants while at the same time protecting the rights of participants through the request of concurrent consent by participants' authorized representatives.

Whoever is selected as authorized representative must meet the three tests to effect consent; that is, he/she must be competent, adequately informed about the factors involved in the decision and be knowledgeable about the person for whom consent is sought, and voluntary (free from coercion or conflict of interest). The authorized representative must act on the basis of the best interest of the person for whom his or her consent is sought. A suggested list of potential candidates for authorized representatives includes, but is not limited to the following: guardian or conservator, parent, participant's spouse, adult child, adult next-of-kin, any responsible relative, and attorney(s). In the absence of an available, suitable candidate, an advocate appointed by the Georgia Advocacy Office may serve as the designated representative.

Process

Step (1) Provide an overview of service options, noting pro's and con's related to each option; this includes inherent and potential risks, benefits and stigmas.

- A) The content of the overview should make one reasonable familiar with service options
- B) The presentation of information should be designed to match the participants' and/or his/her representative's level of comprehension.
- C) Evidence of participant/representative understanding of information should be evidenced by discussion of same.

Step (2) Once information has been provided and appears to be understood, the provider should verify that information has been provided appropriately and is understood. Once verified, the form should be signed at the designated sign-off under verification statement.

Step (3) Informed participant/representative chooses a service option. The informed participant/representative should sign under the appropriate statement that reflects their choice. In cases where the individual participant is a minor, and/or unable due to physical and/or mental causes to sign his/her name, and/or unable to legibly write his/her name, the participant's name should be printed, above signature or mark, if any, and initialed by the participant's authorized representative.

Step (4) Once form is completed (signatures under appropriate statements), it should be attached to the Plan of Care.

APPENDIX J

Rev. 04/07 **MEDICAID MEMBER IDENTIFICATION CARD SAMPLE**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Member ID #: 123456789012
Member: Joe Q Public
Card Issuance Date: 12/01/02

Primary Care Physician:
Dr. Jane Q Public
285 Main Street
Suite 2859
Atlanta, GA 30303
Phone: (123) 123-1234 X1234

Plan: Georgia Better Health Care

After Hours: (123) 123-1234 X1234

Verify eligibility at www.ghp.georgia.gov

If member is enrolled in a managed care plan, contact that plan for specific claim filing and prior authorization information.

Payor: For Non-Managed Care Members
Customer Service: 1-800-766-4456 (Toll Free)

ACS, Inc.	SXC, Inc.	Mail Paper Claims to:
Member: Box 3000	Rx BIN-001553	SXC Health Solutions, Inc.
Provider: Box 5000	Rx PCN-GAM	P.O. Box 3214
Prior Authorization: Box 7000	SXC Rx Prior Auth	Lisle, IL 60532-8214
McRae, GA 31055	1-866-525-5827	Rx Provider Help Line
		1-866-525-5826

This card is for identification purposes only, and does not automatically guarantee eligibility for benefits and is non-transferable.

88795

APPENDIX K-1

DISCHARGE NOTICE DISCHARGE/TRANSFER NOTICE INDEPENDENT CARE WAIVER PROGRAM

PROVIDER NAME: _____

PROVIDER NUMBER: _____

PROVIDER ADDRESS: _____

MEMBER NAME: _____

MEDICAID NUMBER: _____

STATUS: ☐ Discharge ☐ Transfer EFFECTIVE DATE: _____

REASON FOR DISCHARGE:

- ☐ Member or member's caregiver/legal guardian requests member be discharged or transferred (please check appropriate status). If transfer is indicated, please specify reason:

- ☐ Member no longer requires services.
- ☐ Member expired.
- ☐ Member no longer Medicaid eligible.
- ☐ Utilization & Compliance Team recommends discharge.
- ☐ Member has entered a Long Term Care Facility
- ☐ Agency issues. Please provide explanation:

- ☐ Member, member's caregiver/legal guardian engages in/or allows illegal activities in the home or member, member's caregiver or others living in the home have inflicted or threatened bodily harm to another person within past 30 calendar days. (Must provide completed Incident Report).
- ☐ Member or representative fails to adhere to the conditions of the "Member Rights and Responsibilities."
- ☐ Member or representative refuses to comply with "Memorandum of Understanding."
- ☐ Provider is no longer able to provide appropriate staff to render services to the member.
- ☐ The enrolled member has not received ICWP Personal Support Services, Behavioral Management, and/or Case Management for sixty (60) consecutive days.

REASON FOR TRANSFER

- ☐ The member is transitioning to another waiver program.
- ☐ CCSP ☐ SOURCE ☐ NOW/COMP

PROVIDER SIGNATURE: _____ DATE: _____

APPENDIX L

PRIOR AUTHORIZATION REQUEST*

FOR DMA USE ONLY

PRIOR AUTHORIZATION NO.

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
ATLANTA, GEORGIA 30334**

*Include This Number
On All Claim Forms*

807725

1. Recipient Name (Last, First, Init.)			2. Medicaid ID No.		
3. Birthdate	4. Sex	5. Address	Nursing Home ☐ Yes ☐ No	6. Telephone (Area Code/Number)	

7. Prescribing Physician/Practitioner Name And Address		10. Provider Of Service(s) Name And Address	
8. Medicaid Provider Number	9. Telephone (Area Code/Number)	11. Medicaid Provider Number	12. Telephone (Area Code/Number)
☐ HOME HEALTH ☐ PODIATRIST ☐ OPTOMETRIST ☐ PHYSICIAN ☐ PSYCHOLOGIST ☐ DME/OP ☐ DDS ☐ PHARMACY		DEPT. USE ONLY	
13. Authorization Period: Through		14. Description Of Service(s) Requested	
From		15. Rec. Type	16. Ctg. Of Svc.

17. Primary Diagnosis Requiring Service(s)	18. ICD-9-CM
19. Justification And Circumstances For Required Service(s) (Use separate page if necessary)	

STATEMENT OF SERVICE(S)		22. Procedure/ Drug Code	23. Requested Or Estimated Price Per Unit	24. Bill. Units	25. Months or Units Of Service	26. Units Per Claim		27. Max. Units Per Month
LINE NO.	21. Description Of Procedures, Drugs, Equipment, Or Other Services					Max.	Min.	
1								
2								
3								
4								
5								
6								
7								
8								

28. PROVIDER'S SIGNATURE	29. DATE SUBMITTED
---	--------------------

30. REQUEST: ☐ APPROVED ☐ DENIED ☐ PENDING/ADDITIONAL INFORMATION	31. DMA SIGNATURE	32. DATE APPROVED
☐ APPROVED AS AMENDED		
33. Explanation to Provider		

*Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program.

COPIES: WHITE: DMA; PINK: SERVICING PROVIDER; GREEN: RECIPIENT'S FILE; YELLOW: REQUESTING PROVIDER

**INSTRUCTIONS FOR COMPLETING THE PRIOR APPROVAL
AUTHORIZATION REQUEST FORM - DMA 80**

The prior authorization request form consists of the original plus three (3) copies.

1. Participant Name - Enter the participant's complete name, last name first.
2. Medicaid ID Number - Enter the participant's complete Medicaid number exactly as it appears on the Medicaid card including alpha characters.
3. Birthdate - Enter participant's complete birthdate including the year of birth.
4. Sex - Enter M for male or F for female.
5. Address - Enter participant's complete address including city, state and zip code.

In the area titled nursing home please indicate yes or no.

6. Telephone - Enter participant's complete telephone number including the area code.
7. Prescribing Physician/Practitioner Name and Address - Enter name and address of attending physician in this space. This should be the name of the physician who has written the orders for Waivered Home Care Services.
8. Medicaid Provider Number - Enter the provider number of the physician listed in number seven (7). If the physician is not enrolled in the Medicaid program, enter his/her state license number.
9. Telephone - Enter the telephone number of the provider listed in number seven (7).
10. Provider of Service(s) Name and Address - Enter the complete name and address of agency providing services. If form should be mailed to a different address please indicate mailing address.
11. Medicaid Provider Number - Enter the provider number of the agency providing the service(s).
12. Telephone - Enter the telephone number including the area code of the agency providing the services.
13. Authorization Period - Enter the beginning and ending dates of services to be provided. These dates must not exceed twelve (12) months. These dates must correspond with the number of months indicated in item number twenty-one (21).
14. Description of Services - Enter description of services requested.
15. For Division use only.

16. For Division use only.
17. Primary Diagnosis Requiring Services - Enter diagnosis and briefly describe condition.
18. ICD-10 CM – Optional
19. Justification and Circumstances for Required Service(s) - Enter the rationale for requested services including clear and concise explanation of overall condition and needs.
20. Line Number - Enter each service on a separate line. Each line represents one (1) year.
21. Description of Services - Enter the description of services being requested. Enter only one (1) service per line.
22. Procedure/Drug Code - Enter only procedure codes from Appendix O of this manual.
23. Price Per Unit - Enter charge per unit.
24. Bill Units - Enter charge per units for service requested.
25. Months or Units of Service - Enter the exact number of months of service requested. This number must not exceed twelve (12) months and must correspond with the number of months requested in item number thirteen (13).
26. Units Per Claim - For Division use only.
27. Maximum Units Per Month - Enter the maximum number of units to be billed for the total twelve (12) month period.
28. Provider's Signature - Enter signature of person completing this form. The provider of service must sign the form.
29. Date Submitted - Enter the date completed.
- 30, 31, 32, and For Division Use Only - Do not write in these spaces. Read spaces carefully when form is returned to determine the Division's decision.

NON-EMERGENCY MEDICAL TRANSPORTATION

Non-Emergency Medical Transportation (NEMT) services are defined as medically necessary transportation for any eligible Medicaid member and companion, if required, who have no other means of transportation available to any Medicaid-reimbursable service for the purposes of receiving treatment, medical evaluation, obtaining prescription drugs or medical equipment.

How do I get NEMT services?

If you are a qualifying Medicaid recipient and have no other means of transportation for your medical care or services covered by Medicaid, you may contact a transportation broker for transport to and from your appointment. The member must contact the Broker to request NEMT services at least three (3) business days prior to a non-urgent, scheduled appointment. The three (3) day advance scheduling includes the day of the call but not the day of the appointment. Advance scheduling will be mandatory for all NEMT services except urgent care and follow-up appointments when the timeframe does not allow advance scheduling. Urgent care or same day reservations may require verification from your direct provider of service confirming you must be seen that day. Each broker has a toll-free telephone number to schedule transportation services, and available weekdays (Monday-Friday) from 7 a.m. to 6 p.m.

All counties in Georgia are grouped into five regions for NEMT services. A NEMT Broker covers each region. If you need NEMT services, **you must contact the NEMT Broker serving the county you live in** to ask for Non-Emergency Medical Transportation. Contact Southeastrans for Atlanta and North Regions and ModivCare, formerly LogistiCare, for Central, East and Southwest See the chart below to determine which broker serves your county and call the broker's telephone number for that region.

What if I have problems with a NEMT provider or broker?

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. If you have a question, comment, or complaint about a NEMT provider or broker that has not been resolved with the broker, you may contact the Georgia Department of Community Health, NEMT unit.

NEMT REGIONS & COUNTIES SERVED

Region	NEMT Broker & Phone Number	Counties Served
North	Southeastrans <i>Toll free</i> 1-866-388-9844 <i>Local</i> 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield

Atlanta	Southeastrans 404-209-4000 <i>Note: For Georgia Families 360°</i> 1-866-991-6701	Fulton, DeKalb, and Gwinnett
Central	ModivCare (formerly LogistiCare) <i>Toll free</i> 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	ModivCare (formerly LogistiCare) Toll free 1-888-224-7988 <i>Note: For Crisis Stabilization Units and Psychiatric Residential Treatment Facilities</i> 1-800-486-7642 Ext. 461 or 436	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	ModivCare (formerly LogistiCare) Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth

Georgia Advance Directive for Health Care

By: _____ Date _____ of _____
(Print Name) Birth: (Month/Day/Year)

This advance directive for health care has four parts:

PART ONE—Health Care Agent. This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.

PART TWO—Treatment Preferences. This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.

PART THREE—Guardianship. This part allows you to nominate a person to be your guardian should one ever be needed.

PART FOUR—Effectiveness and Signatures. This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care may be used in Georgia.

You may revoke this completed form at any time. This completed form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.

PART ONE—Health Care Agent

PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your health care agent. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your health care agent. If you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.

1. Health Care Agent

I select the following person as my health care agent to make health care decisions for me:

Name: _____
Address: _____
Telephone Numbers: _____
(Home, Work, and Mobile)

2. Back-Up Health Care Agent

This section is optional. PART ONE will be effective even if this section is left blank.

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

Name: _____
Address: _____
Telephone Numbers: _____
(Home, Work, and Mobile)

Name: _____
Address: _____
Telephone Numbers: _____
(Home, Work, and Mobile)

3. General Powers of Health Care Agent

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent's authority includes, for example, the power to:

- **Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;**
- **Request, consent to, withhold, or withdraw any type of health care; and**
- **Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).**

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that under Georgia law:

Independent Care Waiver Services

- My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and
- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.

4. Guidance for Health Care Agent

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

5. Powers of Health Care Agent After Death

(A) AUTOPSY

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

_____ (Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) ORGAN DONATION AND DONATION OF BODY

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my health care agent's power by initialing below.

Initial each statement that you want to apply.

_____ (Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

_____ (Initials) My health care agent will not have the power to donate any of my organs.

(C) FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

_____ (Initials) I want the following person to make decisions about the final disposition of my body:

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

I wish for my body to be:

_____ (Initials) Buried

OR

_____ (Initials) Cremated

PART TWO—Treatment Preferences

PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.

6. Conditions

PART TWO will be effective if I am in any of the following conditions:

Initial each condition in which you want PART TWO to be effective.

_____ (Initials) **A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.**

_____ (Initials) **A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.**

My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

7. Treatment Preferences

State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) _____ (Initials) **Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.**

OR

(B) _____ (Initials) **Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.**

OR

(C) _____ (Initials) **I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:**

Initial each statement that you want to apply to option (C).

_____ (Initials) **If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.**

_____ (Initials) **If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.**

_____ (Initials) **If I need assistance to breathe, I want to have a ventilator used.**

_____ (Initials) **If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.**

8. Additional Statements

This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.

9. In Case of Pregnancy

PART TWO will be effective even if this section is left blank.

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_____ (Initials) **I want PART TWO to be carried out if my fetus is not viable.**

PART THREE—Guardianship

10. Guardianship

PART THREE is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.

State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.

(A) _____ (Initials) I nominate the person serving as my health care agent under PART ONE to serve as my guardian.

OR

(B) _____ (Initials) I nominate the following person to serve as my guardian:

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

PART FOUR—Effectiveness and Signatures

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

_____ (Initials) This advance directive for health care will become effective on or upon _____ and will terminate on or upon _____.

You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:

- Cannot be a person who was selected to be your health care agent or back-up health care agent in PART ONE;
- Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or
- Cannot be a person who is directly involved in your health care.

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

(Signature of Declarant)

(Date)

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

(Signature of First Witness)

(Date)

Print Name: _____

Address: _____

(Signature of Second Witness)

(Date)

Print Name: _____

Address: _____

This form does not need to be notarized.

APPENDIX O

PROCEDURE CODES AND REIMBURSEMENT RATES

The appropriate invoice for reimbursement is the CMS-1500. The following procedure codes are for use in the Independent Care program.

Description	HIPAA Codes	Modifier	Description	Rates
Case Management	T1016		Case management, each 15 minutes	Original fee divided by (4) four. \$6.25/unit Max units 48 a month
Case Management	T1016	U1	Case management, each 15 minutes	\$6.25/unit Max units 48 a month
Enhanced Case Management	T2022		Case Management per month	\$461.00 per month. Max units =1 month
Enhanced Case Management	T2022	U1	Case Management per month	\$461.00 per month. Max units =1 month
Counseling	96152		Health and behavior intervention, each 15 minutes, face-to-face; individual	\$21.40 /unit; max 2 units per day not to exceed 40 units per month
Counseling	96152	U1	Health and behavior intervention, each 15 minutes, face-to-face; individual	\$21.40 /unit; max 2 units per day, not to exceed 40 units per month
Environmental Modification	S5165		Home modification; per service	\$8000.00 per member per lifetime
Environmental Modification	S5165	U1	Home modification; per service	\$8000.00 per member per lifetime
Personal Emergency Response Installation	S5160		Emergency response system; installation and testing	\$75.00 per resident; max unit =1

Personal Emergency Response Installation	S5160	U1	Emergency response system; installation and testing	\$75.00 per resident max unit =1
Personal Emergency Response - Monitoring	S5161		Emergency response system service fee, per month (excludes installation and testing)	\$25.00/month max unit =1
Personal Emergency Response - Monitoring	S5161	U1	Emergency response system service fee, per month (excludes installation and testing)	\$25.00/month max unit =1
Skilled Nursing	T1030		Nursing care, in the home, by registered nurse, per diem	\$49.79/per day; 31 units per month
Skilled Nursing	T1030	U1	Nursing care, in the home, by registered nurse, per diem	\$49.79/per day; 31 units per month
Skilled Nursing	S9123	TD	Nursing care, in the home, by registered nurse, hourly	\$10.00 per 15 minute unit
Skilled Nursing	S9123	U1 TD	Nursing Care in the home, by registered nurse, hourly	\$10.00 per 15 minute unit
LPN Nursing	S9124	TE	Nursing Care in the home, by licensed practical nurse, hourly	\$8.75 per 15 minute unit
LPN Nursing	S9124	U1 TE	Nursing care, in the home, by licensed practical nurse, hourly	\$8.75 per 15 minute unit
Personal Support Level I	T2025	U5 TF	*Attendant care services per hour	\$17.96 per hour, not to exceed 24 hours a day, nor 744 hours a month
Personal Support Level II	T2025	U5 TG	*Attendant care services per hour	\$20.20 per hour, not to exceed 24 hours a day, nor 744 hours a month

TBI Personal Support Level I	T2025	U5 U1/TF	*Attendant care services per hour	\$17.96 per hour, not to exceed 24 hours a day, nor 744 hours a month
TBI Personal Support Level II	T2025	U5 U1/TG	*Attendant care services per hour	\$20.20 per hour, not to exceed 24 hours a day, nor 744 hours a month *Rev.1/15; 10/15; Rev. 7/17
Respite Care Services Level 1	S5150		Unskilled respite care, not hospice; per 15 mins	1 unit =15 minutes. \$2.20/unit; max units 240/calendar month and /or 1440/year
Respite Care Services Level 1	S5150	U1	Unskilled respite care, not hospice; per 15 minutes	1 unit =15 minutes. \$2.20/unit; max units 240/calendar month and /or 1440/year
Respite Care Services Level II	S5150	TF	Unskilled respite care, not hospice; per 15 minutes	1 unit =15 minutes. \$2.60/unit; max units=240 per month and 1440/year
Respite Care Services Level II	S5150	U1/TF	Unskilled respite care, not hospice; per 15 minutes	1 unit =15 minutes. \$2.60/unit; max units=240 per month and 1440 per year
Respite Care Level III	S5150	TG	Unskilled respite care, not hospice; per 15 minutes	1 unit =15 minutes. \$3.00 per unit; max units=240 per month and 1440 per year
Respite Care Level III	S5150	U1/TG	Unskilled respite care, not hospice; per 15 minutes	1 unit =15 minutes. \$3.00 per unit; max units=240 per month and 1440 per year
Respite Service_ Full Day Level 1	S5151		Unskilled respite care, not hospice; per diem	\$70.55/day; 14 days per year
Respite Services Full Day Level I	S5151	U1	Unskilled respite care, not hospice; per diem	\$70.55/day; 14 days per year
Respite Services Level II full day	S5151	TF	Unskilled respite care, not hospice; per diem	\$83.00 per day; 14 days per year
Respite Services Level II full day	S5151	TF/U1	Unskilled respite care, not hospice; per diem	\$83.00 per day; 14 days per year
Respite Services full day Level III	S5151	TG	Unskilled respite care, not hospice; per diem	\$95.45 per day; 14 days per year
Respite Services full day Level III	S5151	TG/U1	Unskilled respite care, not hospice; per diem	\$95.45 per day; 14 days per year

TBI Specialized Medical Equipment and Supplies	T2029	U1	Specialized medical equipment; not otherwise specified waiver	\$1026.00 max per month
Specialized Medical Equipment and Supplies	T2029		Specialized medical equipment; not otherwise specified waiver	\$1026.00 max per month
Behavior Management	H2019		Therapeutic behavioral services; per 15 minutes	\$14.00/unit; max units=16 per day, 368 per month, and 80/week
Behavior Management	H2019	U1	Therapeutic behavioral services; per 15 minutes	\$14.00/unit; max units=16 per day, 368 per month, and 80 per week
Adult Day Services	S5102		Day care services, adult; per diem	\$65.00 per day; max days =31
Adult Day Services	S5102	U1	Day care services, adult; per diem	\$65.00 per day; max days =31
Adult Day Services	S5101		Day care services, adult; per half day	\$39.00 per half day; max units=31 per month
Adult Day Services	S5101	U1	Day care services, adult; per half day	\$39.00 per half day; max units=31 per month
Vehicle Adaptation	T2039		Vehicle modification, waiver; per service	\$225.00 per year
Vehicle Adaptation	T2039	U1	Vehicle modification, waiver; per service	\$225.00 per year
Fiscal Intermediary	T2040	UC	Financial Management services	\$75.00 per member per month
Personal Support Services - Consumer Directed Services	T2025	U5 UC	Consumer Directed Care Personal Support services attendant care	\$20.20 per hour* Level III. See PSS rates above for Levels I & II

Alternative Living Services -Family Model	T1020		Personal Care Services, per diem, not for an inpatient or resident of hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant	\$70 per day (payment to the individual model home must be no less than \$42.00 per day)
Alternative Living Services -Family Model	T1020	U1		\$70 per day (payment to the individual model home must be no less than \$42.00 per day)

ICWP modifiers are as follows:

U1_____Traumatic Brain Injury
TF_____Intermediate Care (Level II)
TG_____High Complexity Care (Level III)
UC_____Consumer Directed Care
U5_____Represent an hourly code

***A claim will not pay if a provider fails to use the correct modifier.

NOTE: Personal Support codes were identified as S9122 with the modifiers for one month in November 2005.

APPENDIX O-1- Public Health Emergency Temporary Rate Increase

Service Current Rate	Current	Effective 7/1/2021
Adult Day Service (full day)	\$65.00 per diem	\$71.50
Adult Day Service (half day)	\$ 39.00 per diem	\$42.90
Alternative Living Service	\$70.00 per diem	\$77.00
Behavioral Support	\$14.00 per 15-minute unit	\$14.40
Case Management	\$6.25 per 15-minute unit	\$6.88
Counseling	\$21.40 per 15-minute unit	\$23.54
Enhanced Case Management	\$461.00 per month	\$507.10
Environmental Modification	\$8,000.00 Lifetime limit per member	\$8,800.00
Fiscal Intermediary	\$75.00 per month	\$82.50
Hourly Skilled Nursing - RN	\$10.00 per 15- minute unit	\$11.00
Hourly Skilled Nursing - LPN	\$8.75 per 15-minute unit	\$9.63
Personal Emergency Response Installation	\$75.00 one-time	\$82.50
Personal Emergency Response Monitoring	\$25.00 per month	\$27.50
Personal Support Services - Level I	\$17.96 per hour	\$19.76
Personal Support Services - Level II	\$20.20 per hour	\$22.22
Respite Care Services - Level 1	\$2.20 per 15- minute unit	\$2.42
\$2.42 Respite Care Services - Level 2	\$2.60 per 15- minute unit	\$2.86
Respite Care Services -	\$3.00 per 15- minute unit	\$3.30

Independent Care Waiver Services

Level 3	\$3.30	
Respite Service – Level 1 per diem	\$70.55 per day	\$77.61
Respite Service – Level 2 per diem	\$83.00 per day	\$91.30
Respite Service – Level 3 per diem	\$95.45 per day	\$105.00
Skilled Nursing RN – Per diem	\$49.79 per day	\$54.77
Specialized Medical Equipment and Supplies	\$1026.00 max per month	\$1,128.60
Vehicle Adaptation	\$225.00 per year	\$247.50

NOTE-

The table above reflects the temporary increase payment rates using Medicaid matching funds available through the American Rescue Plan. The increase in reimbursement rates was approved by the Georgia General Assembly during the 2021 Legislative Session with the Appendix K receiving CMS approval on 12/10/2021.

The changes outlined in the table represents a rate increase of 10% applied to all services. Within six months after the conclusion of the state of emergency, Georgia will submit a Waiver Amendment application for Independent Care Waiver Program to permanently establish the increased rates.

APPENDIX P

CONSUMER DIRECTED CARE

The Georgia Department of Community Health, Independent Care Waiver Program, Home and Community Based Medicaid Waiver program has implemented Consumer Directed Care (CDC) into the 1915 C waiver. The goal of this program is to offer Independent Care Wavier Program (ICWP) members the opportunity to direct their personal support services.

The member and/or representative may direct their personal support services through Consumer Directed Care. The member must be able and willing to be the employer to be considered for CDC. If the member is not able or willing to be the employer, (i.e., TBI) a member's representative may act on the member's behalf. Members must be trained in the roles and responsibilities of the employer and must have the capacity to perform the CDC employer function, e.g. Make hiring decisions; set schedules; and track and report hours of work time and perform other employer related functions.

The Case Manager is responsible for training all prospective EMPLOYERS (member/representative). Once trained, the EMPLOYER agrees to perform all Employer related responsibilities including, but not limited to, hiring, training, and supervising personal care attendants. The policies listed below will assist CDC employers to understand the CDC program requirements. .

Eligibility Requirements for Consumer Directed Care

To be eligible for Consumer Directed Care, an individual must meet all the requirements below and any additional eligibility requirements located in-Chapter 700 of the ICWP Manual Part II:

1. Meet all ICWP eligibility criteria
2. Be motivated and possess the skills to self-direct care
3. Be willing to assume responsibility for cost effective use of Personal Support Services.
4. Does not have a history of behavior that places self or others at risk
5. Must fulfill the training requirements of Consumer Directed Care by successful review and demonstration of understanding of the training content.
6. Is able to maintain maximum control over daily schedule and decisions.
7. Must be able to manage and stay within the established budget to remain eligible for Consumer Directed Care.
8. Is able to make an informed choice to accept Medicaid Waiver services in a Plan of Care.
9. Must be willing to sign the Consumer Directed Care Memorandum of Understanding (MOU).

Program Limitations

Consumer Directed Care is an alternative to Traditional PSS. Being an EMPLOYER is an important responsibility and should not be taken lightly.

The Medicaid Waiver program has the following limitations under the consumer/representative directed option:

1. The member or their representative will not be paid by Medicaid to direct and manage services.
2. A waiver participant's legal guardian (appointed by a probate court) may not be paid to provide services under the Consumer Directed Care Option.
3. A member's representative may not serve as a paid care giver employee.
4. The ICWP only provides services and care for the individual who have been found eligible for the Consumer Directed Care. Therefore, services are restricted to the benefit of the member.
5. Persons with a history of abuse, neglect, or exploitation may not be paid to provide any services under the Medicaid Waiver Program.
6. A participant's spouse or Domestic Partner may not be paid to provide services under the Consumer Directed Care.
7. Paid caregivers thru CDC may only be reimbursed for forty (40) hours a week.
8. Employees are not paid to provide services while the member is admitted to a hospital or nursing facility.
9. Members may remain eligible for the ICWP up to 60 days while in the hospital. However, if any member has not received personal support service for 60 days they will be discharged from Consumer Directed Services.
10. A member's representative employer may only manage one ICWP Consumer.
11. Consumer Directed Care PSS cannot be duplicative of any other services.
12. An Employer may not pay an employee for vacation time or any other services not rendered according to ICWP policies.
13. An Employer may not exceed 12 hours of personal support services in a day per one employee. The work schedule must provide for relief of the employee and adequate rest and recuperation between scheduled work hours. Fatigue is an unacceptable risk to the member and work safety.

Note: Georgia Medicaid will not reimburse for personal care services when provided to recipients by legally responsible relatives, i.e., spouses, parents of minor children, legal guardians, or anyone with any power or attorney, when the services are those that these persons are already legally obligated to provide, or the family normally would provide.

Services provided by relatives or friends, may be covered only if the member is geographically isolated and no one else is available to provide care, for example, in rural areas where the member may not have routine access to employees. All efforts must be made to identify staff to provide personal support services prior to utilizing family. If family or friends are approved to provide care:

* The relatives or friends meet the qualifications and training standards for providers of care;

- * All training and qualifications of an employee must be met prior to rendering services to the member;
- * Payment is made to the relative or friend as providers only in return for specific services rendered.

Employer Eligibility Requirements

Employer Responsibilities

Prior to enrolling in Consumer Directed Care the EMPLOYER must understand and follow the program requirements. The Employer must also agree to perform the following ongoing tasks:

- 1) Sign the Consumer Directed Care Option Memorandum of Understanding
- 2) Notify the case manager of the chosen Fiscal Intermediary (FI) and complete the Fiscal Intermediary Communication form (P2)
- 3) Coordinate services to transition into CDC. When it is determined that the member is approved to transition into CDC, a thirty (30) days written notice must be given to the personal support provider. The member may not move into CDC until the first (1st) of the month.
- 4) Submit required documents to AHS thirty days prior to the month when CDC services will start.
- 5) Must submit all required documents to the chosen FI by the 15th of the month prior to when services will begin. The documents will include employees social security numbers, CPR Card, First Aid training and all other documents requested by the FI. The chosen FI will communicate to the Employer and case manager the potential start date for CDC services to begin.
- 6) Must agree to stay with chosen FI for one year. If an Employer wants to change FI after one year he/she must give the FI a 30 day notice prior to the anniversary date of change request
- 7) Recruit and select employee(s) as outlined under “Program Limitation” section.
- 8) Arrange for substitute or back-up employees as needed.
- 9) Ensure that employees meets the following eligibility requirements:
 - a) CPR
 - b) First Aid
 - c) Basic skills necessary to provide member’s care
 - d) Confidentiality regarding the services of the member’s care
 - e) Environmental and Fire safety
 - f) Document all training sessions and maintenance of the employee file
 - g) Have a 1-9 on the employee completed and maintain on file
 - h) Complete an initial physical that includes TB screening (documentation of TB screening in the past 3 months will be accepted) and symptoms screening yearly per CDC guidelines, verified by the employer.

(all required documents must be on file before a staff person can be paid under ICWP)

- 10) Notify selected employee(s) of their responsibilities
- 11) Assure that employment forms are completed and submitted to the Fiscal Intermediary
- 12) Develop a work schedule based on the approved Care Path
- 13) Train employee(s) to perform specific tasks as needed
- 14) Maintain updated copies of approved waiver Care Path
- 15) Develop and maintain a list of tasks for the employee(s) to perform
- 16) Must document tasks employees perform daily and keep a record of this in a
- 17) Approve employee time worked in the FI EVV system.
- 18) Complete an evaluation on employee(s) at least every thirty 30 days to assure that tasks are performed correctly and completely
- 19) Evaluate employee(s) performance in written document
- 20) Provide ongoing performance feedback to employee(s) verbal/writing
- 21) Terminate employee(s) employment when necessary and complete termination and give to the employee
- 22) Notify the FI provider of any necessary changes
- 23) Participate in the assessment and reassessment of ICWP eligibility
- 24) Communicate with the ICWP case manager on a regular basis
- 25) Track use of personal support hours, so as not to exceed the approved dollars and hours per plan year. Member is required to meet with their case manager at least monthly to review their budget reports
- 26) Must remain within a budget not to exceed 10% of their approved Plan of Care for one month, without a medical reason or approval from the contracting agency. If the member exceeds 10% above their budget for one month the member will be at risk of returning to the traditional option of the Independent Care Waiver Program. If a member exceed 10% of their budget for two consecutive months the case manager, Alliant Health Solutions and DCH will assist the member with returning to the traditional option.
- 27) A member may not approve for one employee to work 24 hours a day. (Medicaid will not reimburse over 40 hours per week or more than 12 hours per day to one employee.
- 28) Avoid conflict of interest with employees, participant and/or other participating agencies.

NOTE: EMPLOYERS must obtain workman compensation insurance for the employees. The Fiscal Agent will assist the Employer (Member) with this task.

Representative employers must be available to perform the above employer responsibilities on an ongoing basis. The Employer must maintain a file of all the required documents of the employees. If requested, these documents must be made available to the Department of Community Health; Independent Care Waiver Program.

Once an applicant has met the general eligibility criteria and approved to be in ICWP by Alliant Health Solutions (AHS) An ICWP CDC Certified Case manager will assess their needs and provide consumer directed care training to the Employer. The following outlines the steps involved with certifying and enrolling EMPLOYERS, and their EMPLOYEES.

Employer Training

During the training process, the case manager completes a “CDC Skills Check List” which documents that the Employer (Member) has been trained and has demonstrated the ability to direct and manage care. By signing the Memorandum of Understanding (MOU) and Plan of Care, the EMPLOYER agrees to perform the required duties. The Member and or Representative must assume the responsibility of an EMPLOYER. The case manager will monitor the EMPLOYER’s ability to manage their personal support service as well as the member’s condition during monthly contact, annual reassessments and as needed. All documents must be forwarded to AHS and the FI prior to member’s participation in this option.

If the case manager and AHS determine that the Employer is out of compliance with the CDC policies the Member will be returned to traditional care services. However, if a member is not in compliance with ICWP policies, he or she may be discharged from the ICWP program.

All CDC Employers must be trained by an ICWP case manager. The case manager will certify that the Employer is as able and willing to direct CDC personal support services.

Once trained, all ICWP members and representatives must choose and enroll with a FI.

1. The member must contact an FI to obtain the necessary forms to become enrolled in the Consumer Directed Option.
2. The following forms must be completed by the EMPLOYER and submitted to the FI in order to enroll in the Consumer Directed Option.

Enrolling Employers

- Form 2678 Employer Appointment of Agent Form (IRS # 2678)
- Consumer/Representative Directed Employer Agreement Form
- Authorization Form
- Durable Power of Attorney Form (if applicable)
- Consumer Information Form
- Consumer Directed Care Memorandum of Understanding
- Employer Agreement
- FI Communication Form

After the case manager has provided training to the EMPLOYER, the Employer must demonstrate the ability to maintain CDC documentation requirements and manage their PSS staffing needs and schedules.

Enrolling Employees

Employees Eligibility

All EMPLOYEES must be legally eligible for employment under state and federal laws. In addition, for the Medicaid Waiver program, eligible EMPLOYEES must:

- Be 18 years or over
- Must possess basic reading, writing and math skills
- Must be a U.S. Citizen or legally authorized to work in the United states
- Must have completed and passed the CPR and Basic First Aid training. The employee is responsible for keeping their CPR and Basic First Aid training current
- Must have a valid social security number
- The FI must complete a criminal background check, prior to employment, to ensure the employee has no history of a felony conviction
- Understands and agree to comply with the Consumer Directed Option requirements as outlined in the ICWP manual, located at www.AlliantHealth.georgia.gov
- Must have basic skills necessary to provide the member's care
- Must not discuss the member's personal health or care with any other person
- Must receive training in environmental and fire safety.

In the case of self-directed care, the following criteria must be met:

- The Employee must meet the qualifications and training standards specified for personal support services;
- The Employee must meet the training qualifications prior to rendering services to an ICWP member;
- An agreement must be in place between the member and employee before services are rendered;
- The Employer must not pay the caregiver at a rate that exceeds that which would otherwise be paid to a provider of a similar service (Refer to Appendix O for rates and units)
- An Employee providing care may not provide more than 40 hours of paid personal support services in a seven day period.
- The Employee must use the FI EVV system to sign in and sign out. Both Employee and Employer must approve the time captured by the EVV system.

Once the EMPLOYER locates a personal support attendant (EMPLOYEE), the EMPLOYEE must complete the following forms and return to the FI. This applies to all employees who have not been employed by the consumer in the current calendar year:

- Form W-4 Employee's Withholding Allowance Certificate

- Form I-9 Employment Eligibility Verification Form
- Record Check Release Form
- Consent for Release of Information Adult Protective Services
- Background Check Release Form
- Optional: Direct Deposit Form
- Employee information form

***Important:** Claims cannot be processed, nor can payments to workers be made, until all of these forms (not including optional forms) have been received and processed by the FI*

Employee Restrictions

The following restrictions apply to all EMPLOYEES:

- Persons with a history of abuse, neglect, or exploitation may not be paid to provide any services under the Medicaid Waiver Program.
- The spouse or domestic partner of the consumer may not be paid to provide any services through Medicaid Waiver funds for care of the consumer.

An employee with the following history may not be employed by a member in the ICWP:

Murder or Felony Murder;

Attempted Murder;

Kidnapping; Rape;

Armed Robbery;

Robbery;

Cruelty to Children;

Sexual Offenses;

Aggravated Assault;

Aggravated Battery; Arson;

Theft by taking (O.C.G.A. 16-8-2), by deception (O.C.G.A. 16-8-3) or by conversion (O.C.G.A. 16-8-4); and

Forgery (in the first or second degree).

Also, DCH prohibits **an employer** from hiring into direct care any employees who have been convicted of child, client, or patient abuse, neglect or mistreatment, regardless of the date.

- A waiver member's legal guardian (appointed by a probate court) may not be paid to provide services under the Medicaid Waiver Program.
- A member's Representative EMPLOYER may not be a paid EMPLOYEE for any services under the Medicaid Waiver Program.

Personal support Service Description

Consumer Directed Personal Support Services includes help with the following:

- Dressing
- Bathing
- Grooming (brushing teeth, shaving, hair and skin care)
- Bed mobility (turning and repositioning)
- Toileting
- Personal hygiene or incontinence care
- Assistance with and care of adaptive equipment
- Transferring(getting to and from chair into bed; bed to wheelchair, etc.).
- Mobility assistance
- Help using the telephone
- Preparing meals and feeding assistance
- General housekeeping (mopping floors and taking out garbage, changing the bed, dusting, vacuuming and doing laundry
- Shopping
- Travel assistance necessary for the person's health and welfare

Payroll Policies and Procedures

Financial Support Services

All Consumer Directed Care employers must select a Fiscal Intermediary to manage their financial personal support funds. There are no exceptions to the policy.

The Financial Intermediary (FI) Services are provided to assure that consumer directed funds outlined in the individual plan of care are managed and distributed as intended. See Addendum P1 for further FI responsibilities.

The annual budget for a member's personal support dollars and hours must be in accordance with the ICWP policy. All services provided under ICWP must have prior approval.

Payroll services are provided by the Medicaid Waiver program, through an enrolled Medicaid provider. The FI will process time worked, paychecks, taxes and maintain individual employment tax records for employees and complete criminal background checks. The FI will conduct up to five background checks for no additional charged to the consumer. Any background checks beyond five, the Employer (member) will be personally required to pay the cost.

The Fiscal Intermediary will provide employers and employees with:

- all of the necessary employment forms
- approved background checks (employee only) up to 5
- an electronic visit verification system
- The FI will provide instructions, training, and technical assistance on using their EVV system
- annual W-2 tax statements to employees
- instructions and technical assistance in completing forms
- The FI will provide an orientation packet to each member that chooses to self-direct
- The FI will provide each member with a budget report monthly

The FI will assure that the account statement will be available on the web to be reviewed by the Employer and Case manager. The FI will be responsible for maintaining ~~the above~~ account records. If the employer changes to a different FI, it is the responsibility of the current FI to forward a copy of the ~~entire~~ member's account record to the new FI.

The FI will collect and track the First Aid and CPR certifications of employees. The FI will provide a monthly report to the case manager regarding upcoming expirations of First Aid and CPR. The case manager will communicate with the employer regarding the need to have the employee's certifications updated timely.

Submitting Time

- Employees must sign in and out using the FI EVV system.
- Both the Employer and the Employee must use the FI EVV system to approve the time worked.

All employees must complete the employment enrollment process prior to receiving a paycheck. **There are no exceptions to this policy.**

Termination of Employment

The Employer is responsible for termination of employees. The employer must notify the case manager of all changes in the employment status of EMPLOYEES. The EMPLOYER must notify the FI of any changes in employment by using the FI Communication Form.

Approved Plan of Care

The total number of dollars and hours for all employees combined must not exceed the authorized number of hours for any service as shown on the individual's approved Plan of Care per year.

Changes in Hours

The EMPLOYER (member) should contact the case manager directly to review the need for changes in approved services. A written change of care must be submitted by the case manager and approved by AHS before any increased service hours will be paid.

Reasons an Employee may not get paid

1. Failure to sign in and out using the FI EVV system.
2. Lack of or incomplete Employer enrollment forms.
3. Lack of or incomplete Employee enrollment forms.

EMPLOYERS and EMPLOYEES should first attempt to resolve payroll problems by directly contacting the FI. If problems persist, the EMPLOYER or EMPLOYEE may contact the case manager for assistance.

Pay Schedule/Rate

FI will generate paychecks twice monthly according to the pay schedule provided by the FI. -

EMPLOYEES who are paid through Consumer Directed Care will be paid an hourly rate as set by the employer. The total amount billed to Medicaid may not exceed the hourly rate in Appendix O, part II, Policies and Procedures for Independent Care Waiver Services, manual. The total annual cost of employment related expenses may not exceed the approved dollar amount approved in the member's Plan of Care.

Workman Compensation Insurance

All Employers must provide Workman Compensation insurance. The FI will process the deduction from the member's budget.

Unemployment Benefits

Every employee is eligible for unemployment benefits. If the employer has questions about unemployment compensation coverage, or about submitting a claim, contact the FI.

Health Insurance

Employees may purchase health insurance at their own expense. The employer is not responsible for this expense. The employee may contact the FI for further information on obtaining the optional health insurance.

Taxes

Payments made to every EMPLOYEE are treated as earned income, and are taxed as earned income. The FI provider processes payroll taxes, withholds taxes from wages and prepares annual W-2 tax withholding statements.

Budgetary Reports

The FI will provide account statements online and mailed monthly (if requested).

Medicaid Fraud

Medicaid fraud is committed when an EMPLOYER (member) or EMPLOYEE is untruthful regarding services provided to Medicaid participants in order to obtain improper payment. The Medicaid Fraud and Abuse Unit of Georgia investigates and prosecutes individuals who commit fraud against the Medicaid program. Medicaid fraud is a felony and conviction may lead to substantial penalties (including but are not limited to, imprisonment up to ten years, or a fine up to \$1,000 or an amount equal up to twice the amount of the assistance or benefits wrongfully obtained, or both). Additionally, individuals convicted of Medicaid fraud will be prohibited from any employment with a program or facility receiving Medicaid funding for a minimum of five years.

Examples of Medicaid fraud include but are not limited to:

- Billing for services not actually provided (e.g. signing or approving time for services which were not actually provided)
- Billing for services provided by a different person (e.g. signing or approving time for services provided by a different person)
- Billing twice for the same service (e.g. signing or approving time for services which were reimbursed by another source or submitting duplicate time for reimbursement from the same source)

Suspected cases of fraud will be referred to the State of Georgia Attorney General's Medicaid Fraud Control Unit and may be referred to local police authorities for further investigation and possible prosecution.

Case Management Services

The case manager is responsible for training EMPLOYERS and monitoring services and the health and welfare of individuals participating on the Medicaid Waiver program. Case Management services are provided to all Medicaid Waiver participants.

To provide case management services under the Consumer Directed Care Option, the case manager must pass the Consumer Directed Care Option test given by DCH through its contractor AHS. A case manager must pass with a score of 85 or better. All case managers will be given two opportunities to become An ICWP Certified Case Manager.

If an ICWP Case Manager is not certified and serves a member that wants to direct his or her PSS hours, the ICWP Case Manager must provide the member with a list of ICWP Certified Case Managers that can serve the member.

Case Manager Responsibilities:

The case manager must contact the member on a regular basis including a face-to-face visit monthly).

Case managers are responsible for:

- Providing training to each ICWP member or member's representative that is capable and willing to participate in the Consumer Directed Care option
- Monitoring the services reported in the FI EVV system, monitoring the notes from employees in the FI EVV system, and monitoring budget reports at least monthly
- Must inform the member when his or her budget exceeds 10% of the monthly budget amount set by the member and the case manager
- Will train the member on documentation requirements
- The case manager and the EMPLOYER must sign the Memorandum of Understanding
- Must review the number of paid hours the member approves for the employee each month
- Notifying AHS if the member is no longer able to demonstrate that he or she can manage the Consumer Directed option
- Answering questions about the Medicaid Waiver Program
- Assisting individuals in gaining access to needed services
- Notifying AHS if a change is identified in the consumer's health status.
- Assisting the consumer in developing a Plan of Care
- Timely submitting the DMA 80 and the DMA 6 to AHS for approval (all members starting services in the CDC option must submit required documents into AHS by the 1st of the month prior to a member services to begin)
- Monitoring the services included in an individual's plan of care
- Assessing the adequacy of care being provided
- Evaluating the ability of a consumer or representative to manage services as an employer under the Medicaid Waiver program
- Reporting suspected cases of abuse, neglect, exploitation to Adult Protective Services
- Reporting suspected cases of Medicaid Fraud to the ICWP Program Specialist
- Monthly audits of training file
- Must convey to the Member and or Member's Representative information concerning the enrolled FI. This will give the Member the opportunity to select a FI from the list of enrolled Medicaid Fiscal Intermediaries.

2. Case Manager Limitations

Case Managers are not responsible for:

- completing or processing payroll forms,
- payroll documentation and submission

- hiring, firing and training employees

An individual's case manager can provide some *advisory* assistance with these activities, but the EMPLOYER is ultimately responsible for all employment issues concerning the EMPLOYEES.

Abuse, Neglect, and Exploitation

The State of Georgia requires, by law that all health professionals report cases of suspected adult abuse, neglect, and exploitation. Those who are "mandated" to report such cases include, but are not limited to:

- Medicaid Waiver Case Managers,
- Personal Care Attendants,
- Home Health Agency Employees,
- Adult Day Employees,
- Hospital Employees,
- Social Workers,
- Physicians, and
- Enrolled Medicaid Providers

Other concerned individuals may also report suspected adult abuse, neglect, or exploitation. In most cases, the identity of the individual making the report shall remain confidential. Reports are made by contacting the Fraud and Abuse Unit at 1-800-533-0686 (toll free).

Appeal Rights

Appeal rights are available upon the denial of an applicant seeking entry into the Consumer Directed Care Option. If a member or member's representative is found to be ineligible to act as the EMPLOYER, and is not certified by the case manager, the application will be denied. This decision may be appealed. Alliant Health Solutions (AHS) will send the member a written notice explaining the basis of the denial/adverse action. This notice will also include information regarding the member's appeal rights.

APPENDIX P1

ADDENDUM	PROVIDER ENROLLMENT APPLICATION
Service Title	Financial Support Services/Fiscal Intermediary (FI)
Service Definition	Financial Support Services are provided to assure that consumer-directed funds outlined in the individual plan of care are managed and distributed as intended. The Financial Support Services Provider (FI) will file claims through the MMIS for consumer-directed goods and services. Additionally, the FI will deduct all required federal, state and local taxes. The FI will also calculate and pay as appropriate, applicable unemployment insurance taxes and worker compensation on earned income. The FI will be responsible for maintaining separate accounts on each Member's consumer-directed service funds and producing expenditure reports as required by the State Medicaid agency. The FI will conduct criminal background checks and age verification on service support workers.
Provider Requirements	• Must understand the laws and rules that regulate the expenditure of public resources. • Utilize accounting systems that operate effectively on a large scale as well as track individual budgets. • Adhere to the timelines for payment that meet the individual's needs within DOL standards. • Develop, implement and maintain an effective payroll system that adheres all related tax obligations, both payment and reporting. • Conduct and pay for criminal background checks (national) and age verification on service support workers up to a maximum of five (5) background checks per calendar year per member. Additional background checks will be performed at the expense of the member. • Collect and track First Aid and CPR documentation on service support workers. Report to case management on a monthly basis those employees whose First Aid and CPR documentation is set to expire in the coming month. • Generate service management, and statistical information and reports during each payroll cycle. • Provide startup training and technical assistance to members, their representatives, and others as required. • Process and maintain all unemployment records. • Provider must use the DCH Electronic Visit Verification (EVV) system or ensure that their EVV system is compatible for use

	for the purposes of member scheduling, employee signing in and out and claims submission. • Have at least two years of basic accounting and payroll experience. • Must have a surety bond issued by a company authorized to do business in the State of Georgia in an amount equal to or greater than the monetary value of the members business accounts managed but not less than \$250,000. • Must not be enrolled to provide any other Medicaid services in the State of Georgia.
State License	Georgia Business License
Certification	Must be approved by the IRS (under IRS Revenue Procedure 70-6) and meet requirements and functions as established by the IRS Code, Section 3504.
Other Requirements or Standards	• Must be able to act in a fiduciary capacity, file claims accurately on behalf of the member, process payroll and other reimbursement services in a timely manner. • Must have successfully completed a Readiness Review by the Department of Community Health (DCH), demonstrating ability to perform all required functions and services, prior to enrollment. • Provide at a minimum an electronic visit verification system for time submission.
Describe Service Delivery Method	Consumer-Directed
Service Requirements:	In general, the Financial Support Services (FSS) provider will: • Act as a “fiscal employer agent” receiving and disbursing public funds in accordance with the members’ direction, approved budgets, and applicable rules, regulations, and policies. • Monitor a member’s spending of public funds for any underage and overage in accordance with the member’s approved budget, review the same with the member, and report to the DCH. • Facilitate and process the payment for health insurance and workman compensation benefits for the service provider. • Electronically collect service worker’s time worked. • The FI EVV system must submit time worked to the DCH EVV system which will submit claims to MMIS. • Pay invoices for goods and services authorized in the member’s budget.

	• Manage payroll for support service workers hired by the member/representative including federal, state and local employment taxes. • Process and pay invoices for goods and services included in individual budgets on the 15th and last day of each month. • Provide skills training to members and/or member's representatives related to employer-related tasks (e.g., recruiting, hiring, training, managing and discharging support service workers and managing payroll and paying bills). • Provide member utilization reports after each payroll cycle. • Provide web access to review member's expenditure activity.
Service Rate	• Per enrolled member will be \$75.00 per month billed on the CMS-1500. • This rate will be reviewed annually for adjustments as needed.

APPENDIX P2

Fiscal Intermediary (FI) Communication Form
Consumer Directed Care (PSS)

Name of FI _____

ICWP Member Name _____

ICWP Member Address _____

Member's telephone number _____

ICWP Case Manager Name _____

Case manager's telephone number _____

TRANSACTION TYPE

↑ I authorize your agency to provide FI service to me.

I _____ authorized _____ to be my Fiscal Intermediary for the ICWP Consumer Directed Option, Personal Support Service. I understand that I must remain with the chosen FI for one year. I also understand that if I decide to change to another FI at the end of one year, I must give the FI a 30 day notice at the end of this agreement.

Consumer's signature _____ Date __/__/____

Hospital Stay

I understand that I or my representative is to notify my case manager and the FI when I am admitted to the hospital. I also agree that I will not authorize work time to the FI for any employee while hospitalized.

☐ I was in the hospital from _____ to _____.

☐ My employees are as follows:

Name _____

Address_____ss#_____

Name_____

Address_____ss#_____

Name_____

Address_____ss#_____

Name_____

Address_____ss#_____

↑ Other:_____

Terminating an FI

↑ I am terminating services from your agency effective_____

Member must stay with chosen FI for one year. A 30-day notice must be provided to the FI before changing to another FI.

ICWP Member/Date

ICWP Case Manager/Date

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 three 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 three licensed CMOs:

 Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	 Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	 CareSource 1-855-202-1058 www.caresource.com
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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 three CMOs are State-wide.**

The Department of Community Health has contracted with three CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

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 (DHACS)
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
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

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 GAINWELL TECHNOLOGIES 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. GAINWELL TECHNOLOGIES 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 GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES 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.

GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES 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 GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES 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
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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 <u>clean</u> claims that have been adjudicated. <u>Pharmacy:</u> 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.
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How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan
Anytime	Members can change their PCP one (1) time 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	Within the first 90 days of a member's 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.

	seeks due to moral or religious objections • PCP moves, retires, etc.	
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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
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24 th day of the month and are effective for the current month. PCP changes made after the 24 th day of the month are effective for the first of the following 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
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com

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 #	GROUP #	Helpdesk
Amerigroup Community Care	IngenioRx	020107	HL	WKJA	1-833-235-2031

CareSource	Express Scripts (ESI)	003858	MA	RXINN01	1-800-416-3630
Peach State Health Plan	CVS	004336	MCAIDADV	RX5439	1-844-297-0513

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL TECHNOLOGIES by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. GAINWELL TECHNOLOGIES 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
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes

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
1 (800) 454-3730	1 (855) 202-1058 1 (866) 930-0019 (fax)	1 (866) 399-0929

APPENDIX R



Information for Providers Serving Medicaid Members

in the Georgia Families 360SM Program

Georgia Families 360SM, the state's new managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

DCH, Amerigroup, and partner agencies -- the Department of Human Services (DHS) and DHS' Division of Family and Children Services (DFCS), the Department of Juvenile Justice (DJJ) and the Department of Behavioral Health and Developmental Disabilities (DBHDD), as well as the Children's and Families Task Force continue their collaborative efforts to successfully rollout this new program.

Amerigroup is responsible through its provider network for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360SM members will also have a medical and dental home to promote consistency and continuity of care. Providers, foster parents, adoptive parents and other caregivers will be involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements.

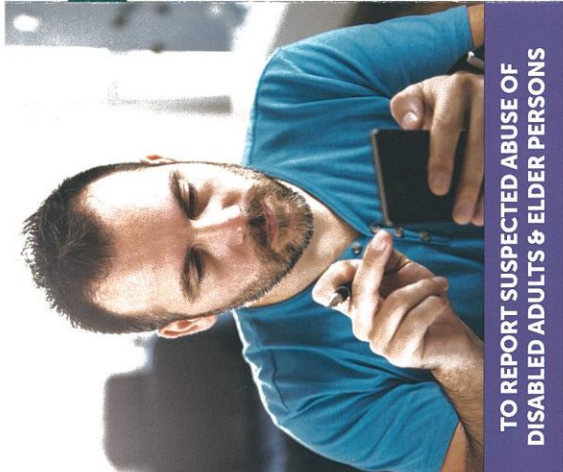
Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management will focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov

APPENDIX S

Adult Protective Services Brochure on Recognizing and Reporting Abuse, Neglect, and Exploitation



TO REPORT SUSPECTED ABUSE OF DISABLED ADULTS & ELDER PERSONS

In a community setting
Call the Adult Protective Services Central Intake line at 866-552-4464 and choose Option 3.

In a long-term care facility or residence
Call Healthcare Facility Regulation at 404-657-5728 or toll-free at 800-878-6442.

In any setting
For immediate, serious risk, call 911.
For nonemergencies, report suspected abuse to your local law enforcement agency.

For residents of a facility who need an advocate
Call the Long-Term Care Ombudsman at 866-552-4464. Choose Option 5.

OTHER HELPFUL SERVICES
Free of charge regardless of income

GeorgiaCares
866-552-4464, Option 4 | mygeorgiacares.org
Provides free health insurance counseling about Medicare, Medicaid, Prescription Assistance Program, and planning for long-term care needs. Also reports suspected fraud in Medicare and Medicaid.

Senior Legal Hotline
404-657-9915
Outside Metro Atlanta: 888-257-9519
georgialegalaid.org/organization/georgia-senior-legal-hotline
Provides legal assistance over the telephone for Georgians 60 and older.

Elderly Legal Assistance Program
866-552-4464, Option 7
aging.georgia.gov/elderly-legal-assistance-program
Provides legal assistance for civil matters for people 60 and older.

Georgia Department of Behavioral Health and Developmental Disabilities
800-715-4225 | mygal.com
Provides 24/7 mental health, substance abuse and emergency services. For nonemergency mental health and addictive diseases services and nonemergency developmental disability services, call 888-785-6954.

Georgia Department of Law's Consumer Protection Unit
404-651-8600
Outside Metro Atlanta 800-869-1123
ocp.ga.gov
Enforces the Fair Business Practices Act and other consumer protection laws. The unit works to prosecute crimes related to telemarketing, home-construction and home-repair fraud, identity theft, and internet fraud.



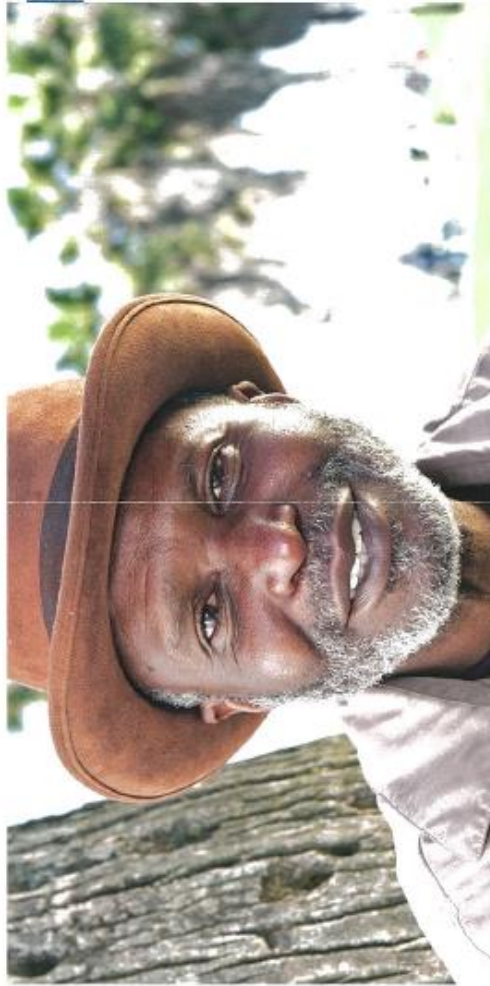
Georgia Department of Human Services
Division of Aging Services

ADULT PROTECTIVE SERVICES



Learn how to recognize the signs of abuse, neglect and exploitation of Georgia's vulnerable adults, and how to report it

aging.ga.gov



FORMS OF ABUSE

Physical abuse

Physical abuse is using physical force to coerce or to inflict bodily harm. It often, but not always, causes physical discomfort, pain or injury. It may include the willful deprivation of essential needs, such as medical care, food or water.

Sexual abuse

Sexual abuse refers to any kind of sexual behavior directed toward an at-risk adult without the person's full knowledge and consent. A spouse, partner, family member or other trusted person can perpetrate sexual abuse.

Emotional abuse

Emotional abuse includes using tactics such as harassment, insults, intimidation, isolation or threats that cause mental or emotional anguish. It diminishes the person's sense of identity, dignity and self-worth.

Visit aging.ga.gov for more information or to report suspected abuse, neglect or exploitation.

Financial abuse or exploitation

Financial abuse or exploitation is described as improperly or illegally using a person's resources for the benefit of another person. Examples include using power of attorney to gain access to an adult's assets for personal gain, or using undue influence, false representation and other means to gain access to an adult's government checks.

Neglect

Neglect occurs when a caregiver refuses or fails to provide essential needs (food, water, shelter, medical care, etc.) to the degree that it harms or threatens to harm an older and/or disabled adult.

Self-neglect

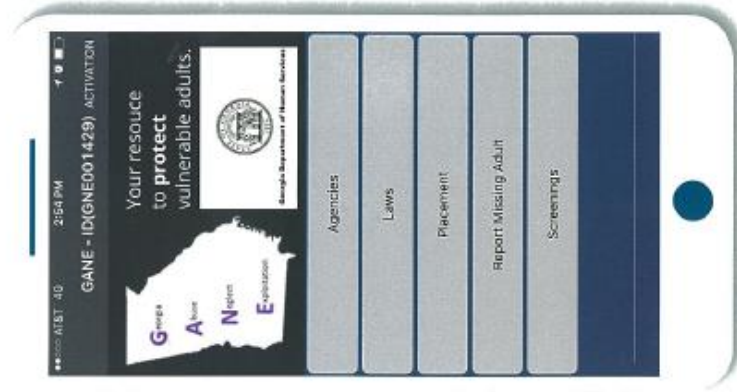
Self-neglect is defined as failing to perform essential self-care such as depriving oneself of necessities such as food, water, or medication. Consciously putting oneself in harm's way or being unable to handle needs of day-to-day living because of medical, mental health or other disabilities is self-neglect, but it is not a crime.

DOWNLOAD THE GANE APP

Download the free Georgia Abuse, Neglect and Exploitation (GANE) app for additional information and resources related to vulnerable adult abuse.

Access resources, find placement options, use easy screening tools and report abuse straight from your phone.

The app is available on all platforms. Simply go to your app store and search "eyeon GANE."



APPENDIX U

ADDENDUM/ CHANGE REQUEST

Member's name: _____ DOB: _____

Which service change is the member requesting?

☐ RESPITE ☐ SUPPLIES ☐ PSS HOURS ☐ OTHER: _____

JUSTIFICATION FOR THE CHANGE REQUEST:

Respite: Is *only* approved for Member's informal caregiver relief. It is provided in the member's home. Please provide detail on who is in need of respite and why. Please provide dates and hours being requested:

Supplies: Write a statement explaining any significant changes in the client's health, physical capabilities, finances that justifies a change in supplies:

PSS hours: What has ***changed*** in member's health, physical capability, mental capability, or support system? Be very specific as to what occurred, and how the change affected the client and current status. Explain in detail how many additional personal support hours are needed and what services are needed to compensate for this change in condition/status.

Other comments:

Case manager signature: _____ Date: _____

Independent Care Waiver Services

WAIVER TRANSFER FORM

Appendix V

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

2. Member Name: _____ DOB: _____

Social Security Number: _____ Medicaid #: _____

3. Other Contact Information: _____

4. Transfer Type:

ICWP to ICWP ☐

ICWP to SOURCE ☐

ICWP to CCSP ☐

5. **Member transfer from:** Agency Name _____

Provider ID _____

County _____ Care Coordination/Contact Person _____

Email _____ Telephone _____

Last Service Date _____

Member current waiver type (circle one) CCSP SOURCE ICWP

Member street address _____

City _____ County _____ State _____

Zip Code _____ Member Phone Number _____

6. **Member transfer to:** Agency Name _____

Provider ID _____

Care Coordination/Contact Person _____

Email _____ Telephone _____

New waiver type (circle one) CCSP SOURCE ICWP

Member new street address _____

City _____ County _____ State _____

Zip Code _____ Member Phone Number _____

WAIVER TRANSFER FORM

Instructions

Independent Care Waiver Program

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

Who Completes/When Completed: The ICWP case manager completes the member transfer form for a member that is being discharged from her agency to another waiver such as Source or CCSP. It accompanies the original case record of the last year of service to the receiving agency. Original agency is also responsible for notifying Alliant by attaching this form and supporting documentation of reason for transfer and client agreement of such. This is attached to the "Contact Us".

Instructions:

1. Enter the Member's Prior Authorization number and expiration date.
2. Enter the Member's name (last name, first, and middle initial), DOB, SS# and Mdcd ID #
3. Enter other contact information
4. Enter the type of transfer.
5. Enter Member transfer from information (Agency, provider ID, Email contact, telephone, last service date, current waiver type, member street address and phone information)
6. Enter Member transfer to information (Agency, provider ID, Email contact, telephone, new waiver type, member address and phone number information)

Distribution: The original form accompanies the original client case record to the receiving agency. A copy is filed in the duplicate case record maintained at the transferring agency.

Appendix W- Intentionally left blank
Previous Appendix W Removed effective 4/1/2023

Appendix X

Reportable Incident Types: Definitions

	Definition
Injury Severity Ratings:	1 - No injury (no treatment required) 2 - Injury requiring first aid (small adhesive bandages, cleaning of abrasion, application of ice packs, over the counter medications as physician ordered) 3. Injury requiring treatment beyond first aid (medical treatment required by a licensed practitioner - MD, NP, PA, etc. that is not serious enough to warrant hospitalization, such as sutures, broken bones, prescriptions etc.) 4. Injury requiring hospitalization (medical intervention and treatment at a hospital, including stays for observation only) 5. Death 6. Refused treatment
Death - Expected	Cause of death is attributed to a terminal diagnosis or diagnosed disease process identified more than 30 days before the date of death, where the reasonable expectation of outcome is death, there is no indication that the individual was not receiving appropriate care.
Death - Unexpected	Death due to any cause where the cause of death is not attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation or outcome is death, does not meet the definition of an expected death. Examples include but not limited to death from suicide, homicide, medication errors, undiagnosed condition, criminal activity, an accident, or possible abuse or neglect.
Suicide Attempt resulting in injury	Self-inflicted harm due to failed suicide attempt. Injury severity scale 2, 3, and 4.
Alleged Abuse - Physical	The willful use of physical force to coerce or to inflict bodily harm, pain or mental anguish. Indicators of physical abuse may include, but are not limited to, rough handling, improper use of restraints, injuries not consistent with medical diagnosis or explanation, or unreasonable confinement.

Alleged Abuse - Sexual	Any kind of sexual behavior directed towards an individual without their full knowledge and consent. A spouse, partner, family member or other trusted person can perpetrate sexual abuse. Indicators of sexual abuse include, but are not limited to, any nonconsensual sexual contact, inappropriate touching, forced viewing of sexually explicit materials, sexual harassment or sexual assault.
Alleged Abuse - Psychological	Using tactics, such as harassment, insults, intimidation, isolation or threats that cause mental or emotional anguish. It diminishes the person's sense of identity, dignity, and self-worth.
Alleged Abuse - Verbal	Verbal abuse is any use of oral, written or gestured language that may be threatening, demeaning, discriminatory, or insulting regardless of their age, ability to comprehend, or disability.
Alleged Neglect	Failure to provide essential services (food, water, shelter, medical, etc.) that cause actual or potential physical or medical harm, mental anguish, or mental illness.
Alleged Self-Neglect	Failing to perform essential self-care such as depriving oneself of necessities such as food, water, or medication. Consciously putting oneself in harm's way or being unable to handle needs of day-to-day living because of medical, mental health or other disabilities.
Alleged Exploitation	Evidence of deliberate intent to manipulate an individual for personal benefit or self-advancement.
Alleged Financial Exploitation	Evidence of deliberate intent to misuse funds or assets of an individual for personal benefit or benefit of another. Examples include, but are not limited to, theft, forgeries, unauthorized check-writing, unexplained disappearance of cash or valuable objects, misuse of an insurance policy, or identity theft.
Accidental Injury	Injuries to individuals with a known cause that were not a result of aggressive acts to self or others.
Fall - Accidental	Uncontrolled, unintentional, downward displacement of the body to the ground or other object.
Fall - Purposeful	Willful intent of an individual to cause downward displacement of the body to the ground or other object.

Fall - Medical condition	Uncontrolled, unintentional, downward displacement of the body to the ground or other object due to a medical condition.
Choking with intervention	An incident of choking that required intervention to clear the airway. Choking is defined as any episode of airway obstruction by food or foreign object as evidenced by one or more of the following: a) inability to speak when asked if choking (if individual is verbal); b) inability to breath or difficulty taking in adequate breaths; c) movements indicating distress such as grasping for neck or throat; d) turning blue.
Medication Error with Adverse Consequences	A failure in the medication process that results in a significant adverse reaction requiring medical attention in an emergency room, urgent care center, or hospital. Errors include but are not limited to: omission of a medication, wrong dose, wrong time, wrong person, wrong medication, wrong route, and/or wrong position.
Medication Error without Adverse Consequences	A failure in the medication process that does not result in harm. Errors include but are not limited to: omission of a medication, wrong dose, wrong time, wrong person, wrong medication, wrong route, and/or wrong position.
Hospitalization - Medical	Any admission to a hospital, either directly or through a facility's emergency room.
Hospitalization - Psychiatric	An unplanned, involuntary admission of an individual to a psychiatric treatment facility.
ER Admission	Any admission to an emergency room.
Aggressive Act for all three types (member against member, member against non-member, staff against member)	Aggressive act resulting in injury of severity ranking 3, 4, and 5.
Seclusion or Restraint	The use of physical holding and mechanical restraints and/or solitary confinement of member, which are prohibited per waiver policy.
Elopement - Greater than 30 minutes	A cognitively impaired person who successfully leaves unsupervised and undetected from a residential location or day program.
Alleged Criminal Act by a Member	Conduct that could result in criminal proceedings.

Violation of Individual Rights	A denial of an individual's rights without good cause regardless of age, race, sex, nationality, ethnicity, sexual orientation, language or religion. Examples include but are not limited to: a denial of individual's rights without the benefit of due process, breaching an individual's confidentiality, purposely allowing an individual's privacy to be invaded or breached, denial of access to the Patients' Rights Advocate, and denial of legal representation.
Environmental Threat	An event with direct impact on member health and safety occurring within or around a residential location or day program. These events can result in but are not limited to mortality, illness and/or injury, and disrupts living arrangements requiring intervention or relocation.
Media Alert	An incident that may have significant impact upon, or significant relevance to, issues of DCH public concern and/or are likely to be reported in the media.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Georgia and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Member Name: _____

Member Identification Number: _____

Health Plan Name: _____

Persons/Organizations authorized to *use or disclose* the information:ⁱ _____

Persons/Organizations authorized to *receive* the information: _____

Purpose of requested use or disclosure:ⁱⁱ _____

This Authorization applies to the following information (select **only one** of the following):ⁱⁱⁱ

- ☐ All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] **Except:** _____

- ☐ **Only** the following records or types of health information (including any dates). This may consist of psychotherapy notes, if specifically authorized:

EXPIRATION

This Authorization expires [insert date or event]:^{iv} _____

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: _____

_____.

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.^v

Neither treatment, payment, enrollment or eligibility for benefits, will be conditioned on my providing or refusing to provide this authorization.^{vi}

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).

Signature of Member or Authorized Representative

Date

If Signed by Representative, State the Relationship or Basis of Authority

ⁱ If the Authorization is being requested by the entity holding the information, this entity is the Requestor.

ⁱⁱ The statement “at the request of the individual” is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

ⁱⁱⁱ This form may not be used to release both psychotherapy notes and other types of health information (*see 45 CFR § 164.508(b)(3)(ii)*). **If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.**

^{iv} If authorization is for use or disclosure of PHI for research, including the creation and maintenance of a research database or repository, the statement “end of research study,” “none” or similar language is sufficient.

^v Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (*see 45 CFR § 164.508(d)(1), (e)(2)*).

^{vi} If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan’s eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. **Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.**

Appendix Z

Member Acknowledgement of Receipt of Forms

Completion of this form is for the Member to acknowledge receipt of the forms and information provided by ICWP Case Managers. The following forms must be provided to all ICWP Members. After receipt of the forms listed below, the member must sign and date this acknowledgement. The Case Manager must retain this form in the members record.

All Members must receive forms in Section 1. Consumer Direct Members must receive forms in both Section 1 and Section 2 and must sign both sections.

Section 1

1. Individual Plan of Care – Appendix H-1, H-2, H-3, and Reference Sheet
2. List of available Service Providers
3. Freedom of Choice Form – Appendix I
4. Member Rights and Responsibilities – Appendix B
5. Memorandum of Understanding - Appendix C or C-1 if CD
6. Advance Directive – Appendix N
7. NEMT – Appendix- M

Additional forms provided:

Member's Signature verifies receipt of the above forms:

Print Name: _____

Signature: _____ Date: _____

Section 2

Additional Forms Provided to ICWP Consumer Direct Members

1. Consumer Directed Care- Appendix P1 and P2
2. Memorandum of Understanding for Consumer Direct Member – Appendix C-1

Member's Signature verifies receipt of the above forms:

Print Name: _____

Signature: _____ Date: _____
